Health institutions as anchors

Establishing proof of concept in the NHS

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Executive summary

Health institutions have enormous potential to be part of a community wealth building framework to advance social, economic and environmental justice. Enthusiasm exists for this within the NHS and a commitment to health institutions as anchors is part of the Long Term Plan.

Despite this potential, however, our research suggests that what is lacking within the NHS is a deep intentional drive to maximise the potential of health institutions as anchors. Enthusiasm notwithstanding, this absence stems from some lack of knowledge around the concept of anchor institutions, as well as certain aspects of the prevailing policy context and NHS structure which appear to undermine the creation of social value at scale.

Background

The responsibilities of health and care organisations extends beyond the commissioning and delivery of services. In this respect, they have a broader role as agents that can affect economic and social wellbeing by developing closer links between the economy, wealth creation and people. In so doing, these organisations affect the social determinants of health - the conditions in which people are born, live, and work.

Central to this project is harnessing the potential of health institutions to advance social, economic and environmental justice through their behaviour as anchors. Anchor institutions are large public and social sector organisations which have a significant stake in a place. They can exert sizable influence by using their commissioning and procurement processes, their workforce and employment capacity, and their real assets such as facilities and land to impact upon economic, social, and environmental priorities, generating what is commonly referred to as social value.

Report summary and key messages

Our research draws on examples of emerging practice from health systems in the US, as well as a series of interviews and empirical data analysis from three typical NHS provider trusts - University Hospitals Birmingham NHS Foundation Trust; Leeds Teaching Hospitals NHS Trust; and East Lancashire Hospitals NHS Trust.

Working with these organisations, we explored the extent to which the notion of health institutions as anchors is being consciously embraced and acted upon. Our research found evidence of progressive practice around employment and the use of land, property and assets. All sites have adopted some form of pre-employment training, some are letting the local community make use of their land and assets, and some have experimented with affordable housing schemes. However,

compared to examples of anchor practice elsewhere, in sectors such as local government for example, activity within these institutions appeared to be limited in both scale and ambition.

We also conducted interviews with a series of wider NHS stakeholders (including senior leaders from NHS England, Public Health England, and the Department of Health), to explore the barriers and enablers with respect to anchor activity within the NHS.

In short, we discovered a number of positives regarding the opportunity to develop an anchor approach:

- Support for the idea of health institutions as anchors in the form of the recent commitment in the Long Term Plan to scale-up emerging practice.
- The potential for an anchor mission to be driven forward by the various collaborative arrangements that stem from both the localism agenda and devolution.
- A strong enthusiasm for the idea of health institutions as anchors. Indeed, this work itself appears to have been a key lever in building an appetite and awareness. This has been the product of both the individual and collective efforts of the Health Foundation, the Centre for Local Economic Strategies (CLES) and The Democracy Collaborative (TDC).

Nevertheless, we also identified a number of challenges that may account for the somewhat limited levels of anchor activity uncovered here.

- The drive for cost and efficiency savings appears to be taking up bandwidth within some NHS trusts, meaning that there is a lack of headroom to contemplate the pursuit of anchor activity.
- The restructuring of the NHS that has occurred post-2012, particularly in relation to the creation of NHS England and NHS Improvement, means that some NHS trusts are at times being subjected to apparently competing demands - the need to make cost and efficiency savings versus considerations of social value, in relation to sale of NHS land, for example. Whilst the two organisations have recently come together to act as a single organisation with a footprint across seven English regions, their statutory responsibilities as individual organisations remain unchanged.
- There appears to be a lack of understanding in some quarters around the concept of anchor institutions and also around how to apply social value, particularly in an NHS context.

Recommendations

The following recommendations offer a number of strategies to support the amplification of health institutions as anchors within an NHS context.

1) Targeted dissemination of key messages. Given the directive in the Long Term Plan to increase awareness of where anchor practice is taking place and encourage its uptake elsewhere, organisations such as the Health Foundation and the NHS England regional teams all have a role to play in

disseminating the key findings from this work. This is particularly important given the current lack of implementation guidance around the NHS' role in promoting anchor practice.

2) Establish a series of demonstrator sites. Whilst dissemination will help to raise awareness and may encourage more activity, it is unlikely by itself to facilitate the widespread adoption of anchor strategies. Indeed, for this to happen, more evidence is needed to both explore the implementation challenges around the adoption of anchor strategies and to generate more direct evidence about their effectiveness. These sites should include sponsorship and support from local Sustainability and Transformation Partnerships (STPs)/Integrated Care Systems (ICS), as well as NHS England and NHS Improvement in their new single integrated regional teams, to consider in more detail and work through national policy challenges - including exploring the potential to flex specific policy and structural constraints within demonstrator activity.

3) Engage the wider NHS architecture. As part of this initial work, we have explored the concept of health institutions as anchors within a hospital context. Consequently, a more complete exploration of the role that other elements of the local NHS architecture may be able to play in supporting anchor strategies ought to be considered. For example, our engagement with a group of CCGs revealed that they can play a role in encouraging social value behaviour within NHS trusts. Through the more widespread adoption of social value through the commissioning process, CCGs could become a key lever to encourage NHS trusts to deliver on social value by adopting anchor strategies.

4) Assert the role of the NHS as a key economic agent. The notion that the NHS has a role to play with respect to its wider economic and social impact should be supported by local economic development planning. As significant employers and customers, the role of the NHS within local economies needs to be more widely recognised, with NHS trusts represented in Local Economic Partnerships (LEPs) and their impact harnessed as part of progressive local industrial strategies.

5) Drive social value through the Future Operating Model (FOM). The FOM has been identified as a means of leveraging the NHS's purchasing power on a national scale to aggregate demand, centralise purchasing and deliver better value for money for NHS trusts and the taxpayer. Its current focus is on achieving the best price and quality for its customers, but this could be expanded to incorporate a much greater focus on social value.

1. Introduction

There is a growing necessity to build local economies that work for all. Poverty, low wages, inequality and under-employment are entrenched features of many local places. The promise of economic growth is often just that, with many failing to see the benefits.

It is increasingly clear that the economy is not always working in ways which support individuals, families and communities. Indeed, last year, OECD data showed that the UK is the only developed economy in which wages fell while the economy was actually growing, albeit meagrely.[1] Nearly eight million people in the UK, including three million children live in poverty despite at least one person in that family being in paid employment.[2] Food bank usage recently reached record highs, with 1.3 million people accessing three-day emergency food supplies in the space of one year.[3] In looking to create a solution, there is a need to develop the connections between the economy, wealth creation and the people.

Central to this project is harnessing the potential of anchor institutions through a community wealth building approach.[4] Community wealth building aims to reorganise and control the local economy so that wealth is not automatically extracted. Instead the intention is that wealth should be broadly held and generative, so that income is recirculated as much as possible, communities are put first and people are provided with opportunity, dignity and well-being.

Community wealth building has a particular focus on the activities of anchor institutions – large public or social organisations which have a significant stake in a place. Conceptually, the notion of anchor institutions is rooted in the discipline of institutional economics and in the views of theorists such as Thorstein Veblen who critiqued organisational cultures that are focused on materialism and the drive for pure profit.[5] This theoretical bedrock sparked a different way of thinking about institutions and the influence they have on people and society and provides the theoretical frame which has informed the notion of the anchor institution as a powerful actor within a locality.

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[1] Valentina Romei, "How wages fell in the UK while the economy grew," *Financial Times,* March 2, 2017, accessed July 2019, https://www.ft.com/content/83e7e87e-fe64-11e6-96f8-3700c5664d30

[2] "In-work poverty hits record high as the housing crisis fuels insecurity," Joseph Rowntree Foundation, 7 December 2016, accessed July 2019, https://www.jrf.org.uk/press/work-poverty-hits-record-high-housing-crisis-fuels-insecurity

[3] "Foodbank Use Remains at Record High," The Trussell Trust, 15 April 2016, accessed July 2019, https://www.trusselltrust.org/2016/04/15/foodbank-use-remains-record-high/

[4] See for example: *Community Wealth Building,* (Manchester: CLES, 2019), (forthcoming); Marjorie Kelly and Sarah McKinley, *Cities Building Community Wealth,* (Takoma Park: The Democracy Collaborative, 2015, https://democracycollaborative.org/cities

[5] Thorstein Veblen, *The Theory of business enterprise*, (New York: Scribner's,1904)

Building on this concept, the term "anchor institution" emerged in the United States in the early 2000s as a response to deindustrialisation, corporate flight, and reductions in public funding for local economic development[6]. In response to these processes, cities and localities began to focus on harnessing the power of public and non-profit institutions that were firmly rooted in place. In Cleveland, Ohio, for example, the idea of leveraging anchor institutions informed the development of the Evergreen Cooperatives, a network of worker-owned enterprises. By purchasing goods and services from these enterprises, local anchors have been able to create jobs and build wealth in areas of high deprivation that experience some of the greatest health disparities.

Various work by both CLES[7] and TDC[8] has highlighted how anchor institutions can use their sizable assets to create economic and social value in their local community. Referred to as adopting an anchor mission, this approach is characterised by a commitment to intentionally apply an institution's place-based economic power and human capital, in partnership with the local community, for the long-term wellbeing and mutual benefit of both.[9] Consequently, by using their procurement processes and spending power, their workforce and employment capacity, and their real assets such as facilities and land, anchors can impact upon the social determinants of health—that is the conditions in which people are born, live, and work.[10]

For example, CLES' work with a group of anchor institutions in Preston has seen the use of progressive anchor strategies, particularly in relation to procurement, transform the local economy.[11] Inspired, in part, by the work around the Evergreen Cooperatives in Cleveland, Preston has recently moved out of the top 20% most

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[6] Barbara Colledge and Paul Hayes, "The next Safety Net ? - Anchor Institutions and the End of the 'Peak State'." In *People, Place and Policy Conference 2016: Governing Social and Spatial Inequalities Under Enduring Austerity*, (Sheffield: 2016), 5, http://eprints.leedsbeckett.ac.uk/3138/; and Henry Louis Taylor and Gavin Luter, "Anchor Institutions: An Interpretive Review Essay," (Anchor Institutions Task Force, 2013), 2, https://community-wealth.org/content/anchor-institutions-interpretive-review-essay

[7] See for example: Matthew Jackson and Neil McInroy, "Community Wealth Building through Anchor Institutions," (Manchester: CLES, 2017), https://cles.org.uk/publications/community-wealth-building-through-anchor-institutions/; Matthew Jackson, " The Power of Procurement II: The policy and practice of Manchester City Council – 10 years on," (Manchester: CLES, 2017), https://cles.org.uk/publications/the-power-of-procurement-2/; " Local Wealth Building in Birmingham and Beyond: a new economic mainstream," (Manchester: CLES, 2018), https://cles.org.uk/publications/local-wealth-building-in-birmingham-and-beyond/

[8] See for example: David Zuckerman, "Hospitals Building Healthier Communities," (College Park: The Democracy Collaborative, 2013), https://community-wealth.org/sites/clone.community-wealth.org/files/downloads/Zuckerman-HBHC-2013.pdf; Ted Howard and Tyler Norris, "Can Hospitals Heal America's Communities?" (Takoma Park: The Democracy Collaborative, 2015), https://democracycollaborative.org/content/can-hospitals-heal-americas-communities-0

