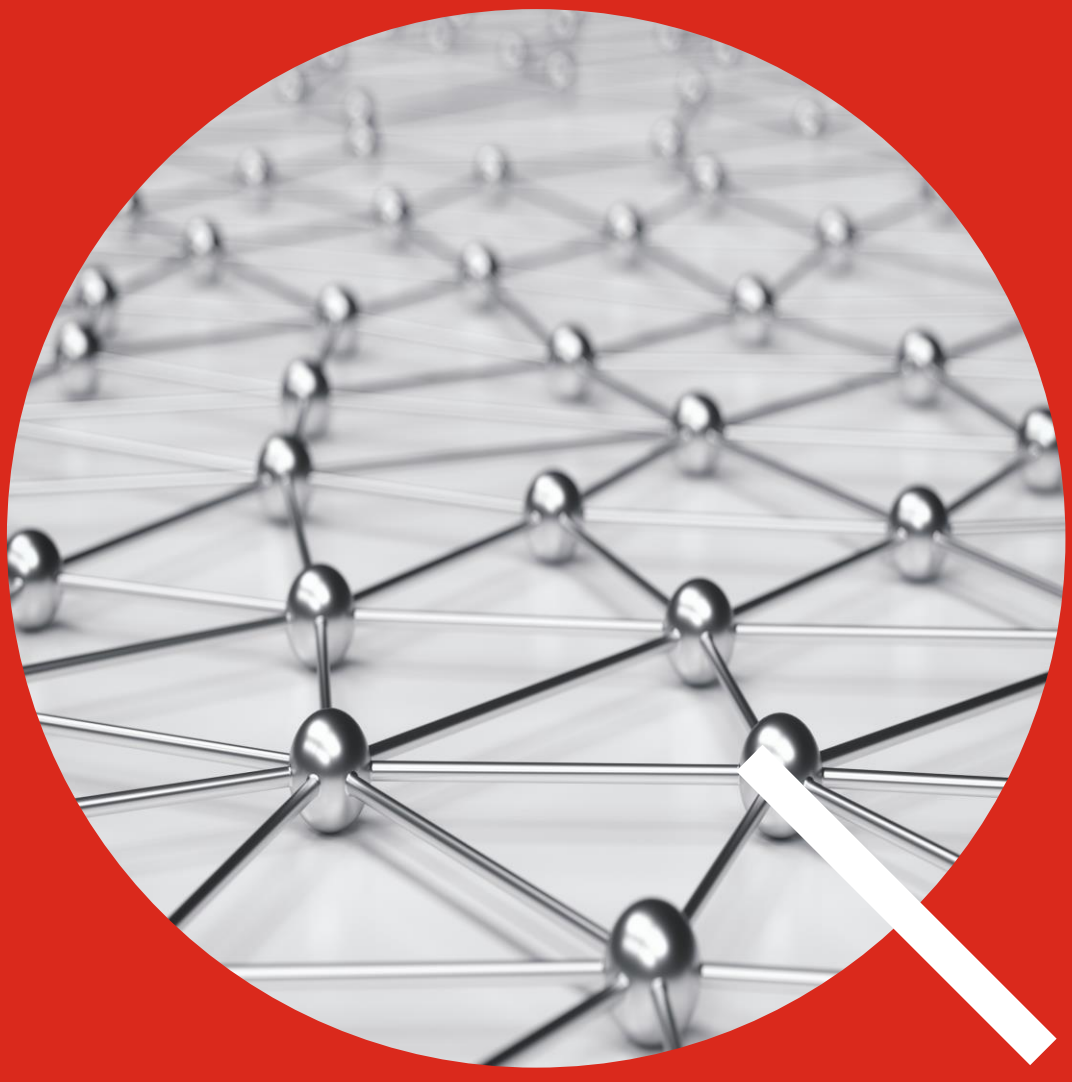
June 2023

Evaluation of the Health Anchors Learning Network

Final report



SQW

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Executive summary

1. Anchors are defined as large organisations, which are unlikely to relocate, that can have a significant impact on their local populations through various roles including employment, procurement and use of capital and buildings/estates. The size and place-based nature of many NHS organisations means they qualify as anchor institutions and thus they have the opportunity to improve the social determinants of health in their local communities via how they choose to employ people, purchase goods and services, use their buildings and spaces, reduce their environmental impact, and work with local partners.

2. The Health Foundation and NHS England jointly funded the Health Anchors Learning Network (the HALN) from February 2021 to February 2023. The aim of the HALN was to facilitate a sustainable learning network of NHS anchors (and their partners) focused on improving social, economic and environmental conditions in order to tackle health inequalities, primarily by increasing awareness of the anchor role of NHS organisations and building capability across the NHS to scale and spread effective anchor practice (that is activities that support an organisation's role as an anchor). The Health Foundation and NHS England agreed that a network would be an effective way to build the capability of organisations to act as anchors by facilitating the sharing of information, clarification and innovation of approaches, development of an evidence base for the impact of NHS-led anchor strategies, spreading of good practice, and supporting delivery of anchor practice.[1]

3. SQW was commissioned by the Health Foundation to undertake an evaluation of the HALN, from May 2021 to February 2023. The aim of the evaluation was to assess the progress of the HALN and capture evidence of the experience and learning of those involved in the HALN to inform the ongoing design and delivery of the network.

4. The HALN has made considerable progress in its two years of delivery. Feedback from participants and stakeholders indicates that the network has grown its profile, generated good quality resources on anchor principles and practice, facilitated peer learning, and supported participants to develop and strengthen their anchor practices. The HALN is seen as a "*piece of the jigsaw*" to support and embed anchor practice in organisations.

5. While improvements to the social, economic and environmental conditions affecting health were not anticipated within the two-year timeframe, achievements to date are opening up routes to positive impact on health inequalities as a result of adoption of anchor practices by HALN participants. The network has also made early progress on HALN participants working with local partners, bringing health and care systems (for example Integrated Care Systems) on board, and influencing local strategy and national policy.

[1] Examples of anchor practice include: embedding social value in procurement frameworks; offering work placements in NHS organisations to people from deprived backgrounds or under-represented groups; and allowing local organisations that offer different types of support to patients such as benefits advice to provide services within NHS premises.

6. Routes by which HALN activities reportedly influenced participants include: offering insight and guidance; bringing together a peer group to offer opportunities for support and inspiration; and making the anchors agenda more visible and tangible through establishing an online presence, producing resources and holding events.

7. Whether the HALN can continue to make progress in achieving outcomes is both supported and constrained by the capacity available to the network, to individual participants and within their organisations; and senior support that gives permission and resources to anchor practice.

8. The HALN was granted a third year of funding to February 2024 from the Health Foundation. There are a number of strengths on which the HALN can build including: the typology of participant engagement that has allowed the network to support people at different stages of their anchor 'journey'; the network's resources and action learning sets; opportunities to network directly with other participants; the expertise of the Innovation Unit as the delivery partner; and the profile of the Health Foundation as the funder. Although NHS England will not be a formal partner in the third year of delivery, continued and visible support from NHS England is likely to be important in attracting and retaining engagement.

9. There are three main issues evident from the first two years of delivery that we suggest require further consideration:

   - More systematic collection of data on network participants to elicit in-depth insights to support planning of network activities. While some resource would be needed to support data collection (upfront) and analysis (longer term), this information should inform future delivery by the network.

   - Continued management of the balance between breadth of the anchors agenda and the depth needed for meaningful learning to occur. Ensuring there is some kind of dedicated support for participants, such as the action learning sets already delivered by the network, may be the best route to accommodating the demand for depth, against the provision of breadth through the network's resources, blogs, videos and case studies.

   - Better positioning of the network within and/or alongside other policy agendas (such as health inequalities and social value) across all four nations. More high-profile endorsement or championing of the network from a range of leaders may support greater reach and engagement. Aligning the network with other policy agendas may also provide some 'futureproofing' for the HALN, enabling it to continue contributing to relevant policy agendas such as economic and social development, social value and health inequalities.

10. There is also a range of opportunities for the HALN to exploit:

    - Maintaining engagement from network participants who are more advanced on their anchor journey to act as champions or 'change agents' within the network.

- Helping members of professional disciplines such as procurement and finance to take collective ownership of anchor practices within their organisations in order to mainstream the anchors agenda.
- Strengthening the four nations approach given the value placed on the HALN's unique mandate to work across the four nations and across all anchor topics.
- Extending the range of partners involved from across different sectors (such as housing and employment support) and different parts of systems to learn from places where anchors is more advanced, to apply anchor practices in different ways at different scales, and ultimately to develop the nature and scale of impact.
- Demonstrating (and supporting participants to demonstrate) the impact of anchor work.
- Growing from an 'information sharing' network to a 'debate leading' network, drawing on and synthesising learning from the network and actively using that to shape conversations about anchors and related topics.
- Actively planning for sustainability beyond the end of the third year from as early as possible. For example, ensuring the bank of resources about anchor practice remains accessible to NHS staff and staff in partner organisations.

Glossary

Table 1: Glossary of key terms

Term	Description
Anchor (also anchor institution or anchor organisation)	A large organisation with significant size, scale and reach that is unlikely to relocate. Anchors can have a significant impact on their local area via procurement, employment, use of capital and buildings/estates, environmental sustainability and local partnership working. The assets and resources of anchors can be used to influence the health and wellbeing of their local community.
Anchor practice	Activities or interventions delivered within organisations or across systems that seek to support an organisation's role as an anchor.
Anchor topics	The ways in which organisations can act as anchor institutions, including (but not limited to) procurement, employment, use of capital and buildings/estates, environmental sustainability, and local partnership working.
Health Anchors Learning Network (HALN)	The Health Anchors Learning Network (HALN) is a UK-wide network for people responsible for, or interested in, anchor practice in health. Throughout this report we use the term the 'HALN' or the 'network' interchangeably.
Network participants	Individuals responsible for, or interested in, anchor practice in health and who have engaged with the network in some way. Throughout this report, we refer to network participants or participants interchangeably.
Partnership	The strategic partnership between the Health Foundation and NHS England to deliver a joint programme of work on the role of the NHS as an anchor.
Programme partners	The organisations involved in the operation and delivery of the HALN (the Health Foundation, NHS England and the Innovation Unit).
Programme stakeholders	Those not directly involved in the network but with an interest in its delivery and progress.
Test and Learn Programme	A Health Foundation and NHS England funded programme providing support and funding to six organisations to make progress on their anchor journey. These organisations are participants of the HALN and learning from the Test and Learn programme was shared back to HALN participants but it was delivered externally to the network.
Four nations	Used to refer to the four UK nations of England, Scotland, Wales and Northern Ireland.

1. Introduction

1.1 The Health Anchors Learning Network (HALN) was established as a joint initiative between the Health Foundation and NHS England[2]. The Innovation Unit was commissioned to design the network and deliver the HALN for two years from February 2021. Total funding for the network over this period was £300k (including £50k for the co-design of the network). The Health Foundation provided additional funding for the HALN to run until February 2024, with NHS England providing strategic support during that period.

1.2 An anchor institution is a large organisation that has a significant size, scale and reach, may be well connected to its local community, and, crucially, is unlikely to relocate. Anchors can have a significant impact on their local area via employment, procurement, use of capital and buildings/estates, environmental sustainability and local partnership working. Many NHS organisations fit the definition of an anchor institution and thus have the opportunity to improve the social determinants of health in their local communities via how they choose to employ people, purchase goods and services, use their buildings and spaces, reduce their environmental impact, and work with local partners[3][4].

1.3 The HALN intended to support NHS organisations, and other organisations that support the health and wellbeing of local populations (see Figure 3-2 for participation by organisation type), to develop as anchor institutions by ensuring that those responsible for, or interested in, anchor practices in health were more informed about and better equipped to apply anchor practices within their organisation. The HALN aspired to act as a vehicle for identifying, collating, and sharing learning about anchor practices across England, Scotland, Wales and Northern Ireland (referred to throughout this report as the four nations). Latterly, in line with the emergence of integrated care systems and boards, the HALN's remit widened to include the application of anchor practices across health and care systems rather than just within individual organisations.

The evaluation

1.4 SQW was commissioned by the Health Foundation (with the support of NHS England as the co-funder) to undertake an evaluation of the HALN, from May 2021 to February 2023. The evaluation had two main aims:

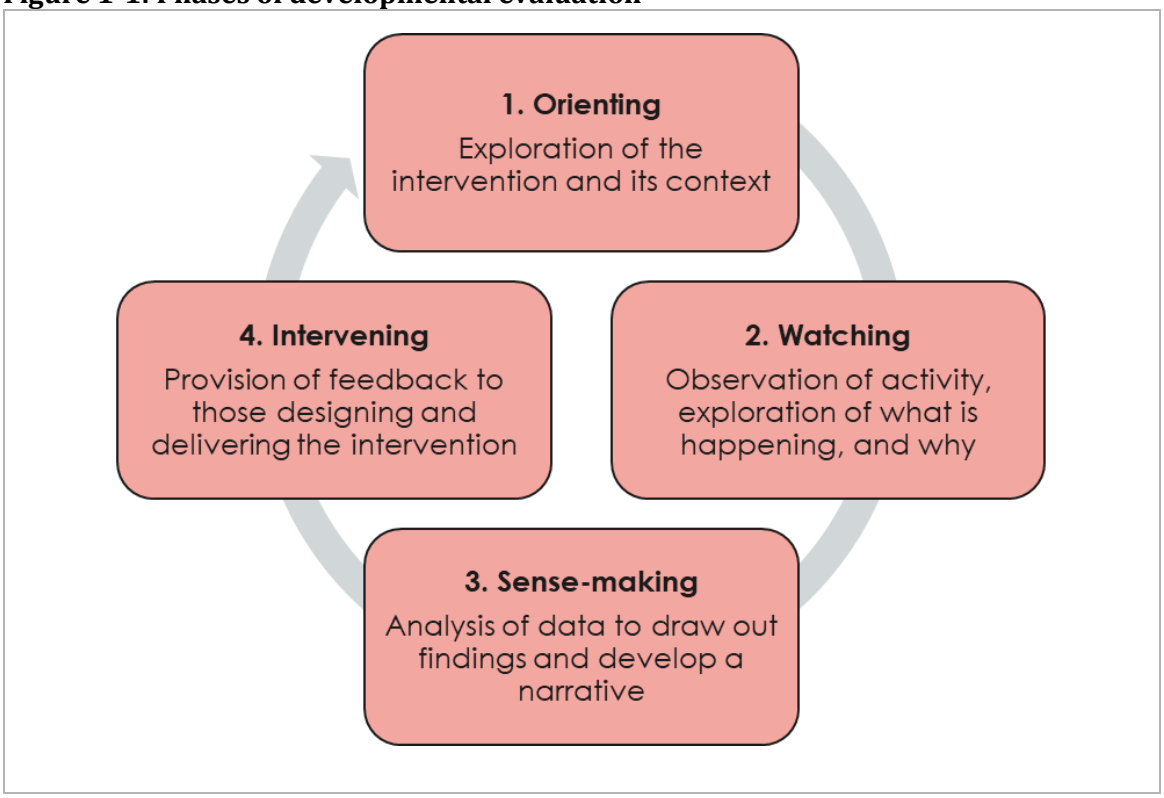
- assess progress against the HALN Theory of Change and provide feedback on how the HALN was meeting its objectives

[2] Specifically, the Health Foundation's Improvement Team and NHS England's Healthcare Inequalities Improvement Programme
[3] The Health Foundation (2019) *Building Healthy Communities: the role of the NHS as an anchor*
[4] The Health Foundation (2021) *Anchors in a Storm*

- capture evidence of the experience and learning of those involved in the HALN to inform the ongoing design and delivery of the network.[5]

1.5 The evaluation took a developmental approach. Developmental evaluation is useful for the assessment of an initiative that is expected to change during implementation and where there is a limited evidence base on what the model should look like and what changes are likely to emerge. It offers a framework in which evaluators can reflect on implementation and revise methods accordingly. Developmental evaluation also supports implementation by collecting and considering a range of evidence quickly and providing timely feedback to those implementing the initiative. It can be divided into four key stages, although in practice they are not wholly distinct and sequential (Figure 1-1). Further detail on why a developmental approach was chosen for this evaluation is presented in Annex A.

