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Building strong integrated care systems everywhere

ICS implementation guidance on working with people and communities

NHS England and NHS Improvement may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at ICS guidance.

Version 1, 2 September 2021

ICS implementation guidance

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**.

Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England and NHS Improvement are publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

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About this document

The ICS design framework sets the expectation that partners in an integrated care system (ICS) should agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services. This guidance sets out 10 principles for how integrated care boards (ICBs) can develop their approaches to working with people and communities, and the expectations.

Key points

- A strong and effective ICS will have a deep understanding of all the people and communities it serves.
- The insights and diverse thinking of people and communities are essential to enabling ICSs to tackle health inequalities and the other challenges faced by health and care systems.
- The creation of statutory ICS arrangements brings fresh opportunities to strengthen work with people and communities, building on existing relationships, networks and activities.

Action required

- ICBs are expected to develop a system-wide strategy for engaging with people and communities by April 2022, using the 10 principles in this document as a starting point.
- ICB constitutions are expected to include principles and arrangements for how the ICB will work with people and communities.
- ICBs should work with partners across the ICS to develop arrangements for ensuring that integrated care partnerships (ICPs) and place-based partnerships have representation from local people and communities in priority-setting and decision-making forums.
- ICBs are expected to gather intelligence about the experience and aspirations of people who use care and support and have clear approaches to using these insights to inform decision-making and quality governance.

Other guidance and resources

- ICS design framework
- Guidance on voluntary, community and social enterprise sector partnerships with ICSs
- Guidance on the functions and governance of the integrated care board

Introduction

Our experience supporting ICS development around the country over the past several years shows that working effectively with people and communities is one of the essential enablers of success.

ICSs enable health and care organisations to apply their collective strength to tackling the health and care challenges faced by the population they serve. Those challenges cannot be tackled successfully without drawing on the diverse thinking of those who know the issues best: local people, those who need services and unpaid carers, for example.

COVID-19 has underlined how health inequalities can only be addressed by listening to and understanding the people we collectively serve. All communities are different and have different assets that can help build better health and wellbeing, as well as improve service outcomes and experience and reduce inequalities.

The creation of statutory ICS arrangements brings fresh opportunities to strengthen work with people and communities. The ICS design framework sets the expectation that each ICB will develop a system-wide strategy for engaging with people and communities.

The good news is that ICSs do not need to start afresh with this work. They have been developing their approaches in this area for several years and there is now a store of strong practice to draw on, some of which is highlighted in this guidance.

This guidance sets out:

- 10 principles for ICBs to use when developing their arrangements for working with people and communities
- practical steps to consider when working with people and communities, whether across the whole system, in places or in neighbourhoods
- more detail on areas including ICS governance, tackling inequalities, co-production in ICSs and working with Healthwatch and the voluntary, community and social enterprise (VCSE) sector, as requested by stakeholders in relation to work with people and communities
- case studies reflecting some of the excellent ICS practice in this area
- links to further resources.

Elements of this guidance are subject to change until the legislation under which ICSs will be established as statutory bodies passes through Parliament and receives Royal Assent.[1]

It will be relevant to those designing partnership arrangements and approaches to decision-making and governance, as well as people redesigning and providing services, and supporting organisational development and engagement across the whole-system geography, at place and in neighbourhoods. It will help them devise practical methods to understand and respond to the priorities of people and communities.

The term 'people and communities' in this document is understood to include residents, people who access care and support (and those who do not), unpaid carers and families.

How we developed this guidance

This guidance builds on more than four years of experience as ICSs have developed and tested the best ways to work with people and communities in the changing health and care landscape. We have drawn on the practice of leading systems to propose approaches and models that have then been developed and tested further; for example, by holding public engagement discovery workshops with internal and external partners in ICSs. In the most recent engagement phase, the guidance has been shaped by hundreds of partners in the NHS and beyond, including local government and members of the public. It develops the 'Working with people and communities' section in the ICS design framework, reflecting contributions from partners during recent work on this policy area.