[9] Adapted from definition established in: Steve Dubb, Sarah McKinley, and Ted Howard, "The Anchor Dashboard: Aligning Institutional Practice to Meet Low-Income Community Needs," (College Park, MD: The Democracy Collaborative, August 2013), https://community-wealth.org/content/anchor-dashboard-aligning-institutional-practice-meet-low-income-community-needs

[10] Natalie Lovell and Jo Bibby, "What makes us healthy? An Introduction to the Social Determinants of Health," (London: The Health Foundation, 2018), https://www.health.org.uk/sites/default/files/What-makes-us-healthy-quick-guide.pdf

[11] "How we built community wealth in Preston: Achievements and lessons," (CLES and Preston City Council, 2019), https://cles.org.uk/publications/how-we-built-community-wealth-in-preston-achievements-and-lessons/

deprived local authority areas in the UK and was in 2018 named 'most improved city in the UK'.[12]

In the US, TDC have worked with numerous healthcare systems and hospitals to explore how they can utilise their existing assets to intervene in the social determinants of health. TDC convenes the Healthcare Anchor Network, a national collaboration of some of the largest health systems in the country, representing more than 600 hospitals, employing more than one million people, purchasing over $50bn in goods and services annually, and representing more than $150bn in investment assets.[13] Through these engagements, TDC has gathered a wealth of literature on emerging best practice detailing how hospitals have:

- leveraged their purchasing power to support diverse and locally owned businesses to fill supply chain gaps;[14]
- used local and inclusive recruitment practices to ensure that employment capacity and career pathways are reaching those residents with the greatest barriers to employment;[15]
- increased the flow of capital into the local community by using their investment portfolios, endowments and cash reserves to provide loans;[16]
- supported the development of affordable housing and promoted community control of land and housing.[17]

However, whilst CLES has worked with various anchor institutions in the UK to understand their role and impact and TDC have worked similarly with health institutions in the US, to the best of our knowledge there has not as yet been any comprehensive attempt to advance an understanding of health institutions as anchors within an NHS context. For this reason, TDC and CLES have joined together to combine their learning and experience.

As a series of large public institutions that are rooted in communities across the UK, the potential for the NHS to generate social value and impact upon the social determinants of health is significant. Employing a total of 1.6 million people in the

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[12] Matthew Jackson and Neil McInroy, "Community Wealth Building through Anchor Institutions," (Manchester: CLES, 2017), https://cles.org.uk/publications/community-wealth-building-through-anchor-institutions/

[13] "Healthcare Anchor Network," Healthcare Anchor Network, accessed July, 2019, https://www.healthcareanchor.network/

[14] David Zuckerman and Katie Parker, "Inclusive, Local Sourcing: Purchasing for People and Place," *Hospitals Aligned for Healthy Communities,* (Washington, DC: The Democracy Collaborative, 2015), http://hospitaltoolkits.org/purchasing/

[15] David Zuckerman and Katie Parker, "Inclusive, Local Hiring: Building the pipeline to a healthy community," *Hospitals Aligned for Healthy Communities*, (Washington, DC: The Democracy Collaborative, 2015), http://hospitaltoolkits.org/workforce/

[16] David Zuckerman and Katie Parker, "Place-Based Investment: Sustainable returns and strong communities," *Hospitals Aligned for Healthy Communities*, (Washington, DC: The Democracy Collaborative, 2015), http://hospitaltoolkits.org/investment/

[17] Jarrid Green, "Community Control of Land & Housing: Exploring Strategies for combating displacement, expanding ownership, and building community wealth," (Washington, DC: The Democracy Collaborative, 2018), https://democracycollaborative.org/community-control-of-land-and-housing

UK,[18] it is often the largest employer in a local area making it a critical source of jobs and economic opportunity for local populations.[19] As one of the biggest publicly funded healthcare systems in the world, the NHS has significant purchasing power. Recent information suggests that the NHS spends approximately £27bn per annum on goods and services.[20] As such, decisions about what the NHS decides to buy, and how, have the potential to build local community wealth and prosperity, with important implications for population health and wellbeing. By leveraging its core business practices to support community wealth building, the NHS can bring more resources to bear in the effort to improve health outcomes.

Report structure

In what follows, we present findings from our work across three NHS provider trusts to conceptualise the role of health institutions as anchors, highlighting relevant learning and case studies from the US context to provide an overview of these strategies in practice (section 2). We then provide an analysis of barriers and enablers affecting the potential for health institutions to fulfil their role as anchor institutions (section 3). Finally, we offer a set of recommendations and next steps for future action to harness the power of the NHS in addressing the social determinants of health in a UK context (section 4).

Methods

A range of research methods were deployed in pursuit of our aims and objectives.

These included:

- Desk-based policy analysis and review of the wider literature;
- Semi-structured interviews and thematic analysis;
- The use of descriptive statistics to analyse spend and employment data.

Further details on the methods used are provided at relevant points within each individual chapter.

Reflexivity statement

The authors of this research draw on a wide range of experience including economic development, political theory, sociology, human geography and health services research. Our ontological and epistemological approach is critical realist.[21]

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[18] "Public sector employment, UK: June 2018," Office for National Statistics, statistical bulletin, 11 September 2018. https://bit.ly/2zO1hn9
[19] "Cultural communities," NHS Employers, accessed July 2019, https://www.nhsemployers.org/your-workforce/plan/recruiting-from-your-community/engaging-with-and-recruiting-from-across-your-local-community/cultural-communities
[20] "NHS procurement in England: background," Gov.uk, accessed August 2019, https://www.gov.uk/guidance/partnering-with-the-nhs-to-sell-goods-and-services#nhs-facts-and-figures
[21] Roy Bhaskar, *A Realist Theory of Science*, (London: Routledge, 2013)

We accept that a 'real world' does exist beyond our construction of it, but that the understanding presented here is inevitably based on the perspectives and constructions of the participants and authors of any cited literature, and of ourselves.

NHS structural and policy context

Finally, before proceeding to section 2, we need to consider this work from the particular NHS structural and policy context that has been constantly evolving since its inception in 1948.

Funded primarily through the general taxation system, the NHS is a heavily centralised organisation with political responsibility and strategic leadership provided by the Department of Health. Since its inception, the NHS has been subject to frequent reform and re-organisation,[22] with public choice theory and new public management[23] providing the dominant discourse and a focus on markets, competition, incentives, commissioning and associated cultural change.[24] The NHS has also been particularly affected in recent times by financial pressures and efficiency drives from central government as well as a move towards localism and place-based planning. These various contextual elements are therefore summarised in more detail below.

Health reforms and marketisation

The first major NHS reform occurred in 1974, placing all health services into regional and area health authorities in an effort to generate better coordination between these agencies. The marketisation of the NHS began in earnest in 1991, under the auspices of the then health secretary Kenneth Clarke. The creation of the "internal market" revolutionised the structure of the NHS in separating the functions of care purchasing and care provision, both of which had been previously directed centrally from the Department of Health via regional health authorities.[25] Most recently, the reforms introduced by the Lib-Con coalition government (2010-2015), whilst building on previous pro-market reforms, also initiated a radical restructure.[26] The Health and Social Care Act 2012[27] removed responsibility for the health of citizens from the Secretary of State for Health, which the post had carried since the inception of the NHS in 1948. It abolished NHS primary care trusts (PCTs) and Strategic Health Authorities (SHAs) and transferred around £80bn of

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[22] Smith et al. "The 'redisorganisation' of the NHS," *British Medical Journal* 323 (2001): 1262-1263, https://www.bmj.com/content/323/7324/1262

[23] See: Boyne et al. *Evaluating Public Management Reforms*, (Buckingham: Open University Press, 2003); and Feelie et al. *Oxford handbook of public management*, (Oxford: Oxford University Press, 2005)

[24] Mark Exworthy and Russell Mannion, "Evaluating the impact of NHS reforms – policy, process and power," in *Dismantling the NHS?: Evaluating the Impact of Health Reforms*, ed Exworthy et al, (Bristol: Policy Press, 2016)

[25] Patrick Butler, "History of NHS reforms: A state of permanent revolution," *The Guardian,* 9 July 2010, https://www.theguardian.com/society/2010/jul/09/nhs-history-reforms-health-policy

[26] Mark Exworthy and Russell Mannion, "Evaluating the impact of NHS reforms – policy, process and power," in *Dismantling the NHS?: Evaluating the Impact of Health Reforms*, ed Exworthy et al, (Bristol: Policy Press, 2016)

[27] Health and Social Care Act 2012, accessed July 2019 at: http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

"commissioning", or health care funds, from the abolished PCTs to several hundred clinical commissioning groups (CCGs), partly run by the general practitioners (GPs) in England but a major point of access for private service providers. To oversee and support the activities of CCGs, the Act established NHS England, which manages around £100bn of the overall NHS budget and ensures that organisations are spending the allocated funds effectively. Also established post-2012 was NHS Improvement (initially called Monitor) which oversees NHS trusts and their financial sustainability. Most recently, from April 2019, NHS England and NHS Improvement have been brought together nationally and regionally in the form of seven single integrated regional teams to act as a single organisation.[28] Nevertheless, their statutory responsibilities are unchanged and they remain as separate legal entities.

Financial pressure and the drive for efficiency

In addition to the above structural context, the NHS has been under increasing financial pressure, particularly since the global economic crisis in 2008.[29] In the aftermath of this event, the NHS had to adapt from a decade of real-term budget increases of 7% each year under the Labour government to around 1% each year under the Lib-Con coalition and current Conservative governments. Furthermore, in order to meet a target of £20bn of efficiency savings between 2012 and 2015, the NHS established a Quality, Innovation, Productivity and Prevention (QIPP) programme to deliver these savings.[30] Within this context have been a number of reviews focused on cost and technical efficiency improvements.

For example, Lord Carter's 2016 report (known as the Carter review) concluded that the NHS could save £5bn by focusing on variations in its costs and practice.[31] A significant portion of this work was focused on procurement, reporting that most NHS trusts still don't know what they buy, how much they buy, and what they pay for goods and services. It found that very few trusts are able to demonstrate even a basic level of control or visibility over total inventory or purchase order compliance that is common practice in other sectors, such as retail. The report also cited what it considered to be a systematic failure to capitalise on the NHS' status as a monopoly purchaser of goods and services. Furthermore, in 2017, Sir Robert Naylor's review of NHS property and estates,[32] set out recommendations as to how

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[28] "NHS England and NHS Improvement: working closer together," NHS England, accessed August 2019, https://www.england.nhs.uk/2018/03/nhs-england-and-nhs-improvement-working-closer-together/

[29] Anita Charlesworth, Adam Roberts and Sarah Lafond, "NHS Finances Under the Coalition", in *Dismantling the NHS?: Evaluating the Impact of Health Reforms*, ed Exworthy et al, (Bristol: Policy Press, 2016)

[30] "Delivering Efficiency Savings in the NHS," (London: National Audit Offivce, 2011), https://www.nao.org.uk/wp-content/uploads/2011/12/NAO_briefing_Delivering_efficiency_savings_NHS.pdf

[31] Lord Carter of Coles, "Operational productivity and performance in English NHS acute hospitals: Unwarranted variations," (London: Department of Health, 2016), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

[32] Sir Robert Naylor, "NHS property and estates: Naylor review," (London: Department of Health, 2017), https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

the government could fund NHS reforms by selling land it no longer needs and buildings that are expensive to maintain.