Figure 1-1: Phases of developmental evaluation

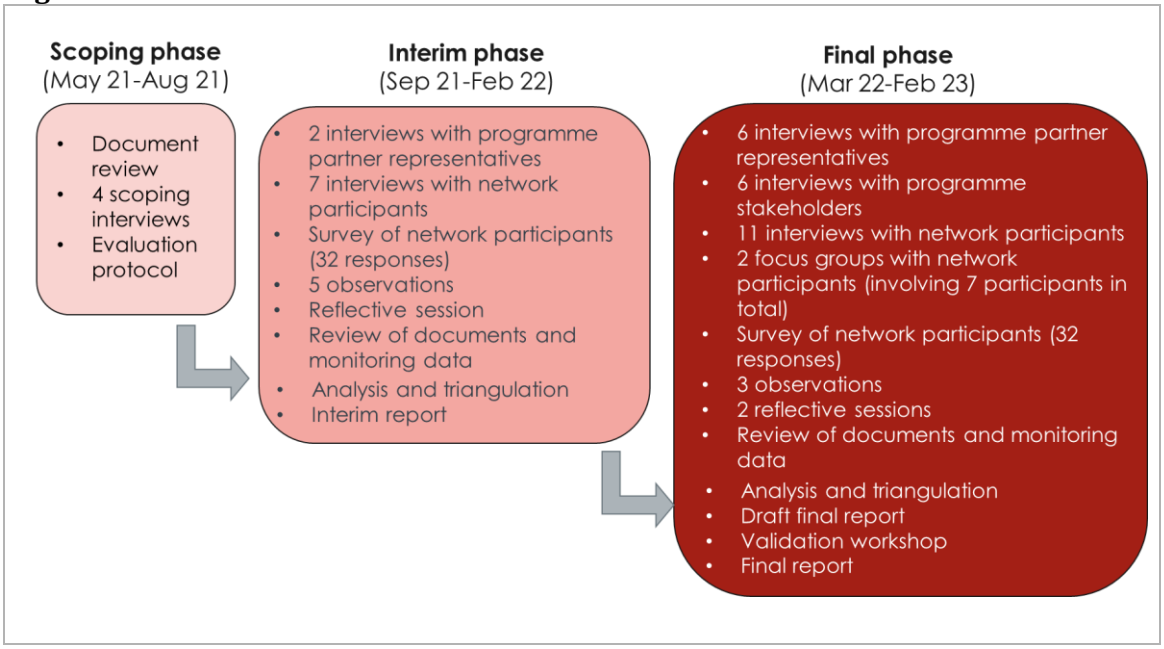


Source: SQW

1.6 The interim evaluation report (February 2022) presented an assessment of the network based on learning from the first cycle of these four stages. This final report is based on the full set of evidence collected through all the research methods, as presented in the diagram below (Figure 1-2). Further detail on the methods is presented in Annex A.

[5] The Health Foundation (March 2021) *Evaluation partner for the Health Anchors Learning Network*

Figure 1-2: Research strands and evidence collected



Source: SQW

Notes: for definitions of terms, please see glossary.

Each survey wave was conducted independently so it is not possible to identify if any respondents from wave one also responded to wave two. Both waves received 32 responses, comprising 0.02% of the newsletter population to which the survey was distributed.

Key considerations

1.7 The report should be read with the following considerations in mind:

- As reflected in Figure 1-2 above, the number of individuals, both absolutely and as a proportion of the HALN's membership, that engaged with the evaluation was small.
  - The interim survey was initially included in the HALN newsletter, with the aim of reaching the widest possible set of individuals that had engaged with the HALN. Subsequently an additional stand-alone email was sent to all newsletter recipients, which saw an increase from eight to 32 responses.
  - For the final survey, a stand-alone email was again sent to all newsletter recipients. This achieved 17 responses. A mitigation strategy was put in place, which included partners sharing the survey link via their networks and an incentive. This resulted in an increase to 32 responses.
- Evidence is primarily self-reported via interviews with programme stakeholders and participants and a survey of participants, supplemented by observations of programme and network activities.
- Network participants voluntarily submitted a response to the survey and agreed to be interviewed. While a range of experiences and views was provided by participants, the self-selecting nature of the sample may mean the evidence is not representative of the full population of participants. In particular, those that engaged less in the network are likely to be underrepresented in the sample of survey respondents and interviewees.

- Qualitative feedback from interviews and focus groups has not been quantified in the report. The qualitative research was undertaken using a semi-structured approach to explore themes important to interviewees. As not all themes were covered by every interviewee, and themes were covered to differing depths, quantification of this feedback may mislead as to the prevalence of a particular view. The report uses the following words to reflect the differing proportions of the sample that made a similar point: 'most' is used when nearly all interviewees reported a point; 'majority' is used for over half of interviewees; 'many' is used for a proportion between a majority and most; 'some' indicates fewer than half; 'few' indicates five or fewer. Points only reflected by one interviewee are made clear.
- Attribution of outcomes and impacts to the HALN is challenging given the relatively low level of engagement of most HALN participants (levels of engagement are discussed in chapter 2) and the multiplicity of factors that influence the uptake and application of anchor practice (meaning many things could cause outcomes, within which the role of the HALN is hard to discern). In response to both of these challenges, the evaluation has used a theory-based approach to measure progress against the steps towards impacts, including outputs and interim outcomes.

1.8 It is worth noting that the HALN has been granted an additional year of funding from the Health Foundation. As the network continues to deliver and develop, it is probable that further insights and learning will emerge.

2. Health Anchors Learning Network design

Chapter summary

Anchors are generally defined as large organisations, which are unlikely to relocate, that can have a significant impact on their local populations through various roles including as an employer, as a purchaser of local goods and services, and as an owner/occupier of sizeable premises or areas of land.

The size and place-based nature of many NHS organisations means they qualify as anchor institutions and thus they have the opportunity to influence the social determinants of health for their local communities via how they choose to employ people, purchase goods and services, use their buildings and spaces, reduce their environmental impact, and work with local partners

The Health Foundation and NHS England jointly funded the Health Anchors Learning Network from 2021 to 2023, based on a shared understanding that a network would be an effective way to build capability among organisations to act as anchors by facilitating the sharing of information, clarification and innovation of approaches, development of an evidence base, spreading of good practice, and supporting delivery of anchor practice.

The aim of the HALN was to facilitate a sustainable learning network of NHS anchors (and their partners), focused on improving social, economic and environmental conditions to tackle health inequalities.

During a three-month design phase, the Health Foundation, NHS England and the Innovation Unit, along with key anchor stakeholders, co-created a set of principles for the design and implementation of the HALN: action-oriented, uniquely placed, always learning, expertly facilitated mission-led, and serious about inclusion.

The Innovation Unit also used a typology of participant engagement to inform and structure the network activities. Community of interest was the lightest form of participation through to community of engagement then community of practice.

The HALN's Theory of Change outlined how delivery of activities would lead to outputs, outcomes and impacts.

2.1 This chapter sets out the rationale for the HALN, its aims, the design process and the Theory of Change.

Rationale and policy context

2.2 There is a growing body of evidence regarding anchors, including research by the Health Foundation on the role NHS organisations can play as anchors[6] and a review of anchor activity

[6] The Health Foundation (2019) *Building Healthier Communities*

during the pandemic[7]. There is also an incentive for NHS organisations to act as anchors given they have to deal with many of the consequences of poor health and health inequalities.[8]

2.3 The NHS Long Term Plan referenced the social value created in local communities by NHS organisations and made a commitment to a partnership between NHS England and the Health Foundation "*to identify more of this good practice*".[9] While the anchors agenda is much broader than the HALN, for both the Health Foundation and NHS England, the decision to fund a network was based on a shared understanding that a network could be an effective way to build capability among organisations by facilitating the sharing of information, clarification and innovation of approaches, development of an evidence base, spreading of good practice, and supporting delivery of anchor practice[10]. The Health Foundation's report 'Building Healthy Communities: the role of the NHS as an anchor' (2019) also recommended the creation of a network to support the anchors agenda.

2.4 This vision was shared by other key healthcare stakeholders[11]: the NHS Reset campaign (from the NHS Confederation) described the development of anchor networks as '*crucial*' in place-based economic and social recovery (from the Covid-19 pandemic).[12] The HALN is a mechanism that can contribute to a range of national strategies and policies:

- The NHS Long Term Plan and People Plan both include commitments to reduce health inequalities and support wider social goals beyond healthcare provision such as employment and the environment.[13]
- NHS England's Integrated Care System (ICS) design framework highlights the need for ICSs to support NHS Trusts and Foundation Trusts as local anchor institutions.[14]
- NHS Scotland's Blueprint for Good Governance (Second Edition, 2022) refers to the need to develop the role of NHS Boards as 'anchor institutions' in the local and national economy.[15]
- The Welsh Minister for Health and Social Services has made a ministerial statement about the role of NHS organisations as anchor institutions as a way to implement care and services to support individuals and communities.[16]

[7] The Health Foundation (2021) *Anchors in a Storm*
[8] Data show than people in more deprived areas (i.e. areas with poor social determinants of health) have a shorter lifespan and spend more of their life in ill health than those in the least deprived areas: Office for National Statistics (2022) *Health State Life Expectancies by National Deprivation Deciles, England and Wales: 2018 to 2020*
[9] NHS England (2019) *The NHS Long Term Plan*, p120.
[10] The Health Foundation (March 2021) *Evaluation partner for the Health Anchors Learning Network*
[11] The King's Fund (2021) *The NHS's role in tackling poverty: Awareness, action and advocacy*
[12] NHS Confederation (2020) *Health as the New Wealth: The NHS's role in economic and social recovery*
[13] NHS England (2019) *The Long Term Plan,* NHS England and Improvement (2021) *We Are the NHS People Plan 2020/21 - action for us all*
[14] NHS England (2021) *Integrated Care Systems: design framework*
[15] NHS Scotland (2022) *Blueprint for Good Governance: Second Edition*
[16] Minister for Health and Social Services (7 February 2023) *Written Statement: Ministerial Priorities for the NHS in Wales*

Aims

2.5 The HALN was a significant part of a broader joint programme of anchor work between Health Foundation and NHS England. The HALN, alongside other activities such as the Test and Learn grant funding programme, intended to contribute to three broader partnership aims:

- **1. Awareness and capability:**
  - increase awareness and understanding of the anchor role of NHS organisations and their partners and how this contributes to social value or inclusive growth
  - specify what anchor initiatives are and how they might be delivered
  - identify how to best support organisations to develop anchor strategies and build capacity across the NHS to scale and spread effective anchor initiatives and practices.
- **2. Analysis and evidence:** build evidence for the impact of NHS-led anchor strategies on socio-economic wellbeing, health outcomes and health inequalities.
- **3. Influence and alignment:** identify and (if relevant) secure changes to national guidance, policy, oversight and wider sector support that will enable NHS organisations to maximise their impact as anchors.

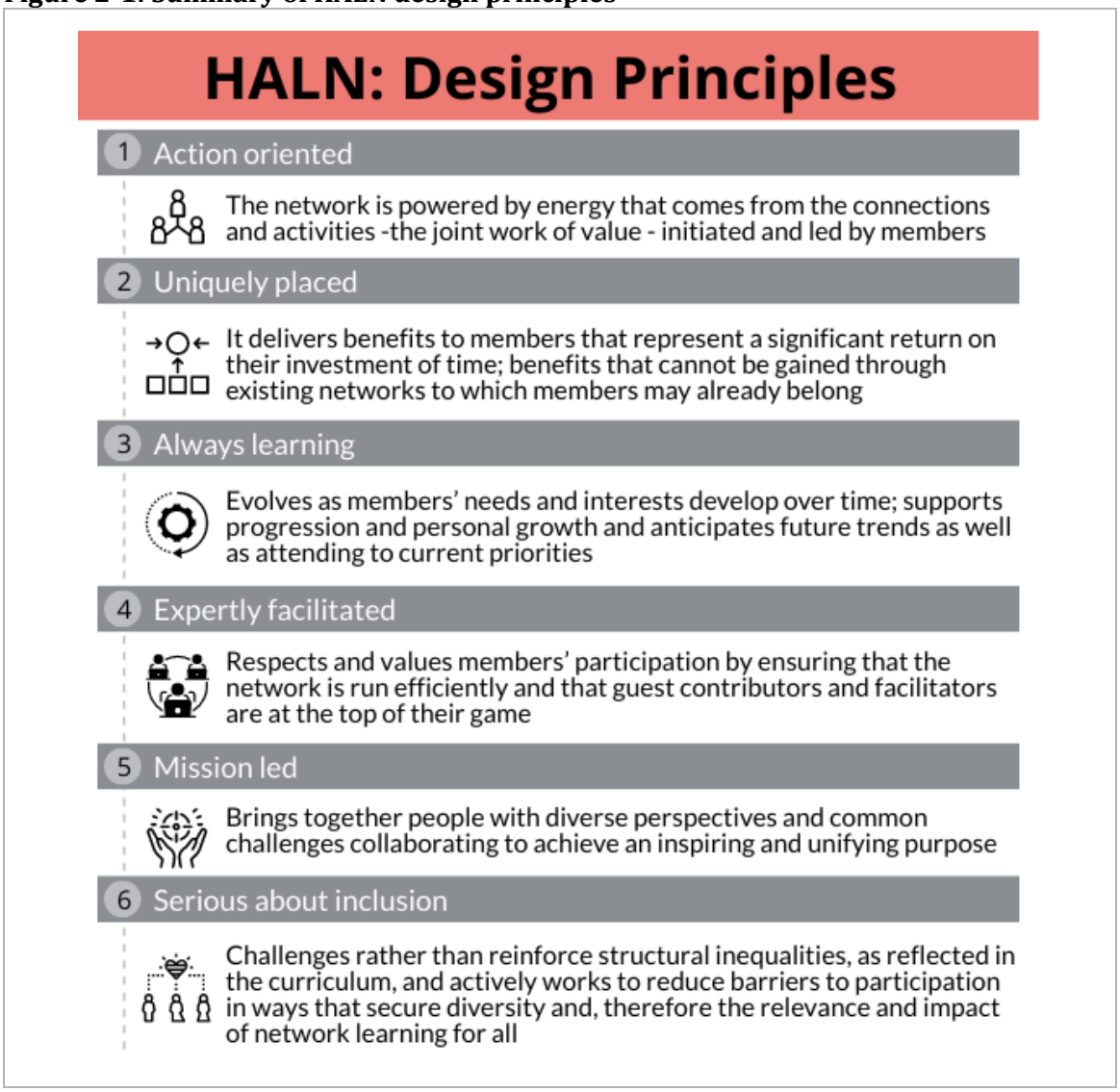
2.6 The specific aim of the HALN was to contribute to the first aim (Awareness and capability), facilitating a sustainable learning network of NHS anchors (and their partners), focused on improving social, economic and environmental conditions to tackle health inequalities.

Design process

2.7 A three-month network co-design phase, facilitated by the Innovation Unit and involving the Health Foundation, NHS England and potential network participants, was completed in January 2021. The intention behind this phase was to learn about existing practice, generate and test ideas with experts, and explore and build interest in the network among potential participants to arrive at an agreed design and plan. It involved a review of existing literature, roundtables, interviews and workshops with stakeholders and experts, collection of views from a wider audience via hosted events, and synthesis work and design sessions.

2.8 During this phase, the Health Foundation, NHS England and the Innovation Unit co-created a set of principles for the design (and subsequent implementation) of the HALN, taking account of stakeholder feedback. These principles are summarised in Figure 2-1.

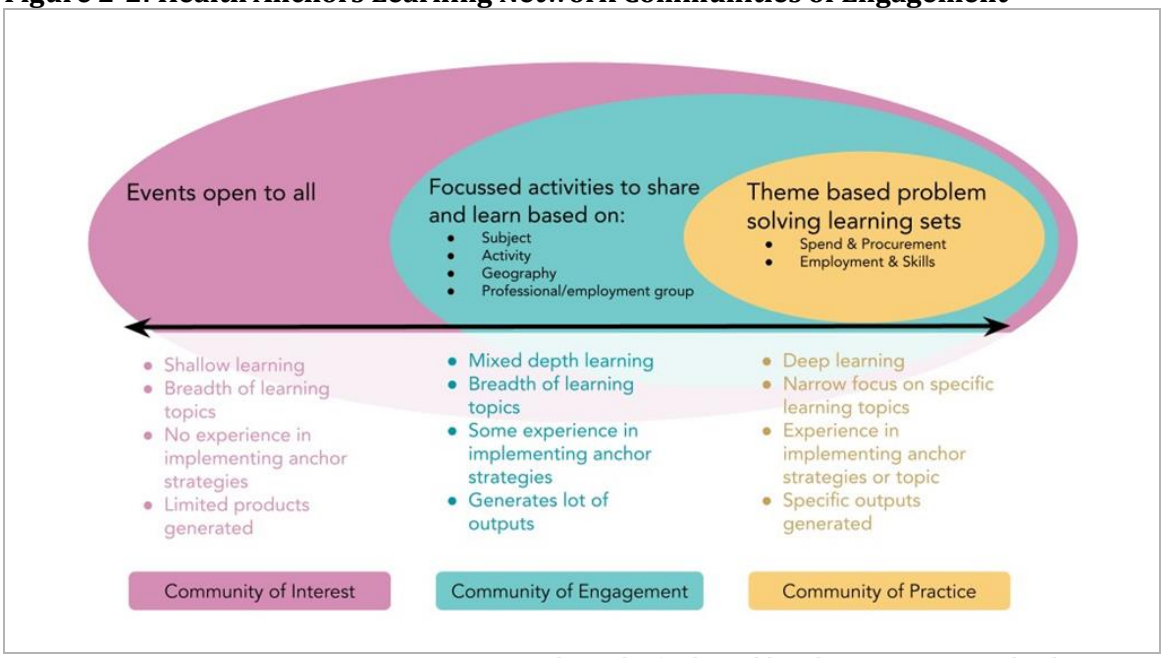
Figure 2-1: Summary of HALN design principles



Source: Innovation Unit, Delivery plan for the Health Anchors Learning Network, February 2021

2.9 Another result of the design phase was a typology of participant engagement in the network based on an understanding that potential participants had differing levels of experience, interest and capacity. There were three categories: communities of interest, engagement and practice. It was anticipated that participants would generally fall into one of these categories, although they might also move from one to the other and/or engage in all three. The Innovation Unit used the typology to inform and structure the network activities as shown in Figure 2-2.