The guidance is part of a set of resources developed by NHS England and NHS Improvement to guide NHS leaders in their preparations to establish statutory ICS arrangements from April 2022. It does not intend to describe the full breadth of arrangements across the ICS or the role of all constituent partners but focuses on how we expect the NHS to contribute. For non-NHS organisations, including other

[1] It is expected that ICBs will have legal duties to involve patients and the public, similar to those which currently apply to clinical commissioning groups (CCGs). Statutory guidance on patient and public participation in ICSs will be provided once legislation is finalised. Assessment of how ICBs work with people and communities will be developed as part of any broader assessment frameworks following confirmation of legislative duties.

health or social care providers, local authorities and the voluntary and independent sector, this guidance frames how the NHS will approach working with people and communities and form a basis for collaborative arrangements across all ICS partners.

Ten principles for how ICSs work with people and communities

The principles that follow have developed from work with systems and build on those that appear in the ‘Working with people and communities’ section of the ICS design framework. They should be considered in the preparation of ICB constitutions outlining arrangements for working with people and communities to create a golden thread running throughout the ICS, whether activity takes place within neighbourhoods, in places or across whole system geographies.

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.
3. Understand your community’s needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
4. Build relationships with excluded groups, especially those affected by inequalities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.
6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
7. Use community development approaches that empower people and communities, making connections to social action.
8. Use co-production, insight and engagement to achieve accountable health and care services.
9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
10. Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.

Core requirements and good practice for working with people and communities

This section looks at how the 10 principles for how ICSs work with people and communities can be applied in practice. It outlines the two core requirements we expect every system to achieve, followed by good practice areas for ICSs to consider as they develop their arrangements for working with people and communities.

Core requirements

1. ICBs are expected to develop a system-wide strategy for engaging with people and communities by April 2022, using the 10 principles in this document as the starting point.

The strategy should describe:

- the ICB's principles and methods for working with people and communities
- the ICB's approach to working with partners across the ICS to develop arrangements for ensuring that ICPs and place-based partnerships have representation from local people and communities in priority-setting and decision-making forums
- the ICB's arrangements for gathering intelligence about the experience and aspirations of people who use care and support and its approach to using these insights to inform decision-making and quality governance.

2. ICB constitutions are expected to include principles and arrangements for how the ICB will work with people and communities.

The list below is intended to stimulate thinking by leaders and all those involved in developing the ICB's strategy for working with people and communities and putting the 10 principles into practice throughout governance and decision-making.

What good looks like
Devising a clear plan for how system partners work together to engage people and communities, linked to agreed system priorities and evidenced in decision-making.
Agreeing a system approach to engagement with shared methods and principles, such as a system-wide citizens' panel, local health champions, working with people with lived experience, health and care experience profiles and co-production approaches.
Encouraging 'engagement and experience' staff to work in an aligned way across all partners, including NHS, local government and the VCSE sector.
Creating regular opportunities to share practice and make connections and build on engagement already taking place.
Making full use of existing insights from national data sources and from place and neighbourhood-level engagement to inform activity and decision-making.
Building trust with clear, regular and accessible communications that can be shared across the system.
Maintaining proactive and systematic dialogue with public representatives, such as councillors and MPs.
Building from the current statutory place-based Healthwatch structures to agree a system-wide approach to working with Healthwatch.
Working through foundation trust governors, non-executive directors and elected members as key partners in connecting to communities.
Agreeing how the ICB will demonstrate that it is meeting legal duties relating to public involvement in health, and assuring effective engagement in places, neighbourhoods and system-wide workstreams.
Supporting place partnerships and primary care networks to work with people and communities to strengthen health prevention and treatment.

Creating the right conditions for volunteering and social action that support health and wellbeing (eg by providing places to meet, small grants, community development support).