Localism and devolution

Notwithstanding its centralised structure, another prominent theme within the NHS context is the drive for localism and place-based planning and delivery of care. Introduced as a central tenant of the Lib-Con coalition government, localism within an NHS context has found expression in its *Five Year Forward View,* published by NHS England in 2014.[33] In essence, this document makes the case that the future sustainability of the NHS, as well as the economic prosperity of Britain, will depend on a radical upgrade in preventative measures. It also emphasises the need for the NHS to break down how care is provided, with more care being provided locally and more local flexibility in the way payment rule, regulatory requirement and other mechanisms are applied.

As part of the implementation of this view, in 2015, NHS England asked all health and care systems to publish sustainability and transformation plans.[34] These plans involved local leaders from NHS trusts, CCGs and local government developing a shared vision of the integration of health with local authority services with a focus on prevention, social care, health and well-being. Based on these plans, new partnerships were formed in 44 areas across England. Known as sustainability and transformation partnerships (STPs) their aim is to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health.[35] In some areas, partnerships have evolved further to form an integrated care system (ICS), a new type of even closer collaboration. Integrated care systems involve NHS organisations, in partnership with local councils and others, taking collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. In return, integrated care system leaders gain greater freedoms to manage the operational and financial performance of services in their area.[36]

Finally, the other element of the localism agenda that has been accelerated under the Lib-Con coalition and subsequent Conservative administrations is devolution. For example, since signing its devolution deal with the Government in 2014, Greater Manchester has taken charge of the £6bn spent on health and social care in its ten boroughs, plus an extra £450m to transform its public services.[37] Overseeing this spending is the Greater Manchester Health and Social Care Partnership,[38] which brings together representatives from the Greater Manchester

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[33] "Five Year Forward View," (NHS England, 2014), https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[34] "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21," (NHS England, 2015), https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
[35] "Sustainability and transformation partnerships," NHS England, accessed July 2019, https://www.england.nhs.uk/integratedcare/stps/
[36] "Integrated care systems," NHS England, accessed July 2019, https://www.england.nhs.uk/integratedcare/integrated-care-systems/
[37] "About Devolution," Greater Manchester Health and Social Care Partnership, accessed July, 2019, http://www.gmhsc.org.uk/about-devolution/
[38] "The Partnership," Greater Manchester Health and Social Care Partnership, accessed July, 2019, http://www.gmhsc.org.uk/about-devolution/the-partnership/

local authorities, NHS Trust and CCGs to utilise collective experience to improve the spending of public money and ensure that decisions are made together.

The Long Term Plan

At the time of writing, NHS England have also just published their Long Term Plan with a view to future-proofing the NHS for the decade ahead.[39] Crucially, the Plan acknowledges the role of the NHS as an anchor institution and recognises that "[as] an employer of 1.4 million people, with an annual budget of £114bn in 2018/19, the Health Service creates social value in local communities." In light of this, the Plan commits to working with sites across England to identify good anchor practice which can be adopted elsewhere. As such this clearly provides a powerful policy driver for anchor activity to be scaled-up and amplified across the NHS.

[39] "NHS Long Term Plan," (NHS, 2019), https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

2. Site work

The following section examines how the notion of health institutions as anchors is both understood and interpreted at a local level by hospital provider trusts in the UK, as well as the extent to which they have adopted and are implementing anchor strategies and for what reason.

Three sites were chosen as the focus for this work:

- University Hospitals Birmingham NHS Foundation Trust (UHB);
- Leeds Teaching Hospitals NHS Trust (LTH);
- East Lancashire Hospitals NHS Trust (ELHT).

In terms of the rationale for choosing these sites, as a "proof of concept" study, it was decided that the project should focus on NHS hospital trusts as these institutions generally have the largest footprint in terms of their spend, workforces and land, property and assets. However, in choosing specific trusts to focus upon, we wanted to capture some of the variation that exists here within the context of the NHS. As such, we have a foundation trust/non-foundation trust distinction. We also have a distinction between the areas served by each trust. The sites in Leeds and Birmingham cover large urban areas, incorporating two of the largest cities in England. East Lancashire covers a less urban area, incorporating the towns of Blackburn and Burnley and their rural hinterlands.

Data collection and analysis

In conducting our research, both qualitative and quantitative methods were deployed. We collected spend and employment data and analysed the findings using descriptive statistics. Semi-structured interviews were used to explore the opportunities, challenges and barriers to anchor activity within each NHS trust. First, we examined the extent to which the ethos of the institution as an anchor is recognised by the leadership team (sense of an intentional anchor approach). Second, we took the main activity areas identified above in the introduction (spend, employment, land, property and assets) and explored the extent to which these trusts are fulfilling their role as an anchor in these areas. Findings for all three sites are therefore captured under these respective headings. Within each site, purposive sampling was used to target appropriate individuals within each NHS trust. At each site we interviewed six or seven senior representatives, covering a mixture of the following roles:

- Chief Executive and Deputy Chief Executive;
- Head/Director of Employment, Procurement and Estates;
- Director of Communications;

- Director of Medical Strategy;
- Non-Executive Director;
- Chair.

The age range of participants was roughly between 35 and 72. The sample contained a significantly higher proportion of men (83%) compared to women (17%) which reflects the profile of senior staff within these three trusts.

Sense of an intentional anchor approach

Anchor activity in each of the three trusts was limited in both scale and ambition. All of the trusts understood the concept of an anchor institution and recognised their potential to impact the social determinants of health. There was, in the main, an awareness amongst leadership teams that they ought to be doing more and even a commitment in some instances to start doing this. In UHB, for example, its 2014-2019 corporate strategy is about retaining its role as a world class care provider, but also about contributing towards wider economic and social goals which will help prevent the need to access hospital services in the first place. As one representative explained, '[o]ur previous mission focused upon being the best in care; this is still part of our mission, but we are also focused on building healthier lives.' In Leeds, they have attempted to benchmark themselves against the various elements of the anchor mission - namely procurement, employment and the use of land, assets and investments. As one of the senior team commented, "all this stuff at the moment is in one sense alien to the way we do business now, but it resonates with the values of our organisation and what we think we're about".

However, in terms of the rationale as to why trusts were not doing more to pursue anchor activity, the comments of a senior manager at ELHT were illuminating. "It's competing with what you're doing rather than part of it". When asked to elaborate, the sense was that trusts are not being measured against this kind of activity and thus there is no demand to do it, especially in a context where day jobs involve so many other pressures around running a hospital: namely treating patients and meeting targets around cost and efficiency.

In short then, there was a tension revealed here between, on the one hand, a sense of moral imperative that NHS trusts could and should be doing more in terms of their wider social and economic footprint, versus the reality and pressure of senior leadership within an NHS trust.

Despite the more limited sense of an intentional anchor approach, we nevertheless benchmarked what sites were doing around the various elements of anchor activity, teasing out the opportunities and challenges for activity to be scaled-up. In what follows, we use the headings of employment, procurement, and land, property and assets to capture this data.

Employment

Overview

Progressive employment within anchor institutions refers to the development of a set of processes to ensure that employment capacity is reaching those residents with the greatest barriers to employment, and that local residents can access career pathways within that institution. In the US, TDC has observed two elements of inclusive employment: "outside-in" strategies that create specific entry points and training opportunities for candidates that might otherwise face barriers to employment, and "inside-up" strategies to ensure that those recruited can then access career pathways.

In Minneapolis, MN, Fairview Health Services has focused on expanding recruitment activities in areas experiencing high unemployment and connecting employees and local residents to career opportunities. Since 1995, Fairview has launched an internal workforce development team to provide pipeline and career pathway opportunities for employees, students, and community residents. Apprenticeship programs were later introduced to help nurses, surgical technologists, and medical assistants with two-year degrees obtain a bachelor's degree, after which they can advance on the career ladder to a higher pay scale. Since 2017, Fairview has partnered with a local workforce intermediary to recruit residents of Minneapolis' Cedar Riverside neighborhood, where the unemployment rate is six times greater than the average. 36 residents have been hired to date.[40]

Activity across NHS sites

Employment is the area where arguably the most anchor-type activity is taking place and this appears to be an area where there is an opportunity for NHS trusts to do more.

Most notably, all three trusts have made a commitment to making employment opportunities more inclusive. Whilst this approach is to some extent linked to the need to fill job vacancies, there was a sense from all three trusts that providing employment opportunities for those furthest from the labour market is important in its own right and is what a large anchor institution ought to be doing.

ELHT work closely with the Prince's Trust and Job Centre Plus to provide pre-employment training for those furthest from the job market – such as the long term unemployed, homeless residents, people who have been struggling with drugs and alcohol and people with learning disabilities. Pre-employment training is then linked to job opportunities within their hospital sites. The trust also works with local colleges in order to create a pipeline from local communities into jobs within its various sites. They provide representatives to sit on college boards and have

[40] "Inclusive, Local Hiring & Workforce Development," Healthcare Anchor Network, accessed July, 2019, https://www.healthcareanchor.network/uploads/2/2/4/8/22483474/inclusive_local_hiring_one-pager.pdf

dedicated staff members responsible for maintaining links and for publicising the range of careers and apprenticeships that the trust has to offer.

Similarly, LTH have a pre-employment training scheme in place, offering a mixture of work experience and knowledge building around basic maths and English. The programme runs for a total of six weeks. The first two weeks are spent training at Leeds City College, then the following four weeks are spent on a work placement within the trust with ongoing support and training (four days in work, one day in Leeds City College). This knowledge building element helps to build confidence in the long term unemployed who, it is felt, often do not apply for roles within the trust because trust job descriptions ask for competency in maths and English. LTH also have a particular focus on promoting careers to young people in the local area. They have established a number of health career ambassadors and have a cohort of staff who go into schools. They offer a programme of work experience to enable young people to directly observe the work that takes place in the trust. They identified that the initial uptake of work experience placements came from younger people in more affluent areas, so they have started to specifically target schools in more deprived postcodes to redress the balance here. However, this kind of work is felt to be a challenge, as it is resource intensive and a lot of staff provide this extra support in their own time.

At UHB, again in conjunction with the Princes Trust, an onsite learning hub has been established dedicated to assisting unemployed people back into work through the provision of pre-employment training, advice and guidance. Since its inception, the activities of the hub have become linked to the direct jobs provided by the trust, in catering, cleaning and building maintenance, for example. Through the learning hub, the Trust believe they are also able to reach and provide employment opportunities for some of the most marginalised individuals in society and from some of Birmingham's most deprived neighbourhoods.

Nevertheless, despite the presence of similar schemes in all three trusts, they have not - on the whole – been integrated into corporate human resources strategy. As a senior representative from ELHT commented, they believe that they do not have a "coherent package of support", and whilst the will is there to be more progressive, "the stresses and demands of the day job mean that this kind of work is always additional; it's one more thing to do".