Figure 2-2: Health Anchors Learning Network Communities of Engagement

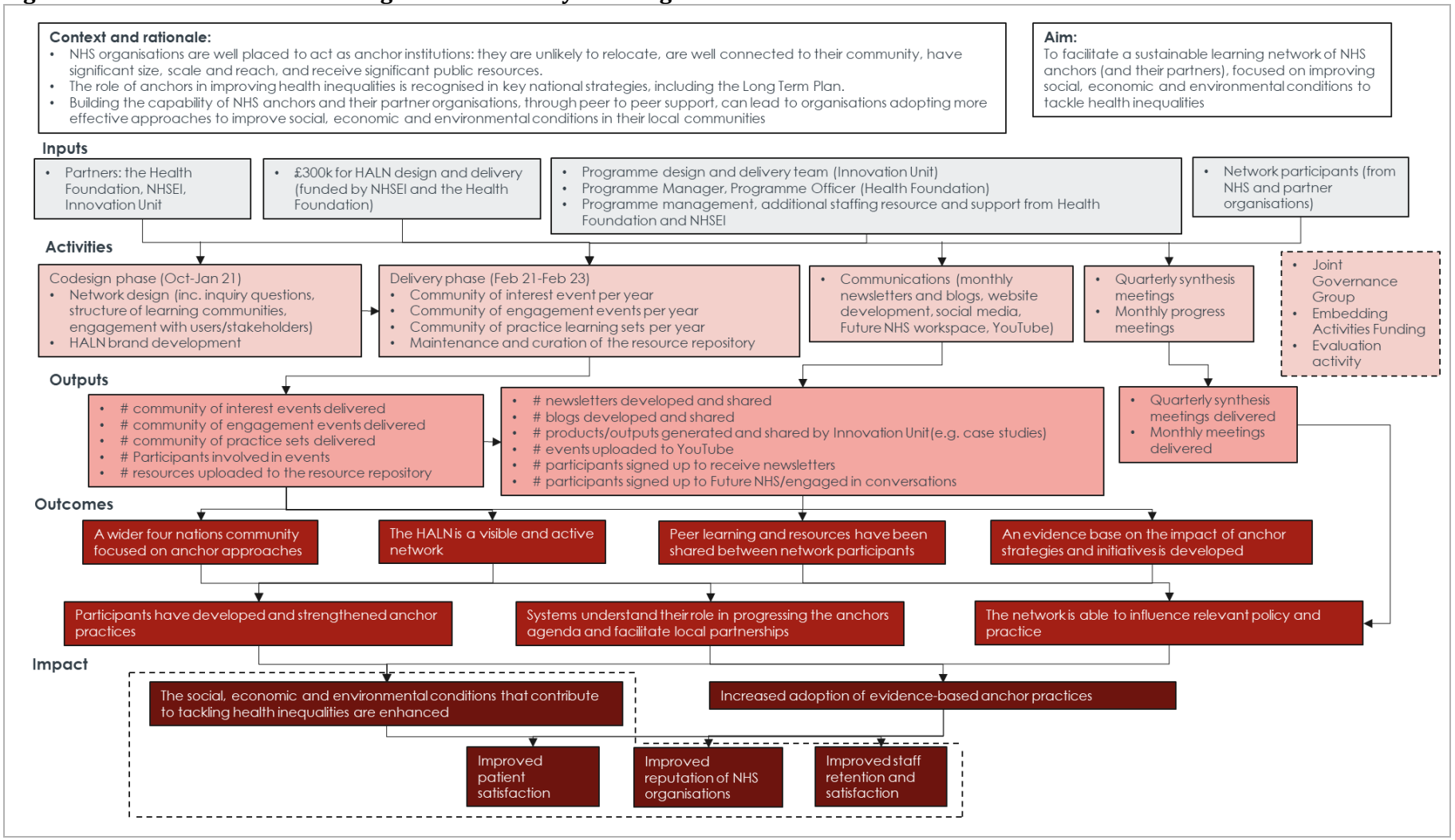


Source: Innovation Unit, Delivery plan for the Health Anchors Learning Network, February 2021

Theory of Change

2.10 The design phase also generated a Theory of Change (ToC) for the Health Foundation and NHS England's wider programme of work on anchors. As part of the evaluation scoping phase, SQW drew on that ToC and more recent learning about the HALN to generate a ToC specifically for the network, showing how the inputs and activities of the network were expected to lead to outputs, outcomes and, eventually, impacts. The ToC is presented in Figure 2-3.

Figure 2-3: Health Anchors Learning Network Theory of Change



Source: SQW

Note: A dashed line around the box indicates elements which are out of evaluation scope, given the timescales and type of evaluation, but are likely to be influenced by the network.

3. Health Anchors Learning Network delivery

Chapter summary

The network began delivery in March 2021 and was funded (initially) for the two years to February 2023.

The programme of activities included: a newsletter, social media, blogs, production and curation of online resources, support of a platform (FutureNHS), webinars, roundtables, and action learning sets. Participants could decide how, when, and how often they wanted to engage with these activities.

The network covered topics across the five 'pillars': employment, procurement and commissioning for social value, use of capital and estates, environmental sustainability, and local partnership working.

As of January 2023, the HALN had 1,608 newsletter subscriptions (which acts as an indicator of participation/membership), and its 19 public events achieved over 1,500 registrations. A majority of participants (67% of newsletter recipients and 75% of event registrants) were based in England.

Participants reported that delivery of events and activities was generally done well, with the quality of delivery resulting from the expertise of the partners.

Developing a network for anchor learning in healthcare was recognised as a challenge because the anchors agenda is both young and broad.

The three-way partnership between the Health Foundation, NHS England and the Innovation Unit generated value as well as bringing complexities and challenges. Partners brought relevant experience and expertise to the design and delivery of the HALN. They also brought different perspectives and priorities that took time to align.

3.1 This chapter reports on the delivery of the network, including its reach, routes to engagement and the partnership between the Health Foundation, NHS England and the Innovation Unit. It is based on monitoring data and programme documentation provided by the Innovation Unit, interviews with programme partners, and interviews and focus groups with network participants.

Delivery of activities

The programme of activities that constituted the network was delivered over two years (March 2021 to February 2023) including a newsletter, social media, blogs, production and curation of online resources, support of a platform (FutureNHS), webinars, roundtables, and action learning sets. Details of the scale of delivery are given in

3.2 Table 3-1.

3.3 Given the scope of an anchor institution, the topics covered through the network were broad. It included topics within the five key anchor 'pillars'[17]:

- employment
- procurement and commissioning for social value
- use of capital and estates
- environmental sustainability
- local partnership working.

3.4 As the network was led by the needs of its participants, it also delivered activities on additional supporting topics, including how to 'get started' in delivering anchor practice, system-wide approaches, how to measure anchor impact, how to enable anchor impact, and taking action on racial inequalities. These were chosen based on the most common participant requests and an understanding of the maturity and experience of participating institutions.

3.5 Participants could decide how, when, and how often they wanted to engage with the network. This enabled participants to create their own 'programme' of activity, based on their own needs, capacity and prior knowledge[18]. The HALN monitoring data show uptake of specific activities. It was not possible to trace an individual participant's engagement with the network: for example, it was not possible to know how many Twitter followers also watched the YouTube videos or participated in the action learning sets.

[17] The Health Foundation (2019) *Building Healthier Communities*
[18] It is worth noting that for some individuals, anchors was the entire focus of their role. Others had anchors as a smaller proportion of their role or even had no formal remit to undertake anchors practice and engaged purely out of interest.

Table 3-1: Nature and scale of activities delivered through the HALN (based on data to January 2023)

Degree of participant involvement	Activity	Scale	Description
Communities of interest	Newsletter	There were 1,608 recipients of newsletters in January 2023 24 newsletters were shared across the first two years of delivery	Newsletters were shared monthly with participants who signed up to receive them. They contained information and links to resources to support participants in their anchor work, as well as highlighting upcoming HALN activity.
	Online resources	16 learning products and resources were produced by the Innovation Unit to share with network participants	Resources were often based on learning generated via the HALN. Resources were curated on the HALN website and on the FutureNHS platform. Examples include: • One page guide to anchor frameworks • Top tips for moving from plan to action • What health anchors can do to tackle deprivation
	Blogs	16 blogs were produced through the HALN	Some blogs were written by individuals from within the partnership or feature guest writers. Examples include: • Anchors and the green agenda: how anchor work can tackle climate change to improve health • Q&A with Dr Bob Klaber: a blog from the Shelford Group • Behind the scenes at HALN - what have we achieved and what's next?
	Social media	The HALN shares learning through a range of social media avenues. This includes: • Twitter (853 followers) • LinkedIn (340 followers)	The HALN's Twitter and LinkedIn pages share links to new online resources, blogs and advertise events/webinars and new action learning sets. The HALN's YouTube channel includes recordings of events and webinars, so individuals can access them if they were not able to attend live or could go back to them if required. Roundtable events were not recorded for YouTube.

Degree of participant involvement	Activity	Scale	Description
		• YouTube (32 videos uploaded, average of 98 views per video, ranging from 22-326 views, 38 subscribers)	
Communities of engagement	Events and webinars	One launch event was held with 341 individuals 18 events were delivered by the Innovation Unit to over 1,500 registrants	The Innovation Unit held a launch event to promote the HALN to potential participants in March 2021. Events included webinars open to all, and roundtables which were targeted at select attendees. Examples include: • Procurement and spend as a lever for change in anchor institutions (April 2021) • Measurement roundtable (April 2022) • Partnership in practice: health anchors and the civic and VCSE sector (October 2022) Seven further events were delivered in partnership (e.g. with the Housing Associations Charitable Trust).
Communities of practice	Action Learning Sets	100 individuals participated in action learning sets	Action learning sets provided a small proportion of participants with a more intensive experience of the network. Action learning sets were delivered by the Innovation Unit, and four cohorts participated in action learning sets, attending sessions focused on: • Session one: reviewing existing anchor work, identifying opportunities and starting activities, developing an anchor mindset • Session two: areas of focus (geography, outcome area, population), workforce and community engagement • Session three: metrics, measures, governance and delivery structures

Degree of participant involvement	Activity	Scale	Description
			• Session four: sharing and celebration of emerging strategies, reflection of learning. A fifth cohort was involved in a 'high fliers' learning set for mature anchors.

Source: Innovation Unit data and HALN social media

Network reach and engagement

Data caveats

3.6 It is important to note that understanding of the HALN's reach is limited:

- The network's 'membership' is measured by the number of recipients of the newsletter. However, participants do not have to sign up to the newsletter to access public events or download resources from the HALN website.
- The evaluation only had access to data on registrations for events rather than attendances, which do not account for attrition or non-attendances. Moreover, the data do not provide an indication of registrants (only registrations), so it is not known how many individuals registered for one (or more) of the network's events.
- Data on participant region and organisation is derived from email addresses as this information was not collected from participants. This means that there are gaps in the data where it is not possible to determine region or organisation type. There may also be errors in the data (e.g. if the email participants used to sign up does not accurately reflect the organisation or region they work, or they have multiple roles in different organisations and have not used their primary email address).
- Linked to the above, data on the region and organisation of network participants was not extracted from the outset, so it is difficult to identify trends or changes over time.

3.7 Therefore, the reach of the network may differ from that reported. While the fact that anyone can access network resources without signing up to the newsletter may extend the reach of the network, the absence of data about who is accessing the network limits the extent to which the network can measure and assess its levels of engagement.

Reach

3.8 In its first two years of delivery, the HALN engaged a reasonable number of participants (although there were no targets set for network membership). As of January 2023, the HALN had 1,608 newsletter subscriptions (which acts as an indicator of participation/membership), and its public events achieved over 1,500 registrations.

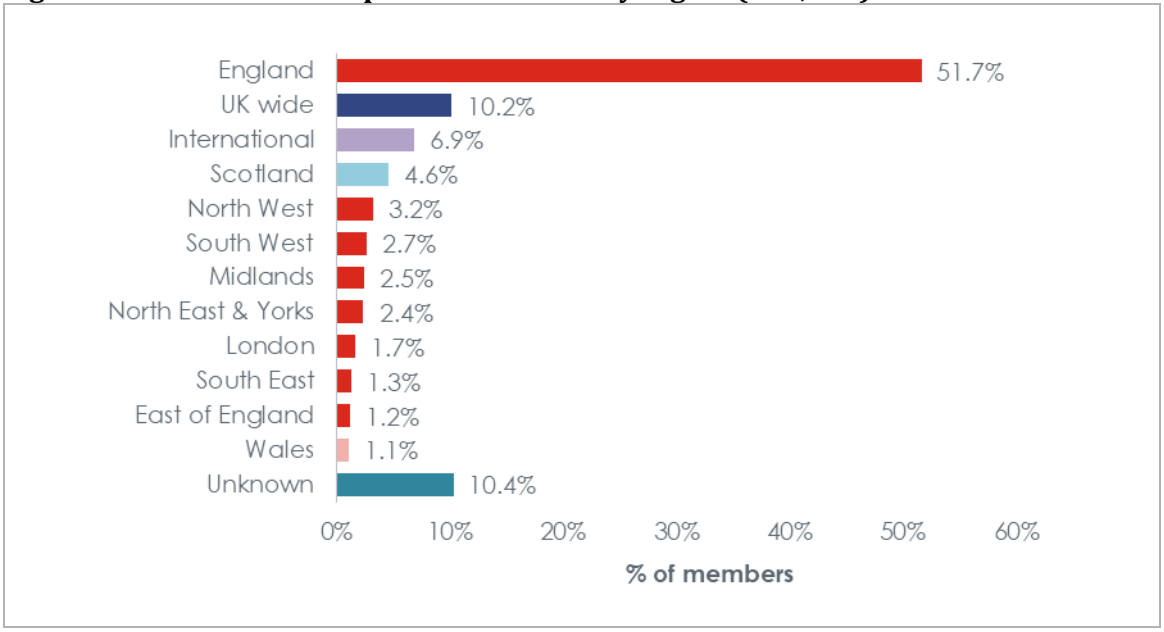
3.9 Routes to engagement with the network varied according to participant interviewees who reported how they had heard about the HALN. Routes included referrals from other participants, through pre-existing relationships with the Health Foundation, via pre-existing anchor networks, and through links in email newsletters. Some long-standing participants recalled a communications campaign to raise awareness prior to the network's inception (although it was not clear through what channel(s) this occurred).

By region

3.10 Figure 3-1 presents a breakdown of HALN participants according to their region (derived manually by the Innovation Unit using email addresses supplied by newsletter recipients). Overall, the data indicates that the HALN has reach across the four UK nations (a key outcome of the HALN), although it is very low in Northern Ireland.

3.11 The majority of engagement is by those based in England: 66.7% of participant email addresses indicated they worked within England or its regions compared to 4.6% from Scotland and 1.1% from Wales. No participant email addresses suggested they worked within Northern Ireland. Partner interviewees reflected that this balance could be due to the fact that the language and terminology used by the network (especially 'anchors') was less familiar outside England, but it also broadly reflects the respective populations of the four nations.[19] While 10.2% of participant email addresses suggested their organisation operated across the UK, it is not clear if those participants themselves worked within one nation or region only (including England).