Case study: Understanding people's experience and aspirations for health and care at system level in Surrey Heartlands

Surrey Heartlands ICS has set up an online citizens' panel to carry out regular survey research online among people who live in Surrey. The panel is 'demographically representative' of the Surrey population and provides a robust and flexible way for the system as a whole to put resident aspirations and experience at the heart of its work; for example, in redesigning its digital, mental health and cardiovascular services. The panel is one of a range of approaches in the ICS's engagement toolkit.

NHS England and NHS Improvement will make available a 'Citizens' Panel How to Guide', to support ICSs in setting up and managing panels, as a valuable system or place-level tool for engagement and insight.

Case study: Making connections to social action in Morecambe Bay

Lancashire and South Cumbria ICS seeks to share and spread grass roots community empowerment work across its system, while recognising that such initiatives need to be locally driven and reflect the assets and concerns of people at a 'micro' level. One such initiative in Morecambe Bay supported a diverse range of local people, including members of the public and health professionals, to build their skills together in areas like dialogue, facilitation and co-creation. Projects that have developed out of this training include an award-winning mental health café offering peer support, and work to tackle child poverty and loneliness among older people.

Supporting implementation of the guidance

This section looks at key areas where we know people often have questions: involving people and communities in ICS governance; working with people and communities to tackle health inequalities; co-production in ICSs; and working with Healthwatch and the VCSE sector.

Involving people and communities in ICS governance

Involving people and communities in governance is about more than membership of different committees. It concerns how decision-making in the ICS takes account of people's experience and aspirations.

Transparent decision-making, with people and communities involved in governance, meetings held in public, published minutes and regular updates on progress, supports accountability and responsiveness to communities.

In developing arrangements for involving people and communities in governance, ICSs are expected to consider the 10 principles above as well these specific aspects:

- Define the role and accountability of members of the public in governance structures. For example, an independent member/non-executive director of a formal governance body may have responsibilities such as providing a lay perspective or particular expertise, or ensuring that statutory duties are upheld.
- Resource and support this participation appropriately by ensuring there is a training and development offer, so people are equipped to contribute to governance arrangements. It is recommended that this is factored into budgets and staffing capacity.[2]
- Avoid creating isolated independent voices. An inclusive approach to representation is recommended to enable balance and diversity of perspective to improve decision-making.

[2] The Learning and development page on NHS England's website includes helpful resources.

- Consider how ICS governance bodies can capture input from a broad range of voices. For example, executive members of ICS governance bodies might involve themselves in the community and bring those perspectives to decision-making.

Considerations for specific parts of the ICS

Integrated care partnership (ICP)

Role	Responsible for developing integrated care strategies for its whole population, covering health and social care and addressing the wider determinants of health and wellbeing.
Public involvement considerations	• The ICP should adopt clear and transparent mechanisms for developing integrated care strategies with people and communities. • There should be arrangements to support transparency and local accountability, including meeting in public with minutes and papers available online. • The ICP should draw on the expertise of professional, clinical, political and community leaders. • It is expected that Healthwatch will be involved in the ICP, with exact arrangements to be determined locally and local circumstances and resources taken into account.

Case study: Co-opted members in West Yorkshire and Harrogate Health and Care Partnership Board

The ICS's partnership board includes four co-opted members whose role is to be an independent 'critical friend' to the board, rather than representing a personal healthcare condition or interest. The co-opted members are transparently recruited to an agreed role specification, bringing significant expertise and experience, and provide strategic, impartial input to decision-making. They also play an important role in providing assurance that the views of the public have been considered.

Integrated care board (ICB)

Role	New statutory organisation leading integration within the NHS, bringing together all those involved in planning and providing NHS services.

Public involvement considerations	• Non-executive members provide an independent perspective on the work of the ICB and help ensure that statutory duties of the organisation are met, including those relating to patient and public participation. • The local authority membership of the ICB can also help create connections to communities and to local democratic representatives. • The ICB constitution should include information on how it intends to involve people and communities, with the principles it will follow in implementing these arrangements staged. • The ICB is expected to adopt clear and transparent mechanisms for developing integrated health plans with people and communities.