Employment data

As a benchmarking exercise we sought to explore and analyse the geographical footprint of each trust's spend on employee wages (summarised in table 1 below). The analysis was produced using home postcode data, along with salary figures for all employees across the three trusts.

Table 1: Geography of employment, ELHT, LTH and UHB

	Employees	% employed in local authority area(s)	% employed in wider region	% outside of wider region
Leeds Teaching Hospitals NHS Trust	18,405	69% (Leeds City)	85% (West Yorkshire)	15%
East Lancashire Hospitals NHS Trust	8,411	48% (Burnley and Blackburn-with-Darwin)	90% (Lancashire)	10%
University Hospitals Birmingham NHS Foundation Trust	9,854	61% (Birmingham City)	95% (West Midlands)	5%

East Lancashire Hospitals NHS Trust

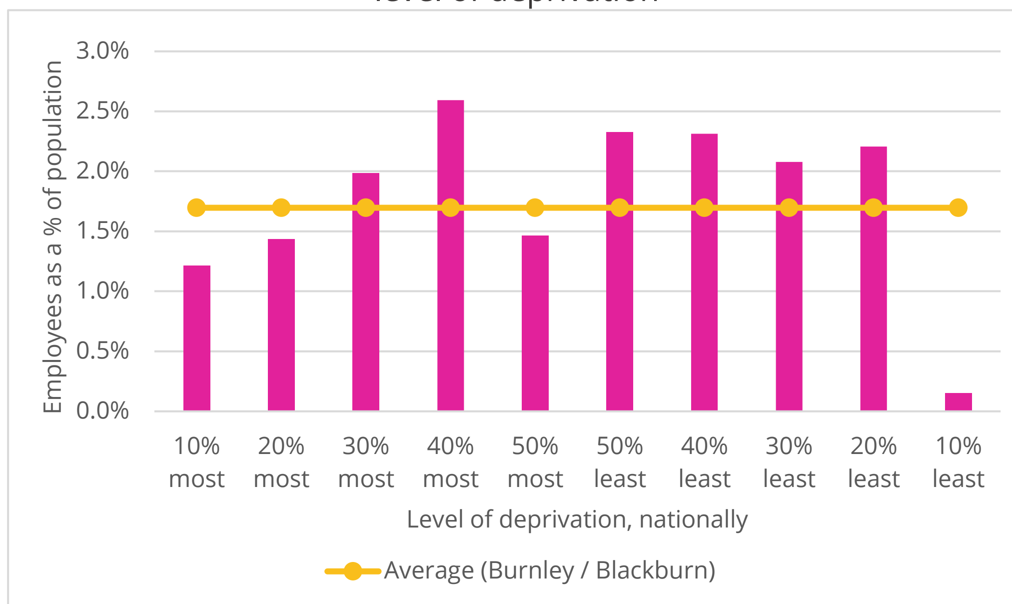
Table 2 below illustrates the gap between the average wage of residents living in the Blackburn with Darwin and Burnley local authority areas (who make up 48% of the workforce but only represent 41% of the total wage bill) and the average wages of residents living outside of these two authorities but within Lancashire. There is another, even larger, gap between employees living in Lancashire (but outside of Blackburn with Darwin and Burnley) and outside of Lancashire (who only represent 10% of the total workforce but 15% of the total wage bill).

Table 2: Wages and employees, ELHT

	Wages		Employees		
	Total	% of total	Average wage	Total (full time and part time)	% of total
Burnley or Blackburn	£90,731,133	41%	£22,615	4,012	48%
Lancashire (excluding Blackburn and Burnley)	£98,227,900	44%	£27,678	3,549	42%
Non-Lancashire	£32,982,087	15%	£38,802	850	10%
Total	**£221,941,120**	**-**	**£26,387**	**8,411**	**-**

In addition, we took data on home postcode of each ELHT employee, classified them according to their Lower Layer Super Output Area (LSOA) level of deprivation (as per the IMD 2015 rankings). Anything below the average line indicates that the Hospital is employing fewer people within these areas than would be expected if employees were distributed according to population. The average line represents the overall employment level of the hospital in relation to the population of the area as a whole. In this instance, 1.7% of residents living in Burnley or Blackburn are employed by the Trust.

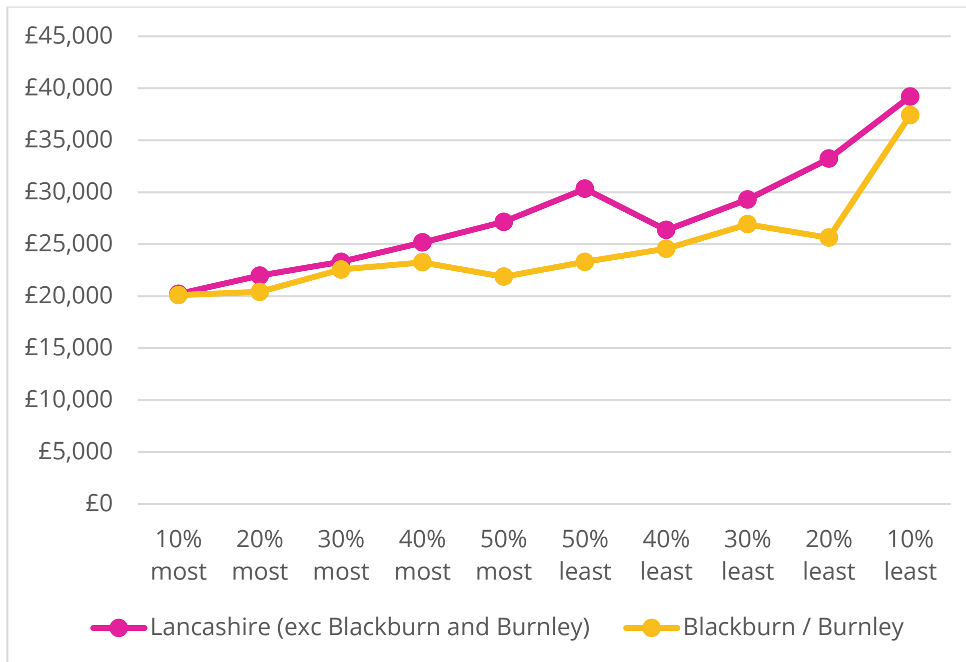
Chart 1: Number of ELHT employees as a % of population; split by level of deprivation



Consequently, chart 1 above appears to show that the hospital trust employs fewer than average people in the top 20% most deprived areas within the authorities of Burnley and Blackburn-with-Darwin.

Finally, the following chart again splits the areas of Blackburn-with-Darwin and Burnley into how deprived they are, from 10% most deprived all the to way the top 10% least deprived. It then plots this against the average salary.

Chart 2: Average wages of ELHT employees; split by level of deprivation



Generally, there is a negative relationship between average wages and levels of deprivation, with a slight gap between average wages of employees living in Burnley and Blackburn-with-Darwin compared to Lancashire (although this divergence is most pronounced in areas of medium to low deprivation).

University Hospitals Birmingham NHS Foundation Trust

As is the case with ELHT, there is a gap between employees living in Birmingham, who have the lowest wages, those living in other parts of the West Midlands, and those living outside of the West Midlands (see table 3). However, the gap in average salary between UHB employees who are employed outside of the region and those in the authority where the hospital is located, around £8,000, is smaller in UHB than in ELHT, which is around £16,000.

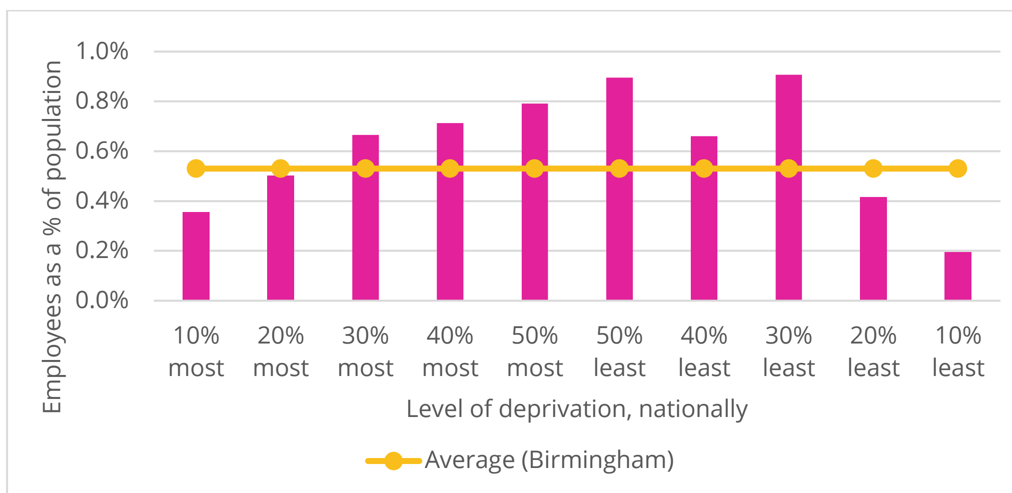
Table 3: Wages and employees, UHB

	Wages			Employees	
	Total	% of total	Average wage	Total (FT and PT)	% of total
Birmingham	£166,244,925	58%	£27,689	6,031	61%
West Midlands (excluding Birmingham)	£103,154,129	36%	£31,344	3,311	34%
Non-West Midlands	£17,938,968	6%	£35,950	512	5%
Total	**£287,338,022**	-	**£29,338**	**9,854**	-

As with ELHT, an analysis of the location of UHB employees against areas of deprivation appears to show a lower than average level of employment in the top 20% most deprived areas of Birmingham City than would be expected if distributed proportionally (see chart 3). The same trend is on display at the other end of the deprivation scale – i.e. there are fewer than average employees of the Trust living in the least deprived areas of the city.

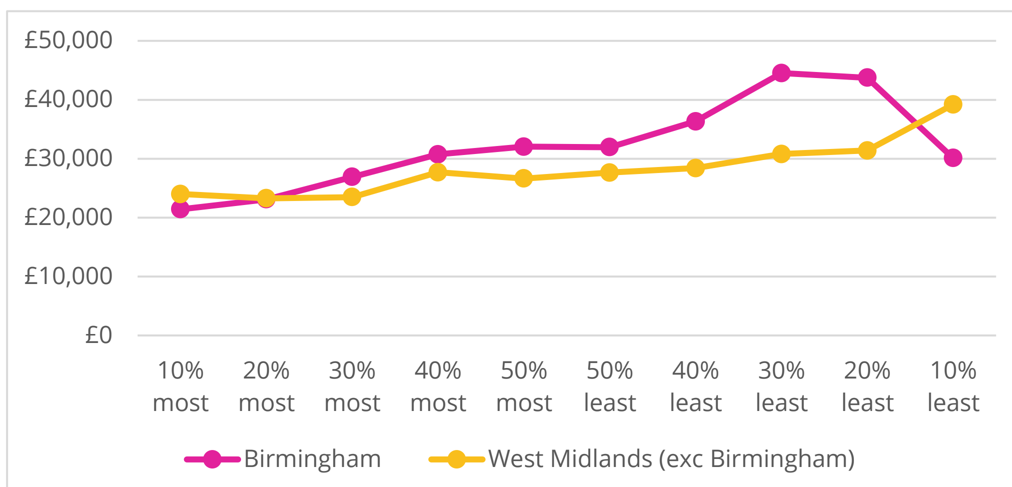
The Hospital represents a lower percentage of total employment - employing on average around 0.5% of total population in each decile, as opposed to around 1.7% within the ELHT.