Figure 3-1: Newsletter recipient breakdown by region (n=1,608)



Source: Innovation Unit (2023) HALN final quarterly report

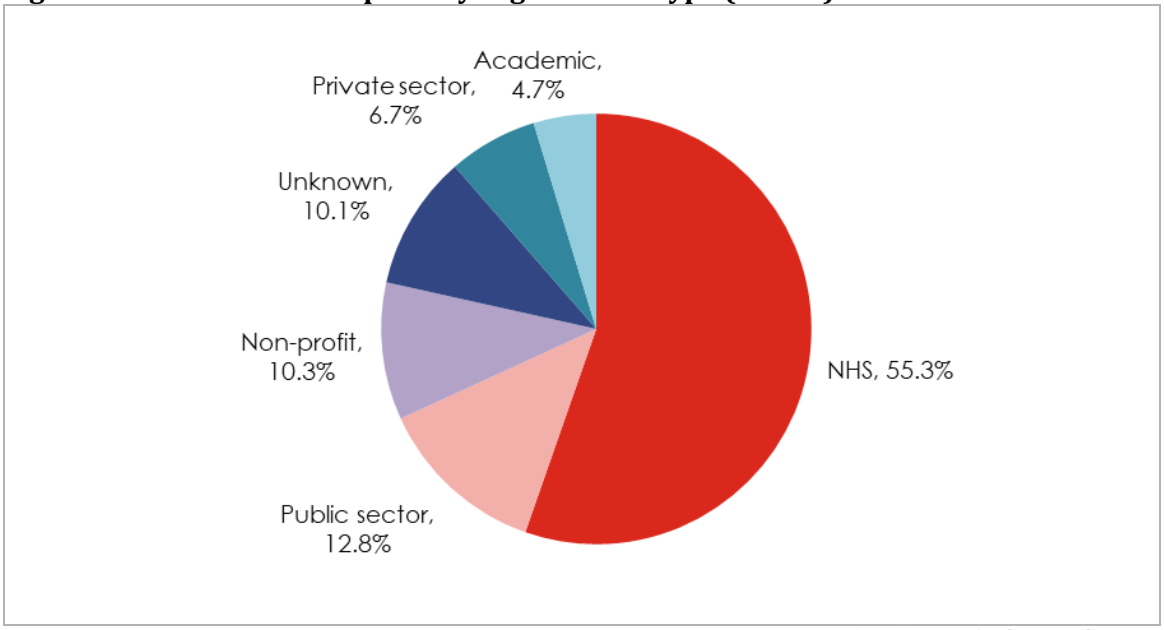
3.12 The breakdown of event registrations by region (for the five events delivered between July 2022 and January 2023, amounting to 847 registrations for that period not total registrations across the lifetime of the network) presents a similar picture with registered email addresses indicating three quarters (75.3%) of registrants worked within England, compared with 7.3% in Scotland, 0.1% in Wales and 0.1% in Northern Ireland (the remainder were unknown).

[19] Office for National Statistics (21 December 2022) *Population estimates for the UK, England, Wales, Scotland and Northern Ireland: mid-2021*

By organisation

3.13 Email addresses supplied by participants who signed up to the newsletter were also used to determine the type of organisations participants worked for. Overall, the data indicate that the HALN caters to both health organisations and their wider partners (Figure 3-2). Over half (55.3%) of participant email addresses were from NHS organisations, including NHS England, NHS Improvement, NHS Trusts, and primary care providers. Public sector, non-profit organisations, private sector organisations academic organisations made up the remainder of the known organisation types.

Figure 3-2: Newsletter recipient by organisation type (n=847)



Source: Innovation Unit (2023) HALN final quarterly report

By maturity of anchor knowledge and practice

3.14 Programme partners reported the HALN has engaged organisations across a broad spectrum of maturity in terms of their anchor work. Feedback from participants indicated the HALN has maintained engagement from organisations who are further ahead in anchor work, whilst also continuing to attract those new to the anchors agenda. Participant interviewees highlighted the value of the network for those early on in their anchor 'journey', particularly those less familiar with what an anchor institution is, or with limited knowledge of how to develop anchor practices. This was reflected on by a more mature network participant:

Sometimes, I've gone to webinars, it sounds [relevant to me] but I hear more of the same rather than something new. That said, that is really beneficial for people who are first timers. The journey that people are on for anchors is so variable. You need to have that beginners' landing page and also meet the needs of those who have anchors framework in place.
HALN participant

3.15 In its second year of delivery, the HALN increased its activity catering to more mature anchor institution. The network delivered 'high-fliers' action learning sets for a small group of participants from organisations already delivering anchor activity to support them to progress and embed their anchor work. While this was valued by most participants, some of those who engaged found the network less valuable given their existing level of maturity and knowledge and felt that the HALN could do more in supporting organisations further ahead in their anchor work.

Quality of network delivery

3.16 Evidence collected from interviews with the Health Foundation, NHS England, the delivery team and network indicates that overall delivery was high quality, with a range of activities implemented to meet the needs of different types of participants, both in terms of degree of their engagement and the subject matter that interested them. In particular, the delivery of events and activities was reported by participants to have generally been done well with the action learning sets singled out as being well-facilitated, some of the resources being high quality, particularly the videos and graphics, and a strong social media presence. From the perspective of stakeholders and participants, the quality of delivery was largely built on the expertise of the partners: the Health Foundation and NHS England brought subject matter knowledge, reputation and profile; the Innovation Unit brought expertise in facilitating learning communities and on anchors, knowledge management skills, and programme management skills and experience.

3.17 According to programme partners, the communities of practice typology had been broadly helpful in providing a way to conceptualise both the potential audience and actual participants and hence to inform the design and delivery of activities tailored to different degrees of knowledge, experience and interest.

Scope for development

3.18 From an evaluation perspective, it might have been useful to have access to more data on participants to better understand who was involved in each activity and their pattern of engagement with the network. This knowledge could have informed delivery during the programme and a refined typology to shape future delivery. From the point of view of the programme, it could have formed the basis of a participant directory, to offer the potential for spontaneous internal networking without the stimulus of a specific event (although noting this would require additional IT infrastructure and hence increased costs).

3.19 A couple of interviewees reflected that there was scope to have used the preparation invested in the events to deliver more iterations of the same events to reach more audiences.

3.20 There was debate among participant and programme partner interviewees about the value of the platforms (a dedicated HALN website and FutureNHS) used to connect participants and share resources. There was support for the use of FutureNHS as being a permanent platform but the dedicated website was seen to be more appealing by a few of the participants

interviewed. However, the dedicated website required its own promotional activity and, as it belongs to the Innovation Unit, will close when their involvement stops.

3.21 There was a consensus among interviewees that establishing a network for anchor learning in healthcare was a considerable challenge, particularly because the anchors agenda in a healthcare context is relatively young, meaning there is a limited pool of well-informed practitioners and a large body of potential participants who are unaware of or have little knowledge of anchors. Working with novices and more mature anchors required provision of a range of appropriate activities. The agenda is also very broad, encompassing procurement, employment, partnerships, social value and estates across the entire health and social care sector and sectors where there is alignment or overlap. In the context of HALN, the anchors agenda also spans the four UK nations, and overlaps with broader issues such as the shift to ICSs, inclusive growth, community wealth building and poverty (amongst others). This has posed challenges for the network in determining what topics should be covered in depth (i.e. covered in greater detail) in order for meaningful learning to occur, versus the breadth of topics of interest to (potential and actual) HALN participants.

4. Participant experience

Chapter summary

Overall, most participants felt their experience of the network was positive, regardless of their journey through, or use of, the network. Participants reported high levels of satisfaction with key activities delivered across the three communities of interest, engagement and practice (Figure 2-2).

Community of interest activities, including resources developed through the network and the monthly newsletter, were considered to be high quality, engaging and easy to disseminate to colleagues to share learning. However, the FutureNHS platform was generally not considered the best way to host HALN resources.

Community of engagement events and webinars were reported to be relevant and stimulating, and the community of practice action learning sets were said to have built understanding, enabled peer to peer support and facilitated shared problem solving. Communities of engagement and practice activities were well facilitated, according to participants, who described facilitation as well-structured and organised.

The network was considered to be accessible and valuable in terms of its structure, content and design. Participants highlighted that the network 'filled a gap' in terms of health anchor support. Other valued aspects identified by participants included its accessibility (being a virtual network) and its endorsement from key reputable organisations. However, while the wide range of content covered through the HALN was valued, the breadth of the anchors agenda meant that not all content was relevant to participants.

The HALN offered opportunities for participants to learn from and connect with others. This included organisations from different places who approached anchor work in a different way, although participants felt that more opportunities to learn from organisations from across the four nations and different sectors could be further incorporated into network delivery. There were calls to increase opportunities for networking between participants across the HALN.

4.1 This chapter reflects on participant experiences of the network and its activities, based on feedback from interviews and focus groups with network participants, and responses from a survey of network participants. It draws on qualitative insights from observations, and partner and stakeholder interviews to contextualise findings where relevant. As outlined in Chapter 1, the number of network participants that engaged with the evaluation was low, particularly when compared with the overall reach of the network as outlined in Chapter 3. Therefore, these findings are indicative of participant experiences but may not represent the views of all participants.

4.2 Overall, most participants had positive experiences of the HALN, regardless of their journey through, or use of, the network. Participant interviewees discussed a range of elements which

influenced their experience, including specific network activities, elements considered unique selling points of the network and the opportunity to learn from others.

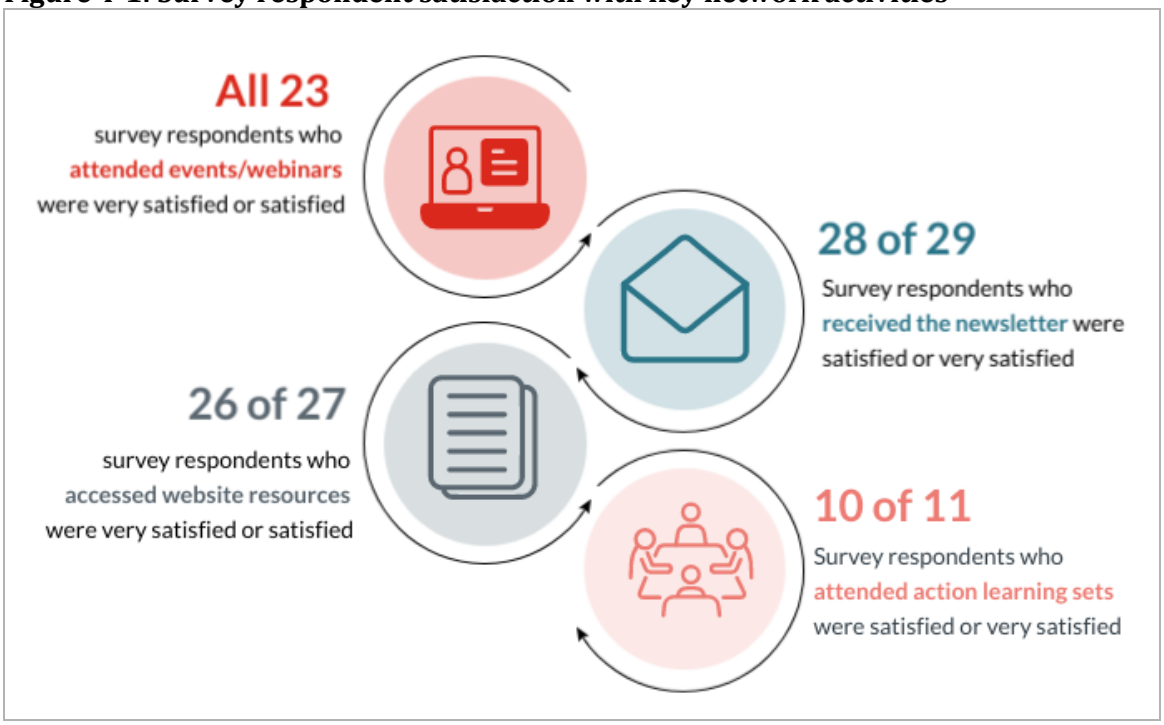
I think they've done a great job in the way they've rolled out the programme. It's something very new and diverse.
HALN participant

Reflections on network activity

Network participants reported high levels of satisfaction with key activities delivered within all three of the network communities.

4.3 Feedback from participant interviewees and survey respondents centred on experiences of specific elements of the network, across communities of interest (monthly newsletter, network resources and the FutureNHS Platform), communities of engagement (webinars and events) and communities of practice (action learning sets). Figure 4-1 presents survey respondent feedback when asked how satisfied they were with key elements of the network. Overall, the data indicate high levels of satisfaction with key network activities.

Figure 4-1: Survey respondent satisfaction with key network activities



Source: Survey of HALN participants

Communities of interest activities were considered high quality, engaging and easy to disseminate to colleagues…

4.4 The HALN developed and shared a range of resources to support network participants. This included blogs, case studies, top tips and guides, and YouTube videos. Resources and outputs

created through the HALN were reported by participants to be of good quality and engaging. One participant interviewee stated that the materials focused on outcome measurement were helping to inform the debate on what a continuous improvement monitoring framework for anchor work looks like in their area. A few participant interviewees also commented on social media resources, noting that they were easily accessible and provided a different medium for digesting learning.

The curated resources are useful… because it's linked in with people that are going on the same journey. I think that's led to resources being there that otherwise wouldn't have been there.
HALN participant

4.5 Resources developed through the HALN were held on both the HALN dedicated website, and a space on the FutureNHS platform[20]. Feedback from participants interviewed and surveyed on the use of the FutureNHS community platform was mixed. A few participants felt it was an appropriate and accessible platform for HALN resources but there was a perception amongst a couple of interviewees that the FutureNHS platform was for NHS employees only, which seemed to pose a barrier to engagement.

4.6 The HALN shared a newsletter every month. Newsletters contained information and links to resources to support participants in their anchor work, as well as highlighting upcoming HALN activity. It was noted by participant interviewees that the monthly HALN newsletters were easy to share with colleagues who may be interested in specific topics, and informing recipients of upcoming events which they or their colleagues may be interested in. This suggests that newsletters expand the reach and visibility of the HALN in addition to supporting deeper engagement with the network by existing participants. In addition, when asked openly about the best part of the network, three survey respondents (of 18 who contributed to the question) specifically mentioned the newsletters, describing them as informative.

… and communities of engagement and practice activities were well facilitated, relevant and built understanding.

4.7 The HALN delivered a range of virtual events, including webinars and roundtables. Most of these events involved guest speakers (including participants themselves, as well as representatives from other sectors). Seven of the 25 events delivered through the network were delivered in partnership with NHS England. Many participant interviewees reported that events and webinars they had attended were relevant and stimulating and addressed the *"wicked problems"* faced by those working on the anchors agenda. As described above, it was highlighted that events that focused on anchor work from different perspectives (for example from different sectors) were particularly useful.

4.8 Action learning sets provided a small proportion of participants with a more intensive experience of the network. Action learning sets were delivered to five cohorts in total. Each

[20] https://future.nhs.uk/

cohort attended multiple sessions focused on foundational anchor knowledge and activities aligned to actions at a local level. Action learning sets were reported by participant interviewees to build understanding, enable peer to peer support and facilitate shared problem solving. One survey respondent noted the ease and friendliness of the sessions they had attended. In addition, the more intensive nature of the action learning sets placed high expectations on attendance for participants, who noted that this approach sustained their engagement.

4.9 Many participant interviewees highlighted the quality of facilitation delivered through both action learning sets and webinars/events. Interviewees described facilitation as well-structured and organised, which made their experience more enjoyable and maximised their learning. Observed sessions offered a range of interactive opportunities which maximised engagement, including the use of breakout groups and regular polls to gather real-time feedback on different perspectives and learning. A few participants reported positive experiences of breakout groups, noting that they were appropriate in terms of length and steer, and gave them a good opportunity to share learning with *"likeminded people"*, including the sharing of challenges and mitigations. However, others felt that the delivery of breakout groups could be improved through greater clarity of instruction and *"curation"* of breakout group attendees in advance (that is sorting participants into groups based on similar roles or areas of interest).

I was impressed with the quality of the facilitators… we had technical experts and subject matter experts, it was seamless in terms of the tech. I found the whole experience enjoyable and I think I learned a lot from it.
HALN participant

Content and approach

The network was considered to be accessible and valuable in terms of its structure, content and design.

4.10 Participants highlighted key aspects of the network which they felt were specific 'selling points' (or USPs) of the HALN, which positively influenced their experience of the network.