Place-based partnerships

Role	Partnerships between the NHS, local government and other system partners working together in a locally defined 'place' to collectively plan, deliver and monitor services.
Public involvement considerations	• Place partnerships should include representation from people and communities, with detailed arrangements to be agreed locally. • Involvement arrangements can build on existing engagement approaches at place, particularly via health and wellbeing boards and neighbourhood teams. • Consider how place-based partnerships can support co-production and the accountability and transparency of the system.

System quality groups (formerly quality surveillance groups)

Role	Responsible for quality governance and oversight across systems
Public involvement considerations	• System quality groups should include at least two lay members.

Public engagement groups

Role	These groups provide a range of ways to involve people and communities at system, place and neighbourhood level, such as: • patient and public reference groups • citizens' panels • forums to engage with specific equalities protected groups • expert by experience and VCSE members of programme boards for specific workstreams • strategic co-production groups.
Public involvement considerations	• It is helpful to define how these groups connect to governance and decision-making.

Further information on practical steps to involve people and communities in governance can be found in the NHS England bite-size guide to governance for participation.

Case study: Supporting accountability through transparent governance and clear communication in West Yorkshire and Harrogate

West Yorkshire and Harrogate Health and Care Partnership regularly communicates about the positive difference the partnership is making, including through a series of public-facing case studies and weekly public-facing bulletins. Governance of the ICS is transparent, with partnership board meetings held in public and live streamed. The ICS recognises that many local people want to know what impact the partnership is having locally rather than the detail of how it works. It uses a range of communication approaches, with a focus on plain English and use of inclusive and accessible formats such as easy read, BSL and vlogs (short videos from a range of leaders). Working through networks is an important element of the approach, with trusted partners such as the health and care champions (people with a learning disability), who can make information relevant and accessible to their communities as well as give advice to programmes on delivery of care and health inequalities.

Working with people and communities to tackle health inequalities

COVID-19 has given fresh momentum to tackling health inequalities across health and care and beyond. Narrowing the health inequalities gap and supporting broader social and economic development are key aims for ICSs, and engaging with local populations and communities is an important element of this. ICS partners should take particular care to hear from people who cannot access care and support, and have poor experience and outcomes, to understand their needs, barriers, aspirations and opportunities for improvement.

Practical steps

- Prioritise building relationships with people who are excluded from services or for whom services are not meeting their care and support needs, and who have the poorest experience and outcomes. This will help counter the 'inverse care law' which highlights that disadvantaged populations need more healthcare than advantaged populations but tend to receive less.[3]
- Take the opportunities presented by collaboration in ICSs to mobilise the strengths and experience of all partners: build and strengthen relationships with people and communities who experience inequalities, and tackle agreed inequalities targets.
- Involve people in agreeing targets for reducing health inequalities, to help ensure that they are appropriate and will achieve their intended purpose.
- Work with the VCSE sector as an essential partner in tackling inequalities.
- Build on the community mobilisation and reciprocity demonstrated during COVID-19 in supporting vulnerable community members and increasing vaccine take-up. Transfer the learning to other priority areas, eg tackling the backlog of care or accelerating cancer diagnosis.
- Use population health management approaches to better understand local population needs and demonstrate how these impact on future commissioning and service delivery.

[3] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00505-5/fulltext.

- Audit and monitor the participation of equalities protected groups and groups and communities who experience inequalities, eg in events, surveys and formal governance roles.

Healthwatch England has developed a methodology with NHS England and NHS Improvement to help ICSs understand the needs and experience of specific groups of their population (see Appendix A for details). ICSs can commission these health and care experience profiles from local Healthwatch partners and use the insights to understand specific at-risk or underserved population groups, such as:

- South Asian people who have diabetes
- people with a learning disability and/or their unpaid carers
- black men with multiple health conditions who have recently received care for cancer.