Chart 3: Number of UHB employees as a % of population; split by level of deprivation



As within the ELHT, there is a negative relationship between average wages and levels of deprivation (see chart 4). Other than in the most and least deprived areas of Birmingham/West Midlands, the average wage of employees living in Birmingham are higher than those living in the West Midlands.

Chart 4: Average wages of UHB employees; split by level of deprivation



Leeds Teaching Hospitals NHS Trust

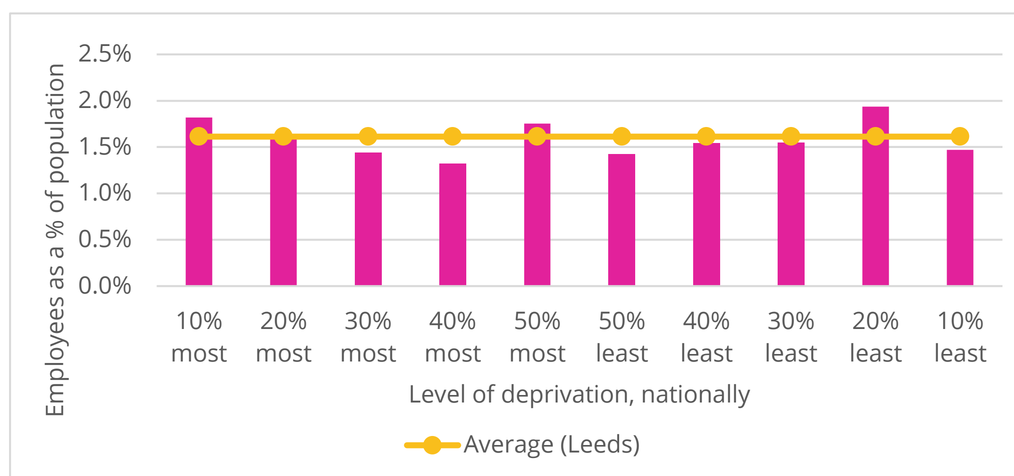
In LTH there is a divergence between Leeds-resident employees (with the lowest average salary), those resident in the rest of West Yorkshire and those outside of the region (see table 4).

Table 4: Wages and employees, LTH

	Wages		Employees		
	Total	% of total	Average wage	Total (FT and PT)	% of total
Leeds	£324,120,450	66%	£25,610	12,656	69%
West Yorkshire (excluding Leeds)	£83,511,100	17%	£27,202	3,070	17%
Non-West Yorkshire	£86,997,880	18%	£32,474	2,679	15%
Total	**£494,629,430**		**£26,875**	**18,405**	

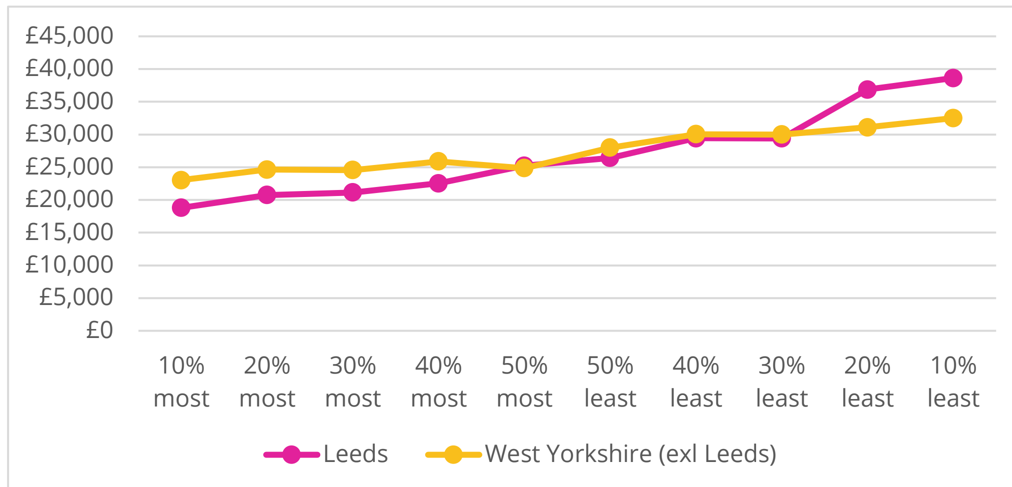
However, LTH employ an average or higher than average share of employees from the 20% most deprived areas of the city relative to its employment trends across the city as a whole (see chart 5). Out of the three trusts analysed here, this is the only one to display this trend.

Chart 5: Number of LTH employees as a % of population; split by level of deprivation



Employees in the most deprived parts of Leeds are getting paid around £4,000 less for their roles compared to employees in the most deprived parts of West Yorkshire (see chart 6 below). However, in middle-level deprived areas wages are broadly equal. The trend reverses within the least deprived parts of Leeds and West Yorkshire – i.e. employees in the least deprived areas of Leeds tend to have higher wages than those in the least deprived areas of West Yorkshire (excluding Leeds).

Chart 6: Average wages of LTH employees; split by level of deprivation



In summary then, the most deprived postcodes in ELHT and UHB are under-represented in the employment profiles of both these trusts. In Leeds, however, they are not, which suggests that its particular approach to employing individuals from the most deprived post codes may be more successful. However, further investigation would be required here to determine the role of other potential contributory factors. Furthermore, the data shows a negative correlation between wage levels and areas of deprivation in all three trusts, suggesting that people recruited from the areas of highest deprivation have not progressed into higher paid roles in the trusts.

Procurement

Procurement refers to the process of sourcing and purchasing goods and services. Within the US, local procurement strategies are becoming more commonplace with a focus on building connections with existing local and diverse businesses to ensure they can access contracting opportunities at anchor institutions.

For example, University Hospitals (UH), based in Cleveland, Ohio, has been a pioneer of inclusive, local sourcing practices. UH has a goal of spending 80% of their construction budget with local firms and increasing spending on local goods and services by 15% each year. With a total annual spend of over $830m on goods and services and $100m on construction, this represents a significant shift. A unique facet of UH's strategy has been to focus on incubating new businesses to support community wealth building in their surrounding neighbourhoods. This can be seen in the relationship between UH and the Evergreen Cooperatives. The Evergreen Cooperatives have an explicit goal to hire individuals with the greatest barriers to employment, such as formerly incarcerated residents, who might otherwise be considered ineligible for a position in the health system. Since the enterprises are worker cooperatives, workers also have opportunities to participate in decision-making and build wealth through profit sharing. The Evergreen Cooperatives are currently comprised of a laundry, greenhouse, and an environmental construction firm, with the goal of creating new cooperatives over time. Each is considered

"greenest in class," helping UH and other area anchors to meet their sustainability goals. [41]

Activity across NHS sites

However, within the NHS adopting these kinds of anchor strategies appears to be particularly challenging. All sites mentioned that the directive to move procurement activity in line with the new Future Operating Model (FOM) for procurement, and its associated procurement towers, has become the guiding principle and there is a definite push away from local procurement, towards the use of national frameworks. The FOM has been identified as a means of leveraging the NHS's purchasing power on a national scale to aggregate demand, centralise purchasing and deliver better value for money for NHS trusts and the taxpayer. However, its current focus is on achieving the best price and quality for its customers and does not appear to focus on social value.[42]

As one senior representative from LTH explained, "the dictate from centre is that you will buy them from this company". This push is said to be linked to the claim that there is too much variation in price and type of products being purchased within the NHS. Consequently, the way in which equipment, consumables and medical devices are procured is being heavily performance managed through NHS Improvement. In short, trusts are being measured on their procurement efficiency and how much national frameworks are being used. As such this makes it very challenging to adopt an intentional strategy to purchase from local suppliers.

Trusts do have more freedom when it comes to procuring services such as laundry, catering and maintenance contracts. Nevertheless, services such as linen and catering tend to be provided by large national firms. Although in theory some of these service contracts could be repackaged into smaller contracts to make them more attractive to smaller suppliers, the sense was that "piecemeal contracts" are not an attractive proposition. Crucially, trusts felt that they would need a larger team to really focus on small contracts and local spending, which would be difficult to justify in the current economic climate. Moreover, the skills mix required for this type of procurement was said to be diminishing. Because of the push towards national frameworks, numbers of staff with local procurement expertise is declining and they are not being replaced when they leave.

Another potential anchor strategy around procurement is the use of social value weighting in contracts which is particularly common in the local government sector.[43] In essence, social value weighting is used to require those supplying goods or delivering services to explain how they will also improve the economic, social and environmental well-being of the local area as part of their activities. It could be

[41] David Zuckerman and Katie Parker, "University Hospitals," Inclusive, Local Sourcing: Purchasing for People and Place, *Hospitals Aligned for Healthy Communities,* (Washington, DC: The Democracy Collaborative, 2015), http://hospitaltoolkits.org/purchasing/case-studies/university-hospitals/

[42] https://www.supplychain.nhs.uk/icc/~/media/Files/News/FOM_HANDBOOK%20Oct%202017.ashx

[43] Matthew Jackson, " The Power of Procurement II: The policy and practice of Manchester City Council – 10 years on," (Manchester: CLES, 2017), https://cles.org.uk/publications/the-power-of-procurement-2/;

used by NHS trusts for procurement activity which is taking place outside of the FOM.

In ELHT - where procurement comes under the jurisdiction of the Lancashire Procurement Cluster – they are looking to introduce a 10% weighting in their procurement frameworks to cover reducing harm, innovation, and social value. This stems from the fact that there is expertise from local government within their team. However, because of the central demand to make efficiency savings through the procurement process, they have not been able to embed this within practice as yet. As one staff member explained, unless they "deliver the numbers", they will not get the opportunity to deliver more progressive activities. Furthermore, the concern at ELHT is that the perception within the NHS is that saving money is the only function for procurement and that the demand for cost savings will keep coming: "you deliver one set and then there's more". In this kind of environment, the perception, therefore, is that it is difficult to see how social value will be able to gain any real traction.

At UHB, social value weighting is more progressed due to the fact that the local STP has a shared social value policy. Consequently, UHB does apply social value weighting in its tenders and for large contracts they monitor social value outcomes. However, social value is only weighted 5%, which is a far smaller proportion to that increasingly applied in a local government context, where it can be as high as 30%.[44]

In addition, the local government expertise at ELHT notwithstanding, there was a concern raised by all three trusts around the lack of people with social value expertise in procurement in the NHS - in essence because it has not been historically considered.

Spending data

As with employment, we sought to benchmark spend by examining procurement data on goods and services from each trusts' top 300 suppliers for 2017/18 (table 5). (Unfortunately, data from UHB was not available at this time due to internal capacity issues related to contingency planning around Brexit).