- It was felt the HALN *"filled a gap"* in terms of health anchor support. Some participant interviewees reported being involved in local or regional programmes or networks but highlighted that the resources available through the HALN, alongside its national focus, meant that it filled a *"niche"* that would not have been done otherwise. In addition, stakeholders reported that the HALN was complementary to other initiatives being delivered in their region or locality, acting as a *"piece of the jigsaw"* to support anchor work to embed and progress within organisations and systems.
- Given when the network began (February 2021), the decision was made to deliver the network completely virtually, due to the Covid-19 restrictions in place at the time. The benefits of a virtual network were highlighted by participants, as it made the network

more accessible to participants. One participant reflected that they would not have been able to attend if it wasn't online. A few partner interviewees felt that the lack of a face-to-face event in year two was a *"missed opportunity",* but this was not an issue reported by the majority of participants.

- The endorsement of the HALN from *"high profile"* and reputable organisations (Health Foundation and NHS England) also affected participants' experience of the network. For example, one participant interviewee stated the Health Foundation's involvement was valued given their previous work on anchors.

While the wide range of topics covered through the HALN was valued, the breadth of the anchors agenda meant that the topics covered were not relevant to some participants.

4.11 Many participants felt that the HALN had covered a wide range of topics within the anchors space, with survey respondents highlighting some topics as particularly useful to them (see chapter 5). The network was responsive to the needs of participants. During events, webinars and action learning sets, participants were continually asked to reflect on what they liked/disliked, and what they would like to learn more about, both qualitatively and through polls. These data were used to develop the network content accordingly. Interviewees welcomed the opportunity to feedback about issues important to them and see the network respond accordingly.

The themes were really good and they seemed really responsive to us and they'd really thought about the themes… they returned to measurement because it was something we'd been interested in.
HALN participant

4.12 Other participants felt that the topics covered were not totally relevant to their needs, although they acknowledged the difficulty of catering to all needs (as detailed in chapter 3) given the breadth of the anchors agenda. The survey highlighted the breadth of topics participants were interested in: when asked what the network could do to support their anchor work over the next year, survey respondents predominantly suggested additional topics that they felt the network could focus on. However, no topic was identified by more than one respondent, illustrating the challenge faced by the network of catering to all. Topics suggested included measurement of impact, mental health, substance misuse, domestic abuse, housing, employability, patient and public engagement, estates, and the environment.

Opportunities to learn from and connect with others

Participants valued learning about how other organisations, particularly from within different regions across England, approach their anchor work.

4.13 When asked about the best part of the network, both survey respondents and participant interviewees highlighted that it was the ability to learn about what other organisations are

doing, particularly through case studies (as well as via action learning sets and webinars, in addition to stand alone case studies and resources). Participant interviewees reported that they valued being able to learn from other health anchors who had been delivering anchors work for longer than they had, with one participant noting that hearing about others' work had given them the confidence to talk more about the approach within their organisation.

Understanding how [a mature anchor institution] looks at processes across the trust (i.e. looking at how they treat issues around specific communities in a more joined-up way) as opposed to specific issues was greatly helpful and learning came as a result of that.
HALN participant

4.14 Many participants commented specifically on the fact that they valued being able to learn from health anchor institutions from different places. This included understanding the challenges and enablers faced by anchors in areas that were different to theirs (for example different geographies, demographics and governance structures), to understand the range of different approaches health anchors took to mitigating challenges. It was felt that the range of viewpoints enabled participants to enhance their own understanding of how to support anchors work locally: "*I think one of the main reasons that the HALN has been so successful is because it is national*".

…but would appreciate additional opportunities to learn from organisations from across the four nations and from within different sectors.

4.15 Although participants valued learning from others in different areas, there were calls for more of a four nations focus, particularly from those outside of England who felt they would have benefited from more perspectives from their area. In contrast, one participant interviewee felt that the four nations approach negatively affected their experience, as they found the different structures and terminology within different countries *"confusing"*.

4.16 While participants generally found it helpful that the majority of case studies and examples were health-focused, many participant interviewees felt that being able to learn from anchor practices within different sectors would improve their experience of the network. In particular, it was reported that more examples of local authorities delivering anchor practices would be beneficial, considering that local authorities are *"key players"* in supporting health and social care. More broadly, participant interviewees reflected that learning from sectors with more mature anchors would likely be transferrable and so would be beneficial for those in health settings. It was acknowledged by a few participants that the HALN had shared learning from housing associations.

Organisations like Norwich Union or even KPMG, they've done a lot on health inequality and social mobility – we could have drawn on these examples. Because the anchor work is so new to the NHS, [the network] could have brought in pre-existing learning from outside the NHS.
HALN participant

Opportunities to network with others were valued, with calls for this to increase as the HALN continues.

4.17 Opportunities for networking were consciously built into action learning sets. This included dedicated time within breakout groups so participants could speak with others more informally. This was loosely facilitated, for example with participants asked to share what they have done recently within their organisations, in relation to anchor work, or any key challenges they had faced.

4.18 It was reported that a few participants had made new connections as a result of engagement with the HALN. In particular, participants valued the fact that that many organisations on which case studies were based were active within the network, with one participant highlighting that these organisations were *"more than willing"* to share their learning and support them *"on their journey"*. This includes Test and Learn participants, who have fed their learning back into the network via events, action learning sets and case studies. The Test and Learn programme was a Health Foundation and NHS England funded programme providing support and funding to six organisations to make progress in their anchor work[21]. These organisations were also participants of the HALN, but the Test and Learn programme was delivered externally to the network.

4.19 However, some participant interviewees felt that more could be done to support them to make connections with others in the network to improve their overall experience. Suggestions included *"matchmaking"* opportunities to build connections, a participant directory to generate new connections, or being able to see who had attended webinars or events they had joined. It was noted that the latter would also be beneficial for maximising learning within organisations: one participant interviewee stated that they were unaware if others within their organisation had attended webinars or events they had participated in but being able to understand the reach of the network within their own organisation would enable participants to get together and consider how the learning could be used more effectively.

Some of the work I've been doing about health inequalities [has involved] linking with one or two Trusts around the country who are at the same stage or have made better progress – it's been useful to link up with them. But there seems to be no great interest [from the HALN] in sustaining connections beyond [the work I'd done within the action learning set] – I'd have to work quite hard to find those people.
HALN participant

[21] https://www.health.org.uk/funding-and-partnerships/programmes/test-and-learn-grant%25E2%2580%25AFfunding-for-health-anchors-learning-n

5. Network outcomes and impacts

Chapter summary

There has been progress against the following outcomes:

- O1 - The HALN is a visible and active network
- O4 - Peer learning and resources have been shared between network participants
- O5 - Participants have developed and strengthened anchor practices
- O6 - Systems understand their role in progressing the anchors agenda and facilitate local partnerships
- O7 - The network is able to influence relevant policy and practice

There is less evidence of progress on the following outcomes:

- O2 - A wider four nations community focused on anchor practice
- O3 - An evidence base on the impact of anchor strategies and initiatives is developed.

In summary, feedback from participants and stakeholders has reported that the network has grown its profile, generated good quality resources, facilitated peer learning, and supported participants to develop and strengthen their anchor practice. There is also early progress on participants working with local partners, bringing systems on board, and influencing local strategy and national policy.

On O2, there is scope to strengthen the four nations community and on O3, an evidence base on anchor principles and practice has been developed but there is scope to develop more resources on the impact of anchor strategies and initiatives.

It was not anticipated that there would be much measurable progress in terms of impact on the wider adoption of anchor practices and improvements to the social, economic and environmental conditions affecting health inequalities within the timeframe of the network and the evaluation.

The HALN is valued for its unique mandate to work across the four nations and across all anchor topics.

Routes by which HALN activities reportedly influenced participants included: offering insight and guidance; bringing together a peer group to offer opportunities for support and inspiration; and making the anchors agenda more visible and tangible through establishing an online presence, producing resources and holding events.

Whether the HALN can be successful in achieving outcomes is both supported and constrained by the capacity available to the network, to individual participants and within their organisations; and senior support that gives permission and resources to anchor practice.

5.1 This chapter presents the outcomes and impacts achieved by the network, alongside a discussion of the conditions that have influenced the achievement of those outcomes.

5.2 The Theory of Change for the HALN (chapter 2) set out seven expected outcomes plus two key impacts (in italics):

- O1 - The HALN is a visible and active network
- O2 - A wider four nations community focused on anchor practice
- O3 - An evidence base on the impact of anchor strategies and initiatives is developed
- O4 - Peer learning and resources have been shared between network participants
- O5 - Participants have developed and strengthened anchor practices
- O6 - Systems understand their role in progressing the anchors agenda and facilitate local partnerships
- O7 - The network is able to influence relevant policy and practice
- *I1 - Increased adoption of evidence-based anchor practices*
- *I2 - The social, economic and environmental conditions that contribute to tackling health inequalities are enhanced.*

5.3 Considerable effort went into developing the Theory of Change for the HALN at the outset of the programme. Over time, there was debate about the extent to which change might be realised, the sequence in which outcomes and impacts might occur, and whether all the outcomes and impacts were actually within the remit of the HALN, as expressed in the Theory of Change. However, the evaluation has examined progress against all outcomes and impacts, as it was felt there would be value in a full assessment.

5.4 The outcomes are presented below in the order they were expected to occur (but without indication of interdependencies or feedback loops) with the first five being those where most progress was expected. The sixth and seventh outcomes were seen to be longer-term outcomes. Equally, measurable change in terms of impacts was not necessarily anticipated within the two years lifespan of the network, particularly in relation to effects on conditions that contribute to tackling health inequalities.

5.5 Overall, there has been progress against all the outcomes (albeit based on a small evidence base) but much less in terms of O2 and O3 (from the list above): there is scope to develop a stronger four nations community and, while an evidence base on anchor principles and practice has been developed, there is room to develop more resources on the impact of anchor strategies and initiatives. Feedback from participants and stakeholders has reported that the network has grown its profile, generated good quality resources, facilitated peer learning, and supported participants to develop and strengthen their anchor practice. It is less certain how the network might influence systems and policy and whether this should be considered as a possible outcome. Detail of the progress against each indicator is given below.

Progress against outcomes

Outcome 1: The HALN is a visible and active network

The HALN is now fairly well-known among those interested in anchor practice and has a unique position because of its exclusive focus on anchors, its breadth of topics and four nations lens. However, there is some confusion regarding the purpose of the HALN so thought needs to be given to clarifying its role.

Visibility

5.6 The HALN has made good progress on this outcome within the two years of implementation. For those interested in anchor practice, the HALN is now fairly well-known. The network provides a steady stream of social media content and a monthly newsletter that means it remains on the radar of participants. One participant commented on the vitality of the HALN's presence on FutureNHS compared to other NHS forums. Another interviewee said the HALN was their *"go-to"* source for information on anchors and the first place they would signpost others too. Others reported directing colleagues to the network. The HALN has also been featured on the NHS England website in relation to reducing health inequalities.[22]

Unique role

5.7 While there are other regional networks and local anchor programmes, for example in Essex, Cornwall, and the Northern Care Alliance, participants reported that there is nothing comparable to the HALN with its exclusive focus on anchors, the breadth of topics covered and the UK lens. In this respect it is valued by participants for offering a broad but anchor-focused range of resources and events, which showcase learning from different places and cover a range of topics not matched by other networks/initiatives. Even the most active regional/local networks tend not to deal with all five of the key anchor topics (employment, procurement, capital/estates, environment/sustainability and local partnerships) at the same time.

Purpose

5.8 There is a sense among participants that while the network is now coalescing, there remains a degree of confusion about the HALN's purpose. Several interviewees described their uncertainty as to who the HALN was for, what its aims were, and how long-lasting it might be, depending on funder and stakeholder commitment and NHS England's strategic priorities. Without clarity on those points, they were hesitant to engage more fully, for example by

[22] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/our-approach-to-reducing-healthcare-inequalities/anchors-and-social-value/ and https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/contacts-and-resources/networks/

contributing information or resources to the network or getting involved in action learning sets or similar activities.

5.9 This participant feedback, combined with data about the current reach of the network, poses questions for the HALN about the desired nature and scale of participation. No target was set for membership or participant engagement but there is likely considerable potential to scale up, if that is deemed the right approach: for a start, there is limited representation from across Wales, Scotland and Northern Ireland. Over the longer-term, there needs to be consideration of the specific role the HALN can play in the context of new and growing regional anchor networks and programmes, for example as a debate-leader, pushing at the boundaries of anchor practice, as a convenor of UK anchors, and/or as an evangelist, spreading the word about anchor practice. This will help the HALN identify whether it wants to work with the most mature anchors or the newcomers or a mix of both and everything in between.

Outcome 2: A wider four nations community focused on anchor practice

There is scope to strengthen the four nations community, with most participants being England-based. If the network wishes to pursue a four nations approach, it will need to invest in tailoring its activities, especially given regional and local conditions are likely to become more relevant than general principles as anchor practices evolve.

Current participation

5.10 As demonstrated in chapter 3, participants are predominantly England-based although there was a small minority from Scotland and fewer from Wales and Northern Ireland. Given the relative youth of the network, the respective populations of the four nations, and the backing from NHS England but not its peers in the other three nations, this is not an unexpected result.

Value of four nations approach

5.11 As reported in the previous chapter, some participants specifically remarked that there was value in being able to learn from health anchor institutions from across the UK. Sixty percent of survey respondents (18/30) stated that they had learned about anchor approaches/strategies used in the other UK nations.

A Scottish-based participant described the inspiration that came from hearing about a project developed by the NHS in Birmingham in conjunction with partners to re-purpose an unused NHS building for homeless people and link them into an employability scheme with the local NHS Trust.

"I just thought it was a fantastic example, and obviously by even renovating the buildings that's local skills and apprenticeships and building the local economy. I just loved the whole ethos of it…. And so I was trying to think locally and what could we do around that?"

5.12 However, learning from elsewhere was valued differently depending on depth of anchor experience. Feedback from those least knowledgeable in anchors was that they welcome information on general principles and practices, and examples from a range of places. Feedback from more mature anchors indicates that examples from further afield may offer inspiration but they were more interested in learning from peers and linking into their relevant national bodies such as NHS England or Public Health Scotland. As anchor practices evolve, the specifics of regional and local conditions are therefore likely to become more relevant than general principles and diminish the value of learning from different places.

5.13 To increase the relevance of the HALN to the other nations and meet the demand from current participants from outside England, the network will need to invest in reaching out and tailoring activities and products such as webinars and newsletters to a four nations audience, including explanation of terminology. There will need to be an active decision on the part of the network to undertake this work because of the resource it will entail.

Outcome 3: An evidence base on the impact of anchor strategies and initiatives is developed

The HALN has made good progress on generating resources about anchor principles and practice but there is scope to do more in terms of creating an evidence base on the measurement of impact of anchor strategies.

Evidence on principles and practice

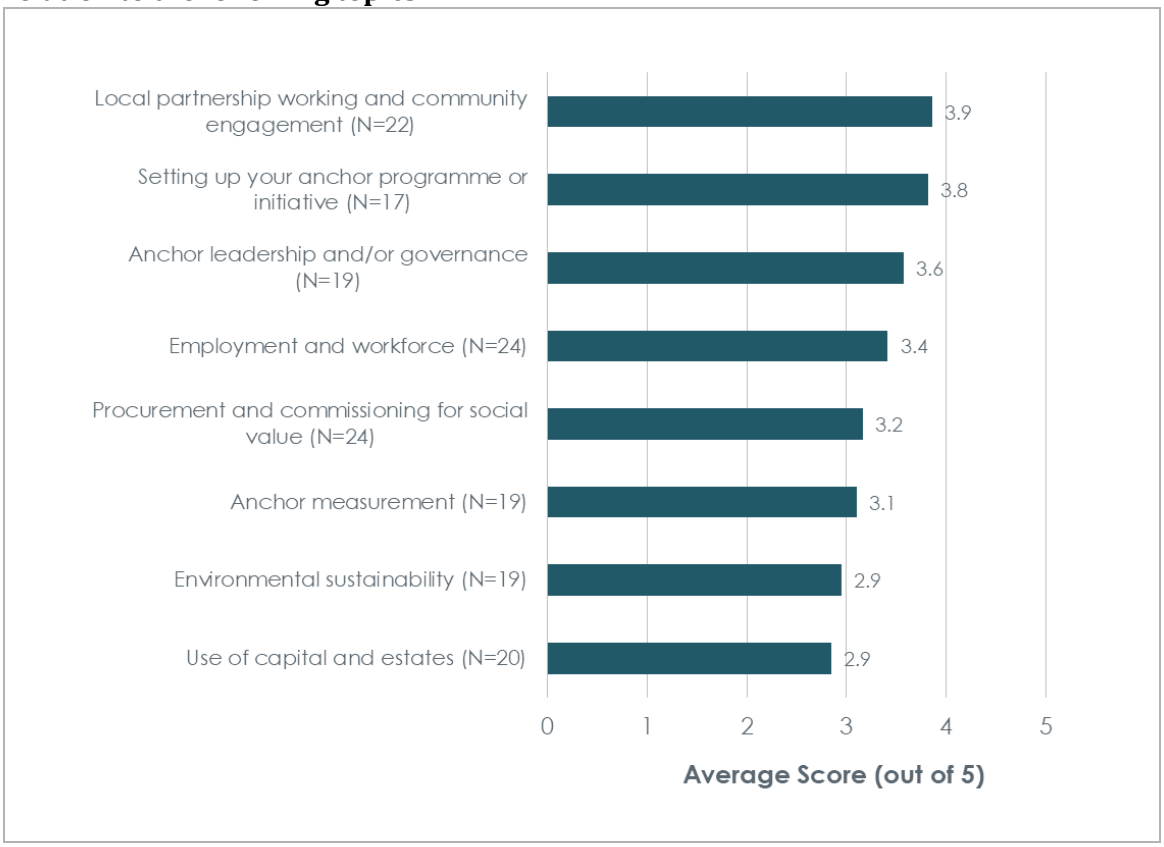
5.14 The HALN has developed a well-regarded evidence base about anchor principles and practice. Just over 70% of respondents to the survey (21/29) agreed that they knew where to go to access resources about anchors and, as outlined in chapter 3, there was almost universal appreciation among interviewees for the quality and coverage of the resources available from the HALN. There was particular praise for the videos as presenting material in a more appealing and accessible way but the written outputs were also valued for containing high quality succinct content, including high quality graphics summarising concepts, that could be utilised more readily for local purposes such as informing a business case.