Case study: Building relationships with excluded groups in South Yorkshire and Bassetlaw

Working with local partners is essential for community outreach. South Yorkshire and Bassetlaw ICS worked with its local Community Foundation and the South Yorkshire Housing Association to help it speak to communities likely to be under-represented in engagement, eg black and minority ethnic groups, LGBT groups, young carers and prisoners.

Co-production in integrated care systems

By co-production, we mean people, family members, carers, organisations and commissioners working together in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.

Co-production is one of the key ways in which ICSs can work with people and communities.[4] It can be especially helpful in building the trust and relationships that are the foundation of collaborative working. ICS partnerships are expected to champion co-production and inclusiveness throughout the ICS and this section includes practical steps to foster this, as part of the toolkit of engagement methods.

[4] The spectrum of involvement in Appendix B shows co-production in the context of other approaches to involving people and communities.

This way of working is important because people who use social care and health services (and their families) have knowledge and experience that can be used to improve services and tackle inequalities, not only for themselves but for other people who need them.[5] People with relevant lived experience can put forward cost-effective ideas that clinicians and managers may not have thought of, leading to changes that better meet the needs of the local population.

As well as giving better outcomes, a co-production approach can help build better relationships. It needs to be based on genuine partnerships, with professionals being comfortable with not having the answers and with sharing resources, responsibility and power. There is no single way of achieving this ambition but there are a number of practical steps that are important.

Practical steps

- Visibly support and sponsor co-production through culture, behaviour and relationships, including senior leadership role modelling.
- Identify where in the system there is a strong culture of co-production, and nurture, share and spread this way of working.
- Support the adoption of co-production approaches such as Making it Real (TLAP), Experience Based Co-Design, strategic co-production for personalised care.
- Support organisations and an infrastructure that enables the voice of people and communities to be heard.
- Invest in people who use care and support, including unpaid carers, to ensure they have the knowledge, skills and confidence to contribute 'on a level playing field'.[6]
- Consider employing people with lived experience to enable others to co-produce, including by providing peer support.
- Invest in communities to assess needs and talk to people on behalf of the system, places and neighbourhoods, eg via networks of community champions.

[5] What is co-production.
[6] NHS England's Peer Leadership Development Programme develops knowledge and understanding of how peer leaders can shape and influence how healthcare is delivered.

Case study: Building relationships in North Cumbria

When proposals for changes to services were opposed by the local community, North Cumbria CCG focused on rebuilding trust and engaging the community in shaping the implementation of those changes. It captured the learning from that experience in its co-production toolkit. This includes practical learning about frequent areas of conflict; an adaptable draft terms of reference; a co-production project 'plan on a page'; and training in listening and influencing skills and body language. Co-production approaches have now been used in many services, including stroke prevention, community hospitals, support for young autistic people and maternity.

Working with Healthwatch

Healthwatch is the statutory body responsible for understanding the needs, experiences and concerns of patients and the public, and to ensure people's views are put at the heart of health and social care. With its network of local organisations, Healthwatch listens to what people like about services and what could be improved, and shares this insight with a range of commissioners, providers and regulators.

Healthwatch has a broad remit, covering health and social care for both children and adults. It serves the whole community, not specific groups, and provides an independent source of insight gathered outside service delivery.

It is expected that legislation will change the existing statutory duties of local Healthwatch to advise and inform CCGs so that they apply to ICSs.

Many systems already have some system-level arrangements in place with Healthwatch. We encourage all ICSs to talk to Healthwatch about arrangements for working together at both system and place level, recognising that the best way to do this will depend on the local authority geography of the system.

NHS England and NHS Improvement are working with Healthwatch England on a national programme to develop ICS and Healthwatch partnerships at the system footprint level.