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[44] CLES. (2017). The Power of Procurement II. The policy & practice of Manchester City Council - 10 years on. Available at: https://cles.org.uk/wp-content/uploads/2017/02/The-Power-ofProcurement-II-the-policy-and-practice-of-Manchester-City-Council-10-years-on_web-version.pdf

Table 5: Procurement spend of ELHT and LTH

	Procurement spend	% spend in local authority	% spend in wider region	% 'leakage' outside wider region
Leeds Teaching Hospitals NHS Trust	£482m	28% (Leeds City)	31% (West Yorkshire)	69%
East Lancashire Hospitals NHS Trust	£117m	19% (Burnley and Blackburn-with-Darwin)	23% (Lancashire)	77%

As highlighted by the data:

- During the 2017/18 financial year, ELHT spent a total of £117,304,072 upon procuring goods and services from its top 300 suppliers (by value). LTH, on the other hand, had a much higher spend, at £482m;
- Of ELHT's spend, 19% is spent with suppliers based in, or with a branch in, the Burnley or Blackburn-with-Darwen Council boundary. This compares with 28% of LTH's spend within the Leeds City Council boundary.
- Of ELHT's spend, 23% is spent with suppliers based in, or with a branch in, the Burnley or Blackburn-with-Darwen Council boundary. This compares with 31% of LTH's spend within the West Yorkshire authorities.
- This means 77% of ELHT's spend is currently with suppliers based outside of the Lancashire economy. This compares with 69% of suppliers to LTH.

To provide context to these figures, CLES has created an average of the spend of the 26 analyses they have carried out over the past few years (covering a range of organisations, from local authorities to higher education institutions, among others). The average figures are 35.9% of total spend inside the local authority boundary and 63.4% within a wider regional area.[45]

From the data then, it is clear that the majority of spend is leaking out of the region which, broadly speaking, is what is to be expected if trusts are spending money on goods through the FOM and are using national suppliers for their service contracts. However, further research is required to determine the extent to which lower levels of spend may or may not be more locally focused.

[45] Internal CLES research.

Land, assets, property and investments

Affordable housing

Overview

Affordable housing strategies leverage the capacity of hospitals to promote access to permanently affordable housing either through the actual development of housing, supporting affordable housing options for local workers, or leveraging institutional resources to promote community control of land and housing.

Within the US context, there has been significant investment in affordable housing from hospitals, given the link between access to affordable housing and health outcomes.[46] There has also been increasing interest in promoting mechanisms that move towards community control of land and housing through democratic, permanent affordability structures such as Community Land Trusts (CLTs).[47] Strategies such as these help to ensure the impact of investments in safe, healthy and affordable housing over the long term. A leading example of this is Bon Secours Health System, based in Marriotsville, MD. Going beyond simple financial investments, Bon Secours have worked with local residents around land use. In Baltimore, Maryland, Bon Secours helped build more than 800 units of affordable housing and worked with residents to convert more than 640 vacant sites into green spaces.[48] Bon Secours also donated $140,000 to support the launch of the Maggie Walker Community Land Trust (MWCLT). [49]

Activity across NHS sites

Similar to the US landscape, the development of affordable housing is something that NHS hospitals are to some extent involved in.

For example, in UHB, the Trust has sold off one of its closed hospital sites to be redeveloped for housing and negotiated that between 16-17% of the new housing stock be sold as affordable homes. In brokering this deal, the trust recognised its role in both helping its own employees to secure a home, as well as the wider community in the Birmingham area.

At ELHT, they are currently involved in two projects to develop affordable housing. First, they are developing a portion of land on one of their sites, working with a local housing association, to provide affordable housing and accommodation for key

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[46] "Healthy and Affordable Housing," Healthcare Anchor Network, accessed July, 2019, https://www.healthcareanchor.network/uploads/2/2/4/8/22483474/summary_of_han_health_systems_investments_in_housing.pdf

[47] Jarrid Green, "Community Control of Land & Housing: Exploring Strategies for combating displacement, expanding ownership, and building community wealth," (Washington, DC: The Democracy Collaborative, 2018), https://democracycollaborative.org/community-control-of-land-and-housing

[48] David Zuckerman and Katie Parker, "Bon Secours," Place-Based Investment: Sustainable returns and strong communities, *Hospitals Aligned for Healthy Communities,* (Washington, DC: The Democracy Collaborative, 2015), http://hospitaltoolkits.org/investment/case-studies/bon-secours/

[49] Jarrid Green, "Community Control of Land & Housing: Exploring Strategies for combating displacement, expanding ownership, and building community wealth," (Washington, DC: The Democracy Collaborative, 2018), https://democracycollaborative.org/community-control-of-land-and-housing

workers. They are also working with Burnley Council, who are again currently developing a piece of land to incorporate more key worker housing. Whilst the focus here is for key workers within the trust, as one representative explained, many of their staff on the lowest wages cannot afford to rent or buy a property in the local area. So whilst building affordable housing is linked to workforce requirements it is also about helping single parent families and people who cannot get on the property ladder.

Local investment opportunities

Local investment refers to the process of redirecting investment portfolios, endowments, cash reserves (including charitable fund holdings), and real assets, to increase capital flows in the local community. This might take the form of direct investments, such as providing loans to local non-profits and businesses, or investing through other institutions by placing cash and cash equivalents into local banks, credit unions or community development financial institutions (CDFIs). Rather than traditional investment vehicles, financial assets can be leveraged to provide capital for affordable housing, minority-owned, women-owned, and worker-owned business development, childcare facilities, increasing healthy food access, transit-oriented development, local infrastructure, environmental sustainability initiatives (including renewable energy projects), or other strategies that promote health and wellbeing.

Within the US, Catholic health systems have the deepest history of place-based investment. This stems from their explicit orientation towards social justice and advocacy. For instance, Dignity Health, headquartered in San Francisco, California has operated a community investment fund since the early 1990s. Dignity's community investment fund has grown to more than $100m, representing one percent of investible assets.[50] TDC is observing a growing number of non-religiously affiliated health systems exploring new, place-based investment options, including using impact investment strategies for their charitable reserves and associated foundations.

Activity across NHS sites

Whilst all three trusts mentioned that they lacked the kind of financial freedom required to offer loans to community groups and/or invest in credit unions, there was a consensus that they could in theory make greater use of their charitable funds to promote economic and social benefit. However, the reinvestment of this resource for more socially beneficial returns would have to be signed-off by the trustees who also have a duty to ensure that the charity maximises its financial returns.

Furthermore, the challenge here was said to be that people often like to donate money to NHS charities for specific purposes, such as new pieces of equipment. As such developing an appropriate communications message to encourage people to donate for general local economic and social good could be difficult as people tend

[50] David Zuckerman and Katie Parker, "Dignity Health," Place-Based Investment: Sustainable returns and strong communities, *Hospitals Aligned for Healthy Communities,* (Washington, DC: The Democracy Collaborative, 2015), http://hospitaltoolkits.org/investment/case-studies/dignity-health/

not to like "fuzzy causes". Also, the sense from ELHT, for example, is that trustees do have a tendency to want to see charitable money spent and with the current equipment bill surpassing monies held in general charitable funds, accumulating a reserve here would present an additional challenge.

Progressive use of land and assets

Overview

Progressive use of land and assets refers to strategies where hospitals leverage their buildings and facilities to support community health promotion and community wealth building. Examples include co-locating non-clinical services such as financial counselling or job training in hospital buildings, or leveraging hospital campuses to increase access to healthy, affordable food. An innovative example of this in the US is ProMedica, a health system based in Toledo, Ohio. In 2015, ProMedica launched the Ebeid Institute for Population Health. Rather than just focusing on clinical care, the Institute houses facilities across sectors, including a grocery store to help increase access to healthy food, and a financial opportunity centre to connect patients and residents to services such as financial coaching. ProMedica also offers job training opportunities through its grocery store, further leveraging their facilities to increase access to jobs for local residents.[51]

Activity across NHS sites

In addition to the establishment of their onsite learning hub, mentioned above, UHB regularly allow local community groups and charities to make use of their buildings and facilities for free, giving over their conference centre to let local charities run annual conferences for example. They run a local farmers market on their land which is specifically targeted at micro enterprise within a 30-mile radius. They are also looking into how their lecture theatres could be used to screen films for free for the local community.

Similarly, ELHT are very willing to let local community groups make use of their buildings and facilities to hold meetings out of hours. They have also used the land at the front of their hospital sites to hold events focused on environmental sustainability and healthy eating, for example.

LTH do not currently allow community groups and local charities to make use of their buildings and admit that this is not something that has been "chewed-over in detail to think about how that would work". Part of the issue here is risk aversion and the perception that this could present a risk to patients or property. However, not all staff share this perception: "if you're working with a community group, these are people that you're investing trust in and therefore they are going to be responsible, in my view".

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[51] David Zuckerman and Katie Parker, "ProMedica," Place-Based Investment: Sustainable returns and strong communities, *Hospitals Aligned for Healthy Communities,* (Washington, DC: The Democracy Collaborative, 2015), http://hospitaltoolkits.org/investment/case-studies/promedica/; and Randy Oostra, "Embracing an Anchor Mission: ProMedica's All-In Strategy," (Washington, DC: The Democracy Collaborative, 2018), https://democracycollaborative.org/sites/clone.community-wealth.org/files/downloads/Promedica-web.pdf, 29

Summary of activity

The above findings highlight the kind of activity that is taking place in three provider trusts that could be included under the rubric of an anchor mission.

1) Employment appears to be the area where the most anchor activity is occurring. All three trusts offer various kinds of pre-employment training for those furthest from the labour market, partnering with other organisations to help provide opportunities that are linked to jobs within each trust.
    a) Nevertheless, compared to hospitals with established inclusive employment programmes in the US,[52] which for example have set targets around recruiting percentages of individuals from certain postcodes in areas of deprivation, activity here is not as far advanced. Indeed, our employee mapping exercise suggests that individuals from the most deprived post codes are under-represented in both ELHT and UHB. LTH appear to be doing better here which suggests that their approach to attracting individuals from areas of deprivation may be more successful. The other aspect highlighted by our employee mapping was that data shows a negative correlation between wage levels and areas of deprivation. **A more focused approach to career progression routes within each of the trusts could therefore help to address this (see recommendations)**.
    b) In addition, the motivation for the approach trusts are taking towards employment is not necessarily driven solely by an anchor mission. For example, the NHS regularly faces recruitment challenges with unfilled posts in areas like nursing.[53] It therefore has a vested interest in making its recruitment offer as strong as possible. Whilst this is understandable, and to be expected, **opportunities will not necessarily be maximised unless there is more intentionality and a firm commitment to an anchor mission in relation to employment**. **This is consistent with findings from TDC's research in the US, which has found that stated goals and commitment from top-level leadership is a critical success factor.**
2) With respect to their use of land, property, assets and investments, there are positive signs of an anchor approach here with UHB and ELHT letting community groups make use of their buildings and facilities, and with LHT having an aspiration to do so.