5.15 Similar to findings above in relation to Outcome 1 regarding the HALN's unique role, the resources, blogs and case studies produced by the network were seen to be unique for its coverage in terms of topics and geography (although mainly England-focused), even in comparison to some local/regional networks and programmes that have their own of set of resources. Typically these smaller networks do not have the capacity to generate and curate lots of evidence.

5.16 Feedback from the survey indicates that participants felt the network had been most successful in providing learning relating to local partnership working and community engagement, setting up an anchor programme or initiative, and anchor leadership and/or governance (Figure 5-1). This corresponds with the finding from qualitative feedback that

while the network's resources were seen to be particularly beneficial for those new to anchor practices, the breadth of coverage meant that more mature anchors could also find relevant material on unfamiliar topics. It was noted that there were genuinely new insights contained in the resources.

Figure 5-1: Average score of responses to 'On a scale of 1 to 5 (where 1 is not at all useful and 5 is very useful), how useful has the network been in providing learning in relation to the following topics?'



Source: Survey of HALN participants

Navigation challenge

5.17 The main issue raised by a minority of participants was the challenge of navigating the material: there was an appeal for more curation such as improved signposting, better labelling, and grouping of material by theme and relevance to anchors at different stages of their journey. As outlined in chapter 3, a smaller set of respondents also queried the most appropriate platform for sharing resources, with mixed views on whether the FutureNHS forum was better than an independent website.

Evidence on impact measurement

5.18 There is less evidence of progress on the development of an evidence base specifically on the measurement of impact of anchor strategies and initiatives. As the network developed, it became evident that it would take longer for strategies and initiatives to be implemented and

generate change, which could only then be measured and reported on. However, a few interviewees highlighted that this was a topic on which they would particularly welcome more insights. It was suggested by a couple of interviewees that the HALN was well-placed to contribute to solving the challenge of measuring the effects of anchor activity as it was a sector-wide problem that would benefit from a sector-wide solution. It was anticipated that NHS England would eventually introduce national guidance on measurement of impact, which it was suggested would be a better product if it were informed by bottom-up insights, for example those generated through the HALN and its participants.

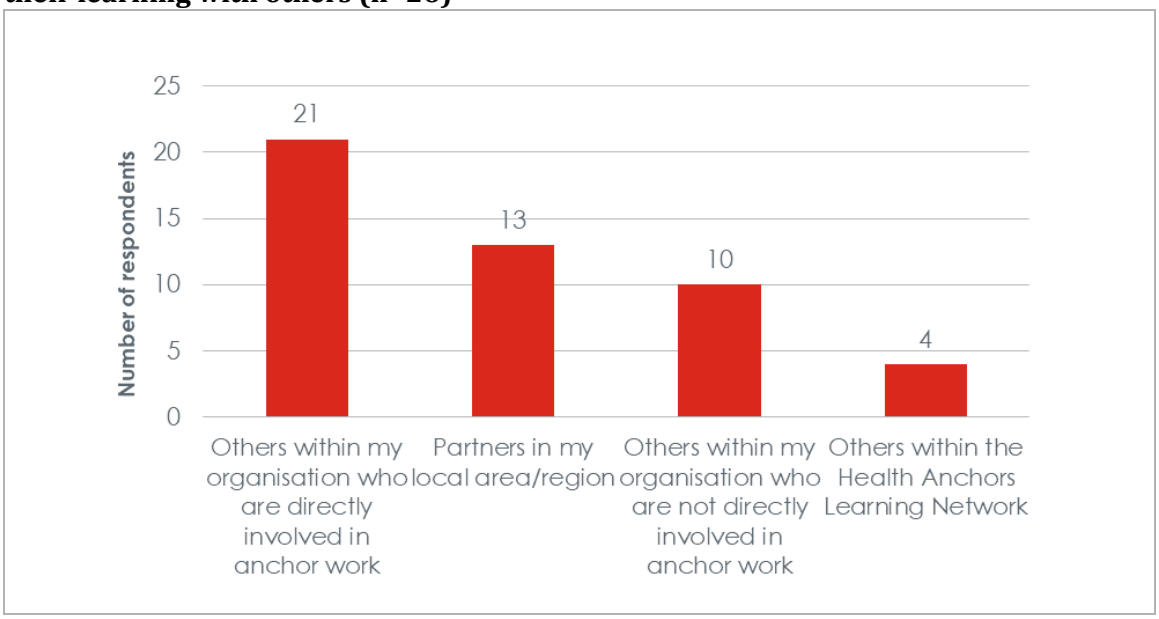
Outcome 4: Peer learning and resources have been shared between network participants

Good progress has been made on encouraging participants to share information. Most sharing is done locally rather than with other network participants. Peer to peer support is valuable in this emergent agenda so facilitating more opportunities for network participants to contact each other is important.

Information sharing

5.19 There is clear evidence that good progress has been made on encouraging participants to share information: over 90% of survey respondents (26/28) had shared or planned to share learning from the network with others. However, only 15% (4/26) reported they had done/were going to do this with others within the HALN. This result may reflect the relative youth of the network and the newness of many participants to the anchors agenda, meaning a large proportion feel like recipients of information rather than equally well-informed peers able to share their own experience and learning. Thus the bulk of sharing appears to be happening locally, rather than with other network participants: eighty percent (21/26) had shared or were planning to share with others within their organisation directly involved in anchor work. Nearly 40% (10/26) had shared or were planning to share with others within their organisation not directly involved in anchor work. Fifty percent (13/26) had shared/were going to share with local partners (Figure 5-2).

Figure 5-2: Number of respondents who shared their learning or planned to share their learning with others (n=26)



Source: Survey of HALN participants

Action learning sets and webinars

5.20 Feedback from interviews indicates that much of the peer learning and sharing of resources occurred through the action learning sets, which then stimulated additional 'offline' sharing of information. One interviewee described how they had met separately with one of the other learning set participants to compare progress and activities around workforce dashboards and how they could be used to support anchor work. Another interviewee described how they had valued support from a peer in a learning set in terms of sharing problems and building confidence in developing solutions.

5.21 The webinars have reportedly stimulated some offline sharing too, with attendees following up with those presenting or others who had made contributions (and shared their details) regarding specific points of interest or requests for local presentations.

Learning shared: Partnership building

One organisation reported that they had used the learning from the action learning set to facilitate collaborations with organisations that were now yielding results, particularly around employment practices.

We've implemented quite a lot around employment. We've put in place lots of collaborative arrangements, lots of partnerships, that in some cases are beginning to feed up actual activity. Some of that is [due to] that guiding hand from HALN.

Action learning set participant

The HALN's contribution to building these partnerships was the provision of learning and development of confidence around how to engage with partners such as local authorities. The confidence resulted from hearing other HALN participants' experiences of engagement, as well as potential challenges and how these had been overcome.

The bit around partnership is not necessarily hard but it's an art form and you need some experience of doing it and some experience of the local authority world. All of the [HALN] activity has helped to build my levels of confidence in what I'm doing, either hearing what other people are doing and their challenges, and seeing what's possible; seeing what Barts and Northern Care Alliance have done with employment.
Webinar and action learning set participant, and Test and Learn recipient

Peer to peer support

5.22 Peer to peer support and sharing of learning is arguably one of the key features of a successful network so evidence that this is happening is to be welcomed. One interviewee highlighted how important peer learning is in terms of anchors being an emergent area of policy and practice, where there are few formal or structured sources of support: in these circumstances, knowing other people are facing similar challenges, exchanging ideas about solutions, and seeing evidence of tangible process offers practical and moral support. In this light, facilitating more opportunities for network participants to contact each other seems important, and is supported by suggestions from participants for a participant directory, the sharing of contact details for event attendees, and face-to-face events.

Outcome 5: Participants have developed and strengthened anchor practices

There is encouraging progress in supporting participants to develop and strengthen anchor practices. The HALN has made anchor practices more accessible, increased confidence among participants in using anchor practices, and helped speed up the development of anchor practice.

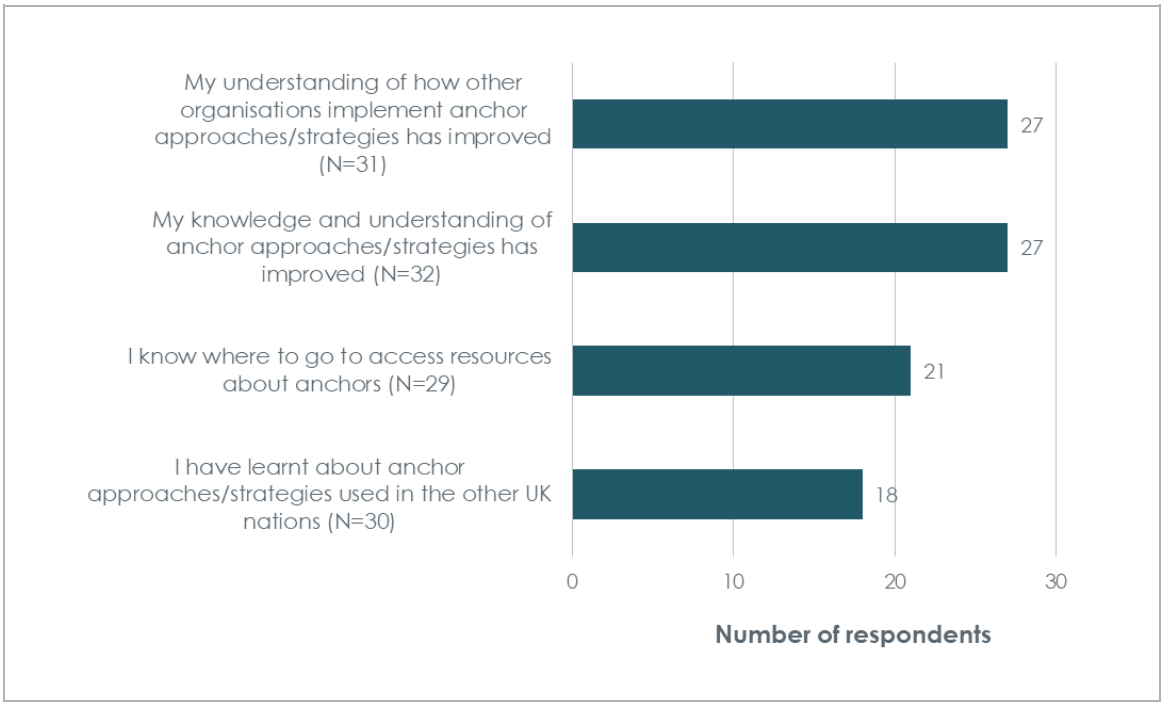
Knowledge and understanding

5.23 Within the network's two years of delivery to date, limited progress was anticipated on outcomes related to systems and policy and impacts. As an interim outcome, participants developing and strengthening anchor practices is therefore important. There is encouraging

progress on this indicator. As a foundation for developing and strengthening practice, a large proportion of HALN participants have improved their knowledge and understanding of anchor practices/strategies (self-reported assessment at the time of completing the survey compared to before they engaged with the HALN. 84% or 27/32 survey respondents; a slightly higher percentage, 87% or 27/31 reported an improved understanding of how other organisations implement anchor practices/strategies, Figure 5-3).

Being part of this journey with HALN has helped to…synthesize my own learning and understanding of the issues.
HALN participant

Figure 5-3: Number of respondents who strongly agreed or agreed that since engaging with the network…



Source: Survey of HALN participants

Use of learning

5.24 Crucially in terms of improved anchor practices, a similarly high proportion of participants had used or had plans to use their learning (88% or 28/32, self-reported assessment at the time of completing the survey compared to before they engaged with the HALN). In some cases, as mentioned above, they were simply planning to share information. But a minority described how they intended to use the information to build local understanding, awareness and engagement, thus generating momentum for anchor work. In some cases this was simply about re-badging existing initiatives as anchor practice. One interviewee reported having shared resources from the HALN website with the board as a means of generating buy in and understanding of anchor practices.

I think that in terms of developing our approach and strategy and informing our engagement with our board, it has helped position that. It draws on the learning and experiences of others which helps us avoid the same traps and helps us to do the right things.
HALN participant

5.25 A little over a quarter (28% or 9/32) of survey respondents gave practical examples of how they planned to use the learning to progress their local anchors work. For example:

Establishing an anchor network locally and using tools from the HALN website to guide development and prepare information for sharing internally.

To develop initiatives to employ more local people to support tackling health inequality.

Setting up my own benchmarking for a health inequalities reduction project.
HALN participants

5.26 Action learning set participants were also able to describe concrete examples of how they had developed anchor practice due to engagement with the network. Examples are given in the boxes below.

Learning implemented: Broadening the network

One organisation reported that the HALN sessions had prompted them to broaden the membership of the network it engages with on anchor practices. They had chosen to expand this network beyond the NHS and public sector to include private sector organisations, thereby changing the scope and scale of their anchor programme.

One thing we've done is that we've broadened our network. Previously it was very much typical NHS, local authority and housing associations but we've broadened to support private sector engagement, including accessing funding from large investors in place. I think that's one thing we've taken forward that we wouldn't have considered an appropriate conversation to pursue.
Action learning set participant

Learning implemented: Employment programmes

One consultee reported that, following the action learning sets, they had implemented a sector-based workplace academy for the ICS, providing both a benefit to the organisation, which received staff, and the people referred who were able to find work.

For us it's been really tangible. We've had 368 people referred through our sector-based workplace academy. It's been a really active recruitment avenue that's fed through to people getting jobs and there being an organisational benefit.
Action learning set participant

Learning implemented: Measurement and impact

One organisation said that an action learning session focused on measurement and impact had prompted them to introduce an online dashboard which pulls together key qualitative and quantitative metrics for measuring anchor impact. This would allow them to monitor these metrics throughout the year, as well as to more accurately report on the impacts of their anchor programme. In addition to the prompt to move forward with measurement of these metrics, the software tool they adopted to pull this data together was one they had seen presented at the Measurement and Impact session.

"[The measurement and impact] session definitely prompted us. It was something we needed to do. It probably prompted that and helped to frame that and the thinking. And now we're at the stage where we can actually look at this properly."
Action learning set participant

Facilitating role

5.27 The role of the HALN in helping participants to develop and strengthen their anchor practice was generally described as that of a facilitator. The network was credited with codifying (rather than designing new) solutions that were then more accessible, building capability among participants, and generating confidence to push ahead with initiatives. Several interviewees specifically identified that the HALN had sped up the development of their anchor practice. One reported that it had increased the pace of delivery on procurement.

Outcome 6: Systems understand their role in progressing the anchors agenda and facilitate local partnerships

There is early progress on systems working with local partners and ICSs are gradually being brought on board (in England). Potential complementarities and differences between providers and systems in anchor practice should be considered.

Work with local partners

5.28 Getting systems to understand their role in the anchors agenda and facilitate local partnerships was a slightly longer-term objective for the HALN. However, there is early evidence of progress on this outcome.