Working with the voluntary, community and social enterprise sector

The VCSE sector is a key provider of services to the most disadvantaged communities and has an excellent understanding of the health and care issues faced by those communities, both at a local and national level. VCSE organisations are often trusted, accessible and skilled at outreach and engagement. The sector is well placed to provide expertise in directly engaging people and communities in service planning and delivery and to advise/support staff.

Many statutory ICS partners have well-established partnerships with VCSE organisations to support the engagement of people and communities, and will want to maintain and strengthen these relationships, building on the progress made during ICS development and the COVID-19 response. ICSs can resource and empower VCSE partners to do this work, especially in relation to reaching communities who experience poorer experience and outcomes.

NHS England and NHS Improvement are working with national VCSE partners on a development programme that supports systematic partnership with the VCSE in ICSs through an alliance model. Our separate implementation guidance on working with the VCSE sector looks at its important role as partners in ICSs beyond engagement.

Beyond the larger VCSE partners, it continues to be important to work with informal groups and networks such as disabled people's organisations, user-led organisations, peer support groups and advocacy organisations.

Case study: Working with Healthwatch and VCSE in Suffolk and North East Essex

Suffolk and North East Essex ICS has representatives from the voluntary sector and Healthwatch on its partnership board, and reports that "conversations, tone, decision-making are all visibly changed due to the make-up of the board". The ICS recognised that it could not deliver on its ambitions for agreed priorities such as child poverty, obesity and loneliness without engaging the voluntary sector and local people. It has worked with two Community Foundations to channel funding to the VCSE sector to support work in priority areas and draw on their experience in grant making and in identifying need. Healthwatch partners supported the involvement of members of the public in the recruitment of the ICS chair, including review of the draft job description. Healthwatch is also commissioned by the ICS to deliver specific pieces of engagement work.

Conclusion

Effective engagement with people and communities is essential to the creation of successful integrated care systems. NHS England and NHS Improvement are committed to supporting systems to make this a reality everywhere. We hope this guidance will help local leaders to strengthen their arrangements, building on learning from around the country.

Appendix A: Further resources and information

Integrated care: www.england.nhs.uk/integratedcare/
ICS design framework

NHS Confederation: Building common purpose; engagement and communications in ICS
Learning on the role engagement and communications play in partnership working and developing thriving ICSs.

NHS England: Integrated care systems and the voluntary, community and social enterprise sector

Understanding integration: How to listen to and learn from people and communities
King's Fund/Picker guide supporting ICSs to understand and act on user experience of services as part of population health management and service improvement and redesign.

Healthwatch Health and Care Experience Profiles
A qualitative methodology giving insight into the needs and experience of specific groups in an ICS population, supporting work to improve services and reduce inequalities. Profiles can be commissioned by ICSs from local Healthwatch partners.

Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England
Contains useful information about public participation principles and approaches. Explains the legal duties on public involvement that apply to CCGs and are expected to transfer to NHS ICBs.

Resources for people involved in health and care

NHS England: Peer Leadership Development Programme
https://www.futurelearn.com/courses/peer-leadership-foundation-step-1

PLDP Promo Film

NHS England: Learning and development
Training and development resources for people involved in health and care.