[52] David Zuckerman and Katie Parker, "Inclusive, Local Hiring: Building the pipeline to a healthy community," Hospitals Aligned for Healthy Communities, (Washington, DC: The Democracy Collaborative, 2015), http://hospitaltoolkits.org/workforce/
[53] "NHS launches multi million pound TV advertising campaign to recruit thousands of nurses in landmark 70th year," *News,* NHS England, 3 July 2018, https://www.england.nhs.uk/2018/07/nhs-launches-multi-million-pound-tv-advertising-campaign-to-recruit-thousands-of-nurses-in-landmark-70th-year/

a) Nevertheless, a comprehensive anchor strategy with respect to the use of land and assets ought perhaps to be about more than ad hoc or token gestures and should consider how anchors can utilise property and assets to support equitable development of the local economy.

b) Whilst affordable housing is being driven forward by both UHB and ELHT, affordable housing quotas are a local authority requirement of all new developments and, as directed towards key workers, they are also a means of facilitating recruitment. Again therefore, the impetus for this drive cannot necessarily be attributed to trusts' anchor approach, although there was more of a moral imperative expressed by ELHT.

c) The use of investment opportunities to promote wider economic and social value is an area of very little activity. However, given the financial structure of the NHS, with budgets controlled by the Department of Health, there is of course much less opportunity for trusts to facilitate wider social value here.

3) Procurement appears to be an area where the NHS is struggling to do more in terms of adopting an anchor strategy. As was made clear by the spend data provided by EHT and LHT the majority of spend is leaking out of the region which, as mentioned above, is what is to be expected if trusts are spending money on goods through the FOM and are using national suppliers for their service contracts. In line with the approach taken by UHB, **social value frameworks could be introduced to guide procurement activity that is taking place outside of the FOM, although higher weighting for social value ought to be considered**.

Conclusion

By engaging with the three NHS trusts, we now have an insight into how the concept of an anchor institution is understood and what anchor activity looks like at a hospital level in these trusts. **Despite a range of anchor-type activity taking place we found a lack of intentionality regarding the pursuit of an anchor mission**.

3. Challenges and opportunities

In light of the above, the aim here is to analyse the policy architecture and structure of the NHS with a view to contextualising the findings from the site work and isolating the barriers and enablers with respect to anchor activity within the NHS. The chapter reflects upon recent debates around efficiencies, privatisation, social value, the social determinants of health, and devolution.

In order to gain insight into the impact of these various factors on the ability of the NHS to fulfil its role as an anchor institution, we conducted a series of interviews with key NHS stakeholders (including senior leaders from NHS England, Public Health England, and the Department of Health) as well a focus group comprising a number of CCG representatives. In what follows, we offer a thematic analysis[54] of our findings.

Key challenges

Structural and policy tensions

The structural impact of the Health and Social Care Act 2012 as well as the recent drive around cost and efficiency was perceived as a source of tension by a number of stakeholders.

> *"The issue we have, and this is almost exactly like the Carter stuff, is that this is basic, kind of, almost NHS England saying the opposite to NHS Improvement, because the Naylor Review basically said, 'Get rid of, sell it all to the highest bidder.' We're kind of saying, 'Really? From a long-term sustainability point of view, are you sure that's a sensible thing to be doing?' In the same way that with the Carter stuff and social value, we're kind of saying, 'Really? Are you sure that buying from the cheapest is always the best idea? Have you thought about other wider considerations too?"*

Stakeholder 2

> *"I mean, the other thing is of course, there's two things here. One is who in these trusts is listening to who, so the finance director's probably listening to NHS Improvement. The strategy director might be more listening to NHS England, so who wins in that? Then there's the tension in the national messages and the local messages, so what we hear generally is that as you*

[54] Barney G Glaser and Anselm L Strauss, *Discovery of grounded theory: Strategies for qualitative research*, (London: Routledge, 2017)

are hearing, which is great, that NHS England are thinking about this sort of stuff in a broader sense, which is really welcome, but if the national people, strategy people and they're a long way from the local offices who have that very specific relationship, which is mostly about performance management, and is about much narrower financial questions,"

Stakeholder 3

"[T]he external, national pressure of, 'Thou shalt deliver a waiting time, thou shalt deliver these quality standards, thou shalt meet your financial control,' which no one would argue against, however that message is beaten down two, three, four, five times a day, so there's little headroom or capacity to contemplate a more broad, strategic view of what we might want to do and how we are positioned as, like I said, a significant organisational body within the local area."

Stakeholder 9

Historical culture

Whilst the NHS is moving towards an increased focus on prevention, as detailed in its Five Year Forward View, a number of stakeholders mentioned the fact that the NHS is still perceived largely as a place where people are treated and that this creates something of a barrier in terms of considering the NHS' role in tackling the wider social determinants of health.

"[P]eople perceive the NHS as, 'you go to hospital for an operation or you go to your GP for a prescription"

Stakeholder 9

In terms of the rationale for this, the following comments are illustrative.

"I think culturally, the reason the NHS struggles is, hospitals are still seen as places where people go when they are ill, and they're not really seen as a place which offers a population-based, or community-based approach to healthcare. Maybe the cultural and philosophical issues go back to-, predating the creation of the NHS, if you like, in terms of hospitals, and their role as sanatoriums, and places where people went when they were ill. I think that's why it's quite hard to break that cultural cycle."

Stakeholder 6

"I don't think the NHS, in terms of its DNA, if that's the right expression to use in this context, really gets, sometimes, that bigger picture. Yes, it can get about, you know, public health and the population health, and the role of the healthcare worker, the health professional, or whatever, in terms of that part of the agenda. I don't think it really thinks through its wider, if I can call it, corporate community agendas in its broader context in the same ways as a university probably would. Universities, I think, for quite a number of years

have been thinking through, how do they connect with their communities in a broader and wider sense than just taking as many bums on seats as they can from the local area. So, you know, I think there is something there where universities and local authorities have thought this through more fully earlier than the NHS have."

Stakeholder 10

"[I]t's got to focus on cancer, it's got to focus on cardiovascular, got to focus on diseases, and services, rather than a real look at community-based, population health management approaches, and so on... We need a greater focus on safe and affordable housing, and much more around community-based approaches to help lonely elderly people, and others who are isolated, and feeling displaced from society. I think that it will make a massive difference to unscheduled attendances in care facilities."

Stakeholder 6

Lack of knowledge and understanding

Coupled to the historical cultural view described above is the perception that the NHS does not really understand social value and how to apply it, particularly in relation to the concept of anchor institutions.

"I think, in many ways, I'd say very, very, very few people I speak to, in the NHS, are aware of this phraseology-, even of the phraseology, let alone what it means. It's almost, it's a step too far at this point, is how it feels, because folk are so entrenched in the daily grind of delivering for the NHS."

Stakeholder 9

"[T]he social value, we are simply asking NHS people, and expecting NHS executives, or procurers, to embed social values without any understanding that much of the value's going to be outside our sector. So, for an NHS manager, you're pretty much being told to spend more. You're not being told to stick to your local partners to understand where the value exists, you know. So, we're expecting social value to take hold, without really understanding anything about the value."

Stakeholder 5

In order to tackle this lack of understanding, as one stakeholder explained:

"There almost needs to be a bit of a bridging lesson between what an anchor institution is, what it means for you... It's not new it's just, part of it is, the language has been around, you've just not been exposed to it, but in different sectors, other sectors, this is standard parlance."

Stakeholder 9

Key opportunities

Despite the challenges faced by the NHS, its unique policy and structural context is felt to offer a number of potential opportunities for it to develop its role as an anchor institution.

Collaboration, localism and devolution

First, the potential for collaboration between both national agencies and other local anchors was felt to be a key driver that could be utilised more within the NHS.

> *"For any of this activity around anchor institutions to really happen we need more effective collaboration. This needs to be between NHS England, NHS Improvement and individual trusts. We need to balance out the need to be both efficient and effective and need to be working towards a set of objectives that balance both out core care work and our wider duty to communities... We also need to work more collaboratively at the local level. We are organisations which are based in communities. We should work in partnership both with our service users and with the range of partners at the local level including local authorities and LEPs"*

Stakeholder 13

In addition, strong leadership was deemed to be crucial to successful collaboration.

> *"[T]o enable the role of health organisations as anchors to be realised there has to be leadership........from the trusts and also from directors of public health and CCGs."*

Stakeholder 16

> *"[I]t is the leaders of-, all of those local system bits and regional system bits, they're the people that matter, because they are the people that have their hands on the decisions."*

Stakeholder 3

Second, and related to the point above about collaboration and leadership, STPs in particular were seen as an area where anchor activity could be focused.

> *"I do think it's the local system leadership which is a big phrase. It is the STP leaders. It is, and some of that gets driven by NHS England. It is the leadership of the STP. Some of that includes local authorities."*

Stakeholder 3

> *"So, how do we, almost, get a vocabulary that becomes commonplace? Part of that could be driven through the STP."*

Stakeholder 9

“I've just been on the health and wellbeing board this morning where, again, we're talking about closer partnership, closer integration. That in itself brings with it, you know, that clout, influence, and determination, how we spend a lot of the money to benefit the population, but also linking in with a whole series of other organisations.”

Stakeholder 10

Two caveats raised here however relate, first, to the pressure of running a hospital and the suggestion that this could overwhelm the capacity of anchor-type activity driven by an STP. Second, the mechanism through which STPs can gain access to additional funding was felt to create a perverse incentive which one stakeholder felt could be detrimental to the pursuit of social value.

“There's only so much capacity that individuals have, individuals that are working really hard, and you know, quite rightly, not to say, 'Oh, we've done the right thing,' but that's a pressing thing in front of you, and have we got enough beds for tonight? So, them [the STP] bringing in the whole prevention and sustainability agenda is there, but isn't at the top.”

Stakeholder 12

"[S]o what NHS England has said is that... 'Right, if you can send us a good plan for how you're being sustainable,' and that's financially sustainable locally, 'You get a slice of this. You can get a slice of this transformation funding,' which is basically a reward, 'But you've got to hit what's called your control total... 'If you don't hit that, you don't get this further release of cash.' What is happening, some areas are going, 'Right, crikey, we've got some unused estate here. If we sell that quickly, that means we get into balance. That means we get access to this cash pot.' So they are being short-term, getting rid of estates, flogging it off, whatever they can get the money for, in order to show their annual accounts are in balance, in order to qualify for this further cash... [B]ut meanwhile, they've sold this asset, which might be useful to them in the future, or at least they haven't thought it through about what it's for, so there are these incentives constantly in the NHS system, usually to try and keep the system into some form of balance.”

Stakeholder 3

In addition to STPs, the health and social care settlement in Greater Manchester was mentioned by one stakeholder as an area where wider social value is being pursued as part of their core function.

“The health and social care strategy that we've got, we very much try to develop that as being a broad plan for the health and wellbeing of Greater Manchester, not purely a plan for the NHS and GM. We're trying to make that distinction, and actually say the whole of the public service, the whole of civic society has a role in improving health and wellbeing.”

Stakeholder 4

However, the settlement in Greater Manchester is of course currently unique and the opportunity for other areas to negotiate a similar deal could therefore be questioned.

> *"I think the appetite in central government to discuss some of this isn't what it was three or four years ago. Obviously, George Osborne was quite a big sponsor of the devolution. He's obviously off the scene now, and obviously, kind of Brexit taking over everything at central government level, whether there's the actual bandwidth in central government to have those conversations at the moment, we're less clear on."*

Stakeholder 4

CCGs as drivers of social value

The potential for the CCG to drive forward an anchor mission was mentioned during our focus group with CCG representatives. In essence, it was pointed out that a large portion of CCGs' budgets is spent commissioning services in NHS trusts. As one focus group representative mentioned, out of their £840m budget, £350m is spent in the local teaching hospital. As such, there was a consensus that CCGs should play a role in encouraging social value behaviour within NHS trusts. "We should be directing the hospitals" remarked one representative. Furthermore, it is precisely this approach that some progressive CCGs are already adopting, as was mentioned during one of the stakeholder interviews.