5.29 A small number of interviewees described work to initiate or progress anchor initiatives in conjunction with local partners. For example, one individual described how they were co-producing anchor practice with their communities to support joint work between anchors across their 'place'. Another person noted work being done within their health and care partnership to develop a series of values and expectations for collaboration with the voluntary organisations in their city. There was a clear recognition among interviewees of the importance of local partners, who were often more advanced in their anchor practice than the interviewees' own organisations.

Involvement of ICSs

5.30 ICSs are gradually being inducted into the anchors agenda (in England), with this typically happening more rapidly in areas with more mature anchors (that is, with organisations that have been delivering anchor practice for a few years). In most cases, respondents reported on anchor institutions trying to put anchors on the ICS agenda rather than the other way around. NHS regional leads were cited as those trying to engage with ICS on anchors, using resources from the HALN to share information and help the ICS understand its potential role. In some cases this involved explaining to ICSs that existing practice was already closely aligned with anchor principles. The evaluation heard from a small number of individuals working in ICSs. One agreed that learning was a precondition for informing strategy that would subsequently lead to action.

Providers vs ICSs

5.31 There was an interesting set of views about the respective roles of NHS providers, particularly NHS Trusts, compared to ICSs. A significant minority thought it was important to explore the difference between say, an NHS Trust, and an ICS, where the Trust had all the standard features of an anchor institutions (rooted in its locality, with potential to have a significant impact on their local area via procurement, employment, and management of buildings/estates) but the ICS did not (although the ICS did have improving economic and social development of its area as one part of its mission). Some interviewees perceived that

involving the ICSs in the anchors agenda would reduce motivation for Trusts to take it on as a priority.

I feel strongly that anchor institutions are a particular focus of anchors and that an anchor system is a different thing…. The ICSs might not be there in ten years time, but our hospital will be and the point of anchors is that you can use the tenure and permanent nature of institutions to drive it.
HALN participant

5.32 Others believed that anchor practice would manifest differently between ICSs and Trusts and that they could be complementary. How they do so is something that should be considered for the future evolution of the HALN.

Outcome 7: The network is able to influence relevant policy and practice

Local strategy and practice is being influenced directly by participants. There is some influence on national policy via the NHS England programme partner. Senior backing is important to supporting implementation of anchor practices at scale and speed.

Influence on local policy

5.33 A report on progress against this impact needs to distinguish between local strategy and practice and national policy. At a local level, there are certainly indications that participants are trying to influence strategy and decision-making and they are using learning from the HALN to inform these efforts. For example, in one locality HALN resources reportedly supported the choice of one partnership to implement the Living Wage. Another HALN participant discussed how:

[Engagement with the HALN] reframed how I was going to work with senior leadership. What it did was change the way I talk about anchors – breaking it down into those parts and holding the leadership to account on what they were doing on each section e.g. procurement and estates.
HALN participant

5.34 Other participants discussed more indirect routes to this impact through raising the profile and credibility of anchors work among senior stakeholders:

[We] gained credibility that this is a national issue, [which] helped raised profile of our work and support resource requests.
HALN participant

5.35 Several interviewees expressed an ambition to generate ownership in other parts of their institutions, particularly among senior procurement and finance colleagues, to embed and mainstream anchor ways of working. One individual described trying to highlight the

complementarity of anchor practice and core institutional goals such as increasing efficiency and reducing costs.

Anchor principles can be adapted to address pressing institutional needs as well. We had an issue where we had a breakdown in catering staff supply because a lot of people left to go and work at a big coffee place around the corner. We can very quickly source catering staff through our anchor programme.
HALN participant

Influence on national policy

5.36 At a national level, there are three routes by which the HALN identified it may be able to influence policy. First, it might do so indirectly simply by being a part of the health landscape and contributing to conversations about the role of healthcare bodies. Second, it might do so cumulatively, through the collective impact of lots of local and regional level changes that, in aggregate, create national policy change. Third, it might have a direct influence by actively collating and synthesising the work of HALN participants and taking that to national stakeholders.

5.37 To date, the HALN has played some role via the first route. The involvement of NHS England staff in the HALN has enabled those staff to feed learning about anchor practice into policy via the 2022/23 priorities for the system and the ICS framework, with particular contribution to the role of ICS in social and economic development.

5.38 At this point, there is no evidence that the HALN has had an impact on national policy through the second route, that is through cumulative local outcomes.

5.39 In terms of the third route, the HALN itself was not expected to actively influence national stakeholders (the direct influence of the NHS England programme partners on other parts of NHS England is described in the first route, above). However, knowledge sharing activities such as speaking at the Institute of Government and Public Policy conference indicate that the HALN is beginning to undertake more strategic activity. The extent to which this should be a core aspect of the HALN's role should be considered in the third year of delivery.

5.40 Interviewees identified a confluence of factors that mean anchors are highly relevant, creating an important opportunity to influence policy and practice. Examples include the ICSs' purpose to contribute to local economic and social development, a mandate to deliver social value in procurement among NHS organisations, and Core20Plus5. A few participants discussed how influence on national policy was important to reducing some barriers to local progress, for example, shifting the balance from NHS centralised procurement to localised procurement, potentially with partners and moving away from the Agenda for Change pay bands. There was a widely held view that anchor practices would be unlikely to take root at speed and scale without strong, consistent policy backing, both locally and nationally but crucially at the latter level, so staff in Trusts, ICSs and other anchor institutions are resourced and empowered to implement anchor practice.

Progress against impacts

Increased adoption of evidence-based anchor practices

5.41 It was not anticipated that there would be much measurable progress on this impact (taken to mean the wider adoption of evidence-based anchor practices beyond those introduced by participants within the network as a direct result of their engagement in HALN, the latter being counted under Outcome 5) within the first two years of the HALN. However, progress on the other outcomes, particularly Outcome 5 'Participants have developed and strengthened anchor practices', offers encouragement that wider adoption of anchor practices is possible, if circumstances are conducive (see below on Factors influencing outcome achievement).

The social, economic and environmental conditions that contribute to tackling health inequalities are enhanced

5.42 There was general agreement among those providing feedback that anchor practice was an obvious route to reducing health inequalities but that it would be (in the main) a long-term project and challenging to attribute, given the multiplicity of factors that affect health inequalities. It was felt that there should be ongoing efforts to improve measurement approaches and frameworks in relation to anchors so the links between practice and impact can be better understood and evidenced.

5.43 While there was positive feedback from the survey with nearly half of all respondents (14/30) saying that the network had supported them to address health inequalities, and more than a quarter (8/30) expecting it to, the free-text responses to this question indicated that people were not thinking of measurable/attributable effects on health inequalities. Respondents were in fact highlighting routes by which they expected anchor practice to affect health inequalities, such as educating people on health inequalities and how anchors can address them, partnering with new organisations such as the voluntary and community sector, and sharing good practice. As one participant stated:

It's quite difficult to say that it's resulted in this specific thing but it's absolutely informed our approach and practice in terms of evolving a clear, more strategic approach to our work around the whole health inequalities agenda.
HALN participant

How progress against outcomes was achieved

5.44 To refine understanding of how the HALN has been able to make progress to date, how it can continue to do so, and how it can address its role and purpose, it is worth reflecting on the routes to impact and other factors influencing the achievement of outcomes.

Routes to outcomes and impact

5.45 In its examination of the links between networks and quality improvement, the Health Foundation's report *Effective Networks for Improvement* (2014) found that:

Evidence demonstrating the impact of networks is scarce. It is difficult to identify precisely a network's effect on clinical outcomes independent of other factors – which is true of many health improvement initiatives but especially of networks, given their intangible nature.

5.46 A similar challenge applies to the HALN: engagement in the network by participants is generally quite light touch, for example by reading the newsletter or watching a webinar, with the exception being the action learning sets (see Chapter 3 for a full set of network activities). There are multiple other factors that are likely to contribute to or confound participants' ability to progress anchor practice and even more factors that will interact between the implementation of anchor initiatives and the achievement of improved social determinants of health and health outcomes. That said, evidence from the evaluation has indicated several routes by which HALN activities reportedly influence participants. These included:

- Offering insight and guidance on why and how to implement anchor practice
- Bringing together a peer group to offer opportunities for support, to build up confidence, to create inspiration, and to refine ideas and practice by sharing outside institutional boundaries
- Making the anchors agenda more visible and tangible through establishing an online presence, producing resources that can be shared, and holding events, building a sense of identity among participant and legitimising anchor ideas and practice.

5.47 In the words of one HALN participant:

Is the fact that the HALN exists going to influence the people who sign off business cases? Probably no. Those who apply for a job or allocate resources differently? Probably no. But for the people who are in the area of work, it's really important. Getting the critical mass, peer support, moral support, check and challenge… it really does speed up the work and practice.
HALN participant

Factors influencing outcome achievement

5.48 Whether the HALN can be successful in achieving outcomes is both supported and constrained by a number of issues. In the main, these factors are outside the control of the network.

5.49 One of the key factors is capacity, in terms of capacity available to the network, to individual participants and within their organisations. The HALN received £300k over two years (of which £50k was for the design of the network). Excluded from that figure is the un-costed expertise and support from NHS England, Health Foundation staff and other partners, which, as detailed in Chapters 3 and 5, was important to the quality of delivery (3.16) and the

achievement of particular outcomes (O3 and O7). The evaluation did not make a value for money assessment of the network but feedback from participants and stakeholders on the quality of delivery plus achievement of outcomes indicates that the funding has been efficient and effective.

5.50 Among participants, capacity was highly variable, with some individuals having anchors as the entire focus of their role, while other had it as a smaller proportion or even had no formal remit to undertake anchors practice and had engaged purely out of interest. Participant capacity was further affected by organisational capacity. Feedback indicated that even where an individual had a designated anchors role, progress on delivering anchors initiatives required support from multiple other colleagues with other priorities and sometimes subject to the intense pressures facing the NHS.

Everything is very challenging at the moment in the NHS so getting people to have time to do anything is difficult…. If you're talking to procurement teams about social value and they're just trying to get enough gloves and linens to cope with overspill from the emergency departments and to ensure that wards are stocked, it's quite difficult. Doing anything that's seen as nice to have is difficult, certainly in NHS providers like ours.
HALN participant

5.51 A second key factor affecting progress is senior support. Again this can be understood in a variety of ways. The HALN itself experienced turnover in senior personnel during delivery, which had to be managed by the partnership to ensure the network did not lose momentum. Participants reported varying degrees of senior support locally, with greater senior backing very closely linked to the ability to implement anchor initiatives through provision of permission and resource to do so. More broadly, it was widely perceived that the anchors agenda existed in a crowded space, along with health inequalities, CORE20Plus5, economic and social development, and social value. While anchors is effectively a mechanism that can support delivery of these other policies, there was also a fear that anchors might 'fall through the gaps', and not receive the same funding and support as other topics.

6. Moving forward

Chapter summary

The first two years of the HALN came to an end in February 2023. The HALN will continue to be delivered for a third year to February 2024, following an extensive sustainability planning process. The Innovation Unit will continue to deliver the HALN, and the network will continue to be funded and managed by the Health Foundation. NHS England will not have direct involvement in network management but will continue to provide support as a key stakeholder.

A range of potential opportunities and risks were identified by those interviewed, as the HALN moves to its third year of delivery. While key risks were considered largely outside of network control (notably capacity of participants to develop anchor practices, and senior support for them), interviewees felt that the HALN could mitigate against these risks through: facilitating cross-organisational approaches to implementing anchor work; linking with other networks or programmes focused on anchors to exploit opportunities for collaboration and partnership development; supporting organisations to demonstrate the impact of their anchor work; and collaborating with cross-sector partners to demonstrate the impact of anchor work.

Further strategic opportunities were identified by interviewees to strengthen the network's value and use. These included linking the anchors agenda to the role of ICSs in supporting broader social and economic development, increasing links with other policy areas, recruiting network champions to raise the profile of anchors and facilitate bottom-up engagement, and actively seeking to influence policy using learning from its first two years. Interviewees also reflected that the network would need to respond to the risk of a lack of clarity in the purpose, focus and audience of the HALN.

6.1 This chapter sets out the next steps for the network and explores some of the opportunities and risks for the network as identified by partners, stakeholders, and network participants during interviews and focus groups. Where relevant, it draws on findings from observations of HALN activities.

Next steps

6.2 In February 2023, the HALN came to the end of its original funding period of two years. The network will continue to be delivered for a third year, to February 2024. This decision followed an extensive sustainability planning process, which began in 2021. A sustainability session was delivered by the partnership in summer 2022, in which a range of options were considered for the future of the HALN. These discussions were open and reflective, considered a range of options (from sustaining current delivery to closure), and there was recognition of

the strengths and limitations of partner roles in the network and what that might mean for the network moving forward.

6.3 In the third year, the Health Foundation will continue to fund and manage the network. The network will continue to be delivered by the Innovation Unit and a delivery plan has been developed that takes account of learning from the first two years. NHS England will no longer have direct involvement in the management of the HALN but will continue to act as a key stakeholder and provide support where possible and appropriate.

6.4 Interviewees outlined a range of opportunities and risks which had the potential to affect the network in its third year of delivery. These are summarised below.

Opportunities and risks

6.5 Capacity among individuals and organisations to develop anchor practice and senior support for them to do so, as described at the end of the previous chapter, were two of the main risks identified for the network in its third year by participants, stakeholders and partners interviewed. The HALN's ability to influence these factors is limited but there are a range of ways it can tailor delivery to appeal to and support those interested in anchors. One of the simplest means is by curating resources to make them more accessible. Partners, stakeholders and network participants identified other opportunities to deliver services or products of value, including:

- **Facilitating cross-organisational approaches to implementing anchor work**. Interviewees noted there may be opportunities for the network to support organisations to develop internal links across departments to drive forward anchor work as a coherent programme of work that can support wider organisational priorities. Some interviewees suggested that the network could pilot activities targeted at organisations, rather than for individuals, to explore the potential of this approach.

- **Link with other networks or programmes focused on anchors** to exploit opportunities for collaboration and partnership development as the network continues to grow and become more visible. Suggestions put forward by interviewees included regional networks or local programmes to support NHS organisations to deliver anchor work (which have increased in number since the HALN's inception), non-sector specific networks or programmes focused on anchor work (e.g. the London Anchors Institution Network), or programmes focused on specific aspects of anchor work (e.g. National Voices for Civic Engagement and the Marmot networks).

- **Supporting organisations to demonstrate the impact of anchor work**. As outlined in Chapter 4, while the evidence base developed through the HALN on how to deliver anchor practice continues to grow, there was reported to be comparably little evidence on the impact of anchor work, and support for organisations to demonstrate impact. This is not unexpected given that the health anchors agenda is a relatively new one. The HALN could draw on ongoing work externally to support this. Funded by the Health Foundation, NHS

England is working with University College London (UCL) Partners to improve the measurement of the impact of anchor practice: interviewees highlighted that this could provide the basis for further support delivered through the network.

A lack of policy direction is a risk for anchors work generally. If it is not a 'must do', then it is challenging [to engage with]. [Anchors] is mentioned in the Long Term Plan, but it is not very strong. If we could demonstrate the impact and savings of what we are trying to do, it would decrease the risk [of the HALN not succeeding].
HALN participant

- **Collaborate with cross-sector partners to demonstrate the impact of anchor work** relatively quickly, using transferrable learning from other sectors. Interviewees reflected that collaborating with a wide range of partners would have benefits for participants in terms of knowledge and skills development but also the network itself, with the potential to increase reach and develop economies of scale through collaboration, easing resource pressures.

6.6 At a more strategic level, interviewees identified several opportunities for the network to strengthen its value and use:

- **Linking the anchors agenda to the role of ICSs to help the NHS to support broader social and economic development**, although interviewees noted the network would need to consider how anchor practice might manifest differently between ICSs and Trusts to ensure complementary delivery.
- **Increasing links with other policy areas such as the Greener NHS agenda, social value procurement changes, and the health inequalities agenda and Marmot principles** to ensure the network can continue to contribute to relevant policy agendas and does not "*fall through the gaps*".
- **Recruiting network champions to raise the profile of anchors and facilitate bottom up engagement.** Its 'high-fliers' learning set was geared towards more mature health anchors to enhance progression and impact. Stakeholder interviewees reflected on the potential for these individuals to become champions of the network, galvanising new participation from their own networks and sharing their learning to those in earlier stages of anchor work.
- **Actively informing policy using learning generated from its first two years, taking on a 'debate leading' role**. This may require support from the Health Foundation as the network funder to leverage its reputation and expertise in this space. However, it is likely this would also require additional resource, which may not be feasible at this point in the network's delivery.
- Importantly, a few interviewees reflected that to grow participation and engagement the network needs to **respond to the risk of a lack of clarity in the purpose, focus and audience of the HALN**, which may discourage people from engaging with the network.