> *"[The] CCG produced their Social Value Charter. So from my perspective, it was really great, because I was able to say to the trust, that we needed, as well as us putting it in contracts, as part of the Public Services Act, we're technically a supplier. We supply healthcare services to the CCG, so now we have to monitor it ourselves."*

Stakeholder 1

Progressive in-sourcing

Finally, as was highlighted, particularly in the previous chapter, embedding social value within procurement is a challenge within the NHS. However, one solution to this may be for trusts to take advantage of insourcing opportunities when they arise and bring certain services back in-house. This was achieved in one NHS trust recently with respect to catering.

"We just brought the contract back in-house, and what we've done is we've guaranteed the staff a return to NHS terms and conditions."

Stakeholder 11

Summary and discussion

As highlighted by the above thematic analysis, the NHS policy context presents both opportunities and challenges with respect to it fulfilling its role as an anchor

institution. To summarise, in terms of the opportunities for anchor activity to be scaled-up:

1) **Despite some apparent lack of understanding, there is an enthusiasm for the idea of the NHS as an anchor institution** and more specifically a sense of responsibility that ought to be fulfilled. Many of the stakeholders talked about what the NHS should or could be doing. Harnessed in the right way, this could be a powerful driver to increase anchor activity. Indeed, this work itself appears to have been a key lever in building an appetite and awareness. This has been the product of both the individual and collective efforts of the Health Foundation, the Centre for Local Economic Strategies (CLES) and The Democracy Collaborative (TDC).
2) Although the policy context presents a challenge, particularly in relation to the cost and efficiency agenda, it does also offer support for the idea of anchor institutions. Despite the fact that treatment is often the NHS' main area of focus this is beginning to change, particularly through policy initiatives such as the Five Year Forward view and the emphasis on prevention. Indeed, the NHS has been described by The King's Fund as "the most powerful policy lever there is over the wider determinants of health".[55] Crucially, with **the explicit support for the NHS as an anchor institutions stated in the Long Term Plan, this acts as a powerful policy driver going forward**.
3) There is the potential for an anchor mission to be driven forward by the various collaborative arrangements that stem from both the localism agenda and devolution. **STPs in particular offer a mechanism through which NHS trusts can interface with and be influenced by the activity of other anchor institutions, especially local authorities**.

Nevertheless, in terms of the main challenges:

1) **The drive for cost and efficiency savings appears to be taking up bandwidth within some NHS trusts** meaning that there is a lack of headroom to contemplate the pursuit of anchor activity.
2) The restructuring of the NHS that has occurred post-2012, particularly in relation to the creation of NHS England and NHS Improvement, means that some **NHS Trusts are at times being subjected to apparently competing demands** - the need to make cost and efficiency savings versus considerations of social value, for example in relation to sale of NHS land.
3) **There appears to be a lack of understanding in some quarters around the concept of anchor institutions and also around how to apply social value, particularly in an NHS context**. Publication of the Social Value Act, 2012 notwithstanding, by merely requiring public bodies to consider social value, rather than enforcing it, there is no strong incentive to implement

[55] David Buck, "The role of the NHS in tackling poverty and the wider determinants of health," The King's Fund Blog, 12 November 2014, https://www.kingsfund.org.uk/blog/2014/11/role-nhs-tackling-poverty-and-wider-determinants-health

social value.[56] As such, where knowledge and understanding are also lacking, the reasons for the absence of a social value agenda is cast into sharp relief.

[56] "Restoring Public Values in Public Services: A route map for national, municipal and citizen action," (Manchester: CLES, 2018), https://cles.org.uk/wp-content/uploads/2018/11/Restoring-Public-Values-in-Public-Services-FINAL-03_12_18.pdf

CONCLUSION AND RECOMMENDATIONS

The aim of this research has been to conceptualise the role of local NHS trusts as anchor institutions and to establish proof of concept. Our work across the three NHS sites examined how the anchor role is understood and interpreted at a local level by hospitals in the UK and the extent to which they have adopted and are implementing anchor strategies.

It told us that although there is a range of activities occurring that could be included under the rubric of an anchor mission, what's lacking here is a strong and focussed intentionality with respect to the attempt to fully embed the various anchor strategies referred to above within the operational structure of NHS trusts. In short, the act of adopting an anchor mission requires an intentional shift in institutional norms, procedures, and policies. In other words, institutions are or are not anchors based on a defined set of criteria. Whether they operationalise this status to benefit people and communities reflects a conscious choice to embrace or reject an anchor mission.

Our findings suggest that the NHS is at the beginning of a journey towards fulfilling its role as a local anchor institution. The concept of an anchor institution is not yet common parlance within the NHS and the insights gathered from our work suggest that it is not yet fully understood. However, the recent acknowledgement in the Long Term Plan that the NHS "creates social value in local communities" coupled to the commitment to identify good practice that can be adopted across England, provides a powerful driver for work to continue in amplifying and scaling-up the kind of activity we have identified as part of our research findings.

Nevertheless, this particular research has been merely to establish proof of concept and work now needs to focus on wider mobilisation. As such, the following recommendations are focused on a number of strategies to support the amplification of an anchor approach within the NHS.

1) **Targeted dissemination of key messages**. Given the directive in the Long Term Plan to increase awareness of where anchor practice is taking place and encourage its uptake elsewhere, organisations such as the Health Foundation and NHS England and the NHS confederation all have a role to play in disseminating the key findings from this work. The purpose of this exercise should be threefold.

    a) First, one of the themes arising from the stakeholder interviews and the site work was the sense that knowledge of social value, and what constitutes an anchor institution (particularly in an NHS context), is not deeply held or embedded. As such, all three organisations have a role to play in explaining what social value is and how it can be advanced through the deployment of anchor strategies and approaches. Furthermore, the link to the impact on the social determinants of health and the way in which anchor strategies can be used to drive improvement here should be made. **Evidence from other sectors, such as CLES's anchor work in Preston, could be cited as an example of impact**.

    b) Second, by highlighting what NHS trusts are already doing (particularly around employment, the use of land and assets and social value weighting in tenders) **the intention should be to encourage others who are as yet to take-up the anchor mission to start doing so**.

    c) Third, for those sites who are already engaged in anchor activity, the message needs to be focused on scaling-up and amplifying the good work that is already being done. In the case of anchor employment strategies, **sites should be encouraged to look more closely at where within their local communities they are recruiting and employing their staff from as well as progression routes into higher paid roles**. As our basic employment mapping exercise highlighted, there are areas of deprivation that are underrepresented in the employment profiles of both ELHT and UHB and a negative correlation between wage levels and areas of deprivation in all three trusts.

The need for targeted messaging and clear leadership directive is also supported by findings from the US experience. One of the key lessons learned from TDC's Healthcare Anchor Network has been the need for leadership buy-in and dedicated resourcing to support anchor strategies. TDC has observed

the greatest success at hospitals and health systems that have articulated the need for these shifts from the top. Practices such as integrating the anchor mission into strategic plans, changing compensation and incentive practices to reward anchor activities, and creating new roles to advance the anchor mission ensure that programs are more than just one-off projects. Internal education is a critical component of ensuring adoption across the system.

2) **Establish a series of demonstrator sites**. Whilst dissemination will help to raise awareness and may encourage more activity, it is unlikely by itself to facilitate the widespread adoption of anchor strategies. Indeed, for this to happen, more evidence is needed to both explore the implementation challenges around the adoption of anchor strategies and to generate more direct evidence about their effectiveness. The need for this is particularly acute given the fact that the current implementation guidance accompanying the Long Term Plan contains no further details on the NHS's role as an anchor. **By establishing a series of demonstrator sites**, in a range of locations to reflect the fact that NHS Trusts are at different stages in their anchor journey, **the benefits and challenges of an anchor approach could be more thoroughly explored**. Demonstrator sites should:

    a) **Make use of action learning to drive forward change and scale-up anchor strategies**. Action learning involves small groups working on real problems, taking action and learning as individuals, as a team, and as an organisation. It helps organisations develop creative, flexible and successful strategies to pressing problems. For example, **this approach could be used to determine how employment programmes could make better use of deprivation data for more targeted recruitment. It could help delve into where, despite the procurement limitations imposed by the FOM, there may still be opportunities to localise certain elements of spend. It could also look at how charitable funds could be used to generate wider social value, working through any governance and regulatory issues that this might present**.

    b) **Include sponsorship and support from local STPs/ICSs, NHS England and NHS Improvement (in their new regional guise)** to consider in more detail and work through national policy challenges, including exploring potential to flex specific policy and structural constraints within demonstrator activity. **There is an apparent tension in the current policy direction within the NHS**. The kind of directives contained within the Long Term Plan

(support for the NHS as an anchor institution and the drive to improve population health via STPs/ICSs which will involve taking action on the social determinant of health) are not necessarily in harmony with the drive for cost and efficiency savings. Whilst all of these elements are important, our research suggests that the drive around cost and efficiency may be taking up bandwidth to contemplate other policy agendas. There was also the suggestion that STP/ICS directives may, in practice, end up playing second fiddle to the demands of running a hospital. **By involving both STPs and national NHS bodies directly in the demonstrator sites there is potential to further investigate and test alternatives to these apparent conflicts**.

Providing a series of real-life examples of health care anchors in practice should help to mobilise knowledge and facilitate implementation, particularly where there may be scepticism around the lack of an evidence base. It should also help to build skills and capacity within the sector. Again, this approach has been successful in the US with the development of the Healthcare Anchor Network, where structured peer learning opportunities have led health systems to shift their business practices.

3) **Engage the wider NHS architecture**. As part of this initial work, we have explored the concept of the NHS as an anchor institution within a hospital context. Consequently, a more complete exploration of the role that other elements of the local NHS architecture may be able to play in supporting anchor strategies ought to be considered. For example, **our engagement with CCGs revealed that they can play a role in encouraging social value behaviour within NHS trusts**. Through the more widespread adoption of social value through the commissioning process, CCGs could become a key lever to encourage NHS trusts to deliver on social value by adopting anchor strategies. Furthermore, **appropriate social value frameworks could also be used to encourage social value behaviour in other deliverers of NHS services such as GP practices, as well as other private or VCSE sector partners**.

4) **Assert the role of the NHS as a key economic agent**. The notion that the NHS has a role to play with respect to its wider economic and social impact should be supported by local economic development planning. As significant employers and customers, **the role of the NHS within local economies needs to be more widely recognised, with NHS trusts represented in Local Economic Partnerships and their impact harnessed as part of progressive local industrial strategies**.

Drive Social Value through the Future Operating Model (FOM). The FOM has been identified as a means of leveraging the NHS's purchasing power on a national scale to aggregate demand, centralise purchasing and deliver better value for money for NHS trusts and the taxpayer. Its current focus is on achieving the best price and quality for its customers **but this could be expanded to incorporate a much greater focus on social value.**

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