[The network is] far too broad. What is the purpose of the network? When it was first established it seemed to be about raising profile of anchor work. But they might need to… clarify who they are for and what they do. Is it a repository of resource and information? Or does it connect people?

HALN stakeholder

6.7 Crucially, partner, stakeholder and participant interviewees also voiced concerns about the sustainability of the network following its third year of funding, given the risks outlined at the start of this chapter. The presence of the network, and particularly its growing bank of resources, was seen to be important to sustain long term. The implications of these opportunities and risks, as identified by interviewees, are explored in the following chapter.

7. Conclusions and implications

7.1 This final chapter sets out evaluation conclusions, and the implications of its key findings. However, it is important to note the limitations of the evaluation, which was only able to access a small, self-selecting proportion of those engaged with the network. This was not unexpected given most engagement in the network is lighter touch (and therefore individuals have limited incentive to engage in evaluation). However, the nature of the evidence available to the evaluation limits the robustness of conclusions about the achievements of the network, particularly in terms of outcomes and impacts.

Achievements

7.2 Feedback indicates that the network has been managed and delivered effectively during its first two years. During the programme design phase, the Innovation Unit developed six design principles, which they expected would provide a framework for delivery (see chapter 2). Overall, network delivery and implementation has shown (varied) fidelity to these principles.

- Based on evaluation evidence, it is clear that the network is **uniquely placed** to support participants to develop their anchor activity. Both stakeholders and participants highlighted that the HALN is often the *"go to"* programme to access resources and information about anchor activity, reporting that it complemented, rather than duplicated, support networks and programmes at regional or local levels. It seems that the 'USP' of the network is its national focus and its curation of up-to-date resources across a wide range of topics.

- Evaluation evidence asserts that the network is **expertly facilitated**. This is evident at a network level, with participant experiences of the network on the whole positive, with particular praise for the high-quality facilitation of network activity. The network has also been increasingly well delivered and managed at a partnership level, as programme partners aligned their working practices more effectively.

- Linked to this, the network can be described as **always learning**, with participants reflecting that delivery had been responsive to their needs, and the Innovation Unit placing particular importance on this aspect of delivery. This is commendable, given the breadth of the anchors agenda and the myriad topics that could potentially be covered.

- To some extent, the network has been **mission-led**. Following the design phase, the programme set out the network's purpose and focus within its delivery plan. However, evaluation feedback indicates that this has not been consistently clear and communicated to participants and stakeholders to date.

- The network is beginning to become more **action oriented**. Engagement with the network is sustaining and continues to increase. Learning shared in resources (including case studies and blogs) and through events is often 'crowd-sourced' and based on

participant experiences, creating feedback loops. There is limited evidence to date to suggest that this process is *initiated* by participants but spontaneous sharing of materials may increase as the network and its participants mature.

- The network is free to access, and participants can engage with learning as much or as little as needed. In addition, the fact that the network is open to those across the UK, and is virtual, makes the network highly accessible. The network also aims to support the reduction in health inequalities in local areas, through anchor strategies. In this sense, it can be argued that the network is **serious about inclusion**. However, there is limited data available to assess the extent to which the network promotes inclusivity of participation beyond regional variation, which suggests there is more to be learnt about, and potentially done to address, inclusion.

7.3 The evaluation aimed to assess progress against the Theory of Change, and the extent to which the HALN was achieving its aims, objectives, and outcomes and impacts. It is evident that, overall, **the HALN is making good progress against most of its expected outcomes**. It is particularly encouraging that the network has supported participants to develop and strengthen their anchor practices, indicating that the network has generated tangible changes on the ground. Evidence indicates that this work is opening up routes to impact on health inequalities, although it should be noted that tangible reductions in health inequalities were not anticipated within the timescales of the evaluation.

7.4 **Progress towards the overall aim of the network is less clear** at this point. From the outset, the programme aimed to facilitate a sustainable learning network of NHS anchors, focused on improving social, economic and environmental conditions to tackle health inequalities. However, there is a fundamental **question around the intended definition of sustainability**. If the HALN considers sustainability to allow for dedicated resource and management over the medium to long term, then achieving a third year of funding is a (small) positive step towards this concept. But, if the HALN defines sustainability as the development of a self-sustaining network (built entirely on grassroots / bottom-up support), there is more work to be done.

7.5 However, **in terms of its objectives** (sharing information, clarifying approaches, developing an evidence base, spreading good practice and supporting delivery), overall evidence indicates that **the HALN has made good progress**. There are, of course, aspects of the network where further work could be done to strengthen this success, which is discussed further below.

7.6 **The Health Foundation's *'effective networks for improvement'* model outlines five core features of an effective network** (common purpose, cooperative structure, critical mass, collective intelligence, and community building). It argues that the combined effect of these features enables effective quality improvement, learning and change. **Assessed against this model, the HALN has made considerable progress within two years.** While the clarity of the network's common purpose could be improved, its overall focus on supporting anchor institutions in the health sector seems to be understood. The network has developed a

cooperative structure and collective intelligence, evident through shared learning facilitated by the HALN. In terms of the remaining two factors (critical mass and community building), evidence indicates that these are growing but are still at an early stage.

Building on strengths

7.7 Delivery has been positively received by participants and other stakeholders despite the challenges faced by the network. This means there are a number of strengths on which the HALN can build in the third year:

- The **programme partners have considerable expertise and constructive working relationships**, which evolved over time to strengthen and improve. Even though they will no longer be a formal partner in the network's delivery, continued clear support from NHS England is likely to be important in attracting and retaining engagement.
- The **three communities structure** (Figure 2-2) has allowed the network to support people at different stages of their anchors 'journey' using a range of activities, helping the network achieve diverse participation. It may be worth the network considering how this structure can be useful over the next year. For example, it could continue to inform delivery by helping the Innovation Unit to anticipate the expected scale of engagement by each 'community' over the next year and apportion resource accordingly. It could also support engagement by being communicated to potential audiences, alongside signposting to resources and activities. Both of these uses may help in bringing participants 'through the funnel', from initial engagement with the network, to learning and doing, and to maturing as an anchor institution, by providing clear routes to doing so.
- The network's **resources and action learning sets** were highlighted as positive features of the HALN. These should continue to be offered and refined according to participant need.
- **Opportunities to network directly with other participants** were valued. Additional routes to engagement could be explored to maximise networking amongst participants.
- An effective network, as defined by the Health Foundation,[23] is facilitated by critical mass, including the presence of 'change agents'. Change agents are characterised as those who are committed, longstanding 'champions' of the network who can create and sustain momentum, and drive engagement. **Ensuring that engagement from more mature anchor institutions is maintained** will be important, to act as champions or 'change agents' within the network, as well as the effective capture and sharing of learning around the impact of anchor work.
- The **four nations approach** forms part of the network's 'USP'. The network may wish to consider the extent to which this should still be a core focus (or expected outcome). If so, it will be important to think about the resource which may be required to drive

[23] The Health Foundation (2014) *Effective Networks for Improvement*

engagement across Scotland, Wales and Northern Ireland, especially given the existing challenges of achieving breath in other areas (for example across the anchors agenda, and across the spectrum of participant maturity).

Addressing issues

7.8 There are three main issues evident from the first two years of delivery that need to be addressed:

- **The systematic collection of data on network participants could be enhanced**, to elicit more in-depth insights to support planning. It is understandable that the network has not wanted to overburden potential participants in asking a range of questions on sign-up. However, collecting a small amount of information about participants when they first engage with the network, and tracking their engagement, is likely to help the HALN to understand their participants better, including who is engaging with the network, patterns of engagement and how these vary by different characteristics. While some resource would be needed to support data collection (upfront) and analysis (longer term), this information should inform future delivery and activity.

- **Management of the balance between breadth of the anchors agenda, and the depth needed for meaningful learning to occur**. There were, and are, continued calls for a wide range of topics to be covered through the network but there is a limit on the extent to which these can be covered (and to what level of detail) given resourcing and capacity constraints. Within the network, the action learning sets have addressed this to some extent, by giving participants the tools, frameworks and (importantly) dedicated support to deliver anchor work in topic areas of their own choosing. Externally, the network's sister project, Test and Learn, has taken this approach a step further, by providing funding to projects seeking to develop anchor practices. Ensuring there is some kind of dedicated support for participants in future (including, but possibly not limited to, action learning sets) may be the best route to accommodating the demand for depth, against the provision of breadth through the network's resources, blogs, videos and case studies. In addition, linked to the point above, additional data could give an indication of the preferred approach by participants. However, it is recognised that there will likely always be tensions between breadth and depth, given the scope of the anchors agenda, and while there does not seem to be an 'easy fix', the issue should continue to be recognised (and mitigated against where possible).

- Better positioning of the network within and/or alongside other policy agendas across all four nations. More high-profile endorsement or championing of the network from a range of leaders at national, regional and system level may support greater reach and engagement. Aligning the network with other policy agendas may also provide some 'futureproofing' for the HALN, enabling it to continue contributing to relevant policy agendas such as economic and social development, social value and health inequalities.

Exploiting opportunities

7.9 Chapter 5 outlined a range of opportunities and risks for the network but the HALN is well-positioned to take advantage of these.

7.10 One of the major issues for consideration is **who the HALN looks to engage with and who it seeks to work with**.

- To date, the network has focused primarily on reaching and engaging individuals. This includes individuals from the same organisations, although it is unclear whether these individuals are connecting to drive forward change within their organisations or are working in silos. The HALN may wish to consider how it can support individuals to understand who else in their organisation is actually engaged in the network, or even to offer organisational support (although this may not be within scope, and may be challenging to progress in the current resource envelope).
- Feedback suggests that the majority of participants are not specialists, that is they do not deliver specific functions such as finance, procurement or HR. Reaching beyond existing participants and getting professional disciplines to take collective ownership of anchor practices may seem challenging but is important if the network is going to generate sustainable change and achieve long-lasting impact. Mainstreaming the anchors agenda would be greatly supported by the adoption of anchor practice among those with these more specialist roles. In the next year, the HALN could promote clear links with other policy areas, and make the case for how anchor practice can support other NHS priorities (e.g. staff retention), to attract a wider range of participants.
- There is a clear demand for working with a broad set of partners, including those from different sectors (as the network successfully did with the housing association in year two), and from across systems, particularly the ICSs. Extending the range of partners offers opportunities to learn from places where anchors is more advanced, to apply anchor practices in different ways at different scales, and ultimately to develop the nature and scale of impact.

7.11 There are three other areas in which opportunities have been identified:

- **Demonstrating (and supporting participants to demonstrate) the impact of anchor work.** This was key for many participants, and the HALN should ensure that any new data emerging (for example the ongoing NHS England and UCL Partners work around anchors measurement) is effectively incorporated into content and disseminated, to maximise learning.
- **Growing from an 'information sharing' network to a 'debate leading' network**, drawing on and synthesising learning from the network and actively using that to shape conversations about anchors and related topics. Of course, this is an additional strand of work, for which there may not be resource, and it may not be considered within the remit of the network's third year.

- **Actively planning for sustainability** beyond the end of the third year from as early as possible. For example, the network has generated a substantial bank of resources about anchor practice that could continue to be used to support anchor institutions. It will be important to consider how these resources can remain accessible.

7.12 Finally, given the challenges associated with evaluating a network, it is worth the HALN re-visiting the Theory of Change to clarify routes to impact (for example by increasing participants' knowledge and confidence) and the best indicators against which to monitor progress.

7.13 In conclusion, there is much the network should be pleased about as it transitions into its third year of delivery. Its first two years have established a tried and tested approach, and there are a number of opportunities that the network can act on to strengthen and enhance its delivery, not least the opportunity to engage with other partners and networks to add value to its offer. While there are risks which the network will need to be sensitive to and mitigate against, the ethos of responsiveness that has been adopted by the network indicates that it should continue to learn and adapt accordingly.

Annex A: Methodology

A.1 SQW was commissioned by the Health Foundation to undertake an evaluation of the HALN, from May 2021 to February 2023. The evaluation had two main aims:

- assess progress against the Theory of Change and provide feedback on how the HALN was meeting its objectives
- capture evidence of the experience and learning of those involved in the HALN to inform the ongoing design and delivery of the network.

Evaluation approach

A.2 The evaluation took a developmental approach in light of these aims and consideration of the challenges in this study, namely:

- rapid evolution of the HALN during its two years of operation
- diversity in terms of participating individuals and organisations, their experience in implementing anchor practices, their places (hence local contexts) and areas of interest/themes
- complexity in terms of multiple factors affecting changes within local communities (making it difficult to attribute outcomes to the HALN)
- limited consensus on how to measure the quality and effectiveness of both networks and anchor practices
- limited evaluation resources to handle novelty, diversity, complexity and uncertainty.

A.3 Developmental evaluation is useful for the assessment of an initiative that is expected to change during implementation and where there is a limited evidence base on what the model should look like and what changes are likely to emerge. It offers a framework in which evaluators can reflect on implementation and revise methods accordingly. Developmental evaluation also supports implementation by collecting and considering a range of evidence quickly and providing timely feedback to those implementing the initiative. It can be divided into four key stages, although in practice they are not wholly distinct and sequential.

- **Orienting**: in which the evaluators begin to explore the context and intervention, building relationships with key stakeholders. This involved attending the inception meeting, conducting scoping consultations, reviewing documents and data, and joining informal catch ups. It also included our first attendance at the monthly call and a synthesis session.
- **Watching**: whereby evaluators observe implementation activity and explore what is happening and, importantly, why. Our watching activities included observation of subsequent synthesis sessions, monthly calls, and HALN events; interviews with delivery

stakeholders and HALN participants; a survey of HALN participants; and other informal engagements with the network.

- **Sense-making** refers to evaluators analysing data, drawing out findings and piecing together a narrative of the development of the initiative. Our sense-making included analysis of the qualitative information collected during the watching phase, and review of data provided by the IU. We used the Theory of Change as the framework for organising much of the evidence and producing a narrative for the development of the HALN.
- **Intervening**: describes the process by which evaluators provide feedback to those designing and delivering the initiative. We developed a learning framework to help structure some of our watching activities that, combined with the findings from the sense-making phase, helped us produce reflections on how the HALN structure evolved, the implications of evolution, and how further change might be managed. We held reflective sessions with the Health Foundation, NHS England and the Innovation Unit to consider the emerging learning and reflections.

Evaluation methods

A.4 The evaluation followed a three phase approach beginning with a thorough scoping phase. The scoping phase (delivered from May-August 2021) involved:

- An inception meeting with the Health Foundation, NHS England and the Innovation Unit.
- A review of documents and data, including programme management documents, delivery documents, co-design documents and contextual reports.
- Four scoping interviews with seven individuals involved in the management and delivery of the HALN from each of the three partners.

A.5 Findings from the scoping phase were summarised in an evaluation protocol, which set out key findings.

A.6 The second phase (delivered between September 2021 and February 2022) fed into an interim report, which was submitted to the Health Foundation in January 2022. This phase involved:

- Interviews with two programme partner representatives
- Interviews with seven network participants
- A survey of participants, which was hosted in Smart Survey and disseminated by the Innovation Unit to participants (via the network newsletter and stand-alone email bulletins). The survey yielded 32 responses
- Five observations, including of two network events, and three programme partnership meetings

- A reflective session to share emerging learning, attended by programme partners
- A review of documents and monitoring data including monitoring data and learning set survey data collected by the Innovation Unit.

A.7 The final phase of evaluation was delivered between March 2022 and February 2023. It involved:

- Interviews with six programme partner representatives from the Health Foundation, NHS England and the Innovation Unit
- Six stakeholder interviews, including with a sample of NHS regional leads
- Interviews with seven network participants
- Two focus groups with seven network participants, including test and learn participants
- A survey of participants, which was hosted in Smart Survey and disseminated by the Innovation Unit to participants (via the network newsletter and stand-alone email bulletins). Again, the survey yielded 32 responses
- Three observations of two network events and one programme partner meeting
- Two reflective sessions to share emerging learning, attended by programme partners
- A review of documents and data collected by the Innovation Unit (e.g. quarterly reports).

A.8 Findings from both the interim and final phases of the evaluation fed into a draft final report. Following a review workshop with the partners, a final report was developed.

A.9 The final and interim reports were also informed by frequent catch up calls with the Health Foundation. These were held approximately every fortnight for the duration of the evaluation (although were reduced to monthly during quieter evaluation periods).

A.10 Throughout the evaluation, all qualitative data was analysed using MaxQDA qualitative analysis software. All quantitative data was analysed in Excel.

SQW

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