Co-production resources

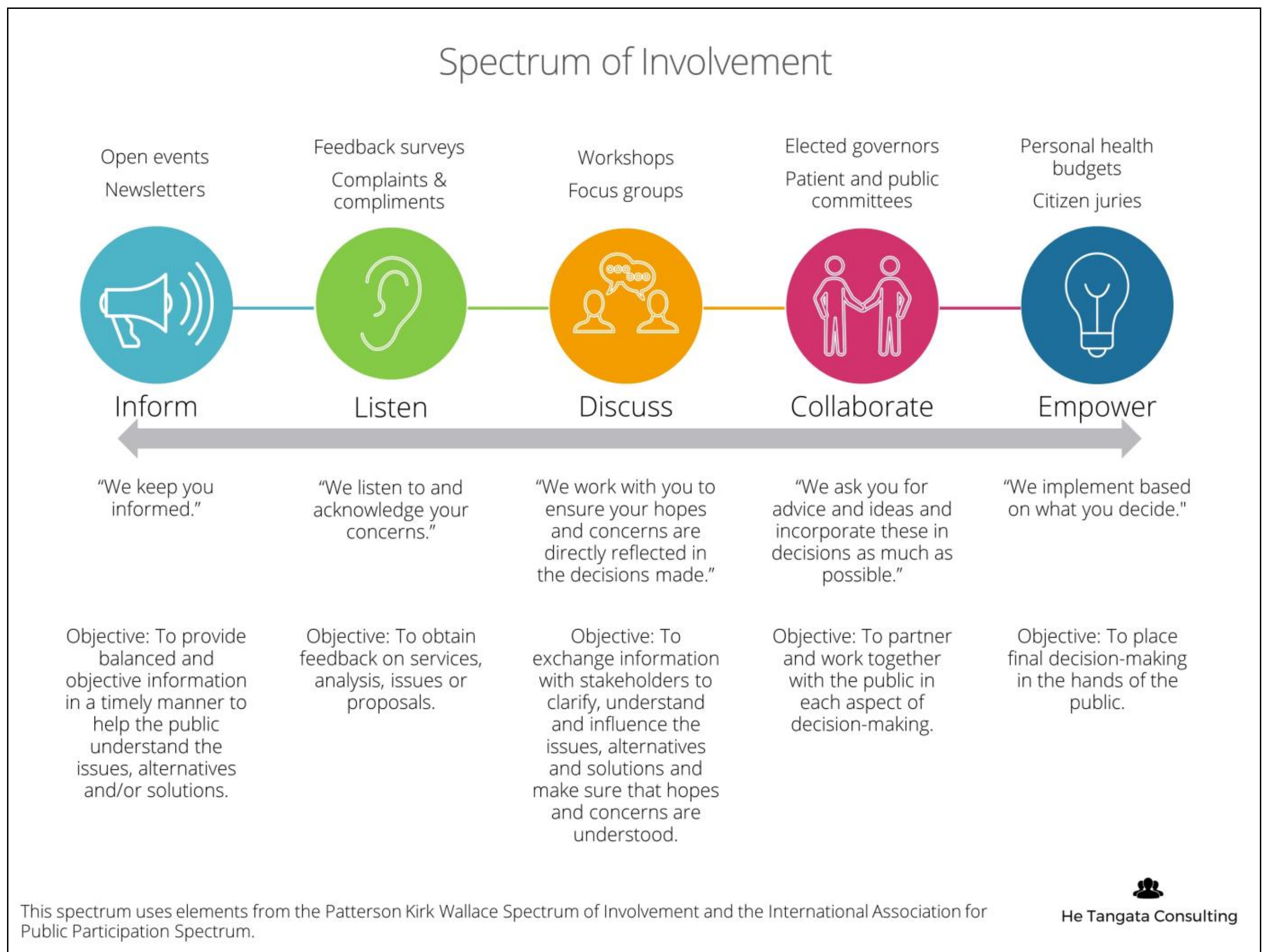
NHS England: Model for co-production

Co-production Collective
A co-production community which aims to learn, connect and champion co-production for lasting change.

Asset-based approaches: SCIE/TLAP Asset-Based Model

Appendix B: The spectrum of involvement

NHS England and NHS Improvement recommend the spectrum of involvement as a useful tool for understanding the range of approaches to working with people and communities, and which approach might be appropriate when.



For more information on integrated care systems visit: www.england.nhs.uk/integratedcare/

Find us on LinkedIn: www.linkedin.com/showcase/futurehealthandcare/

Sign up to the Integrated Care bulletin: www.england.nhs.uk/email-bulletins/integrated-care-bulletin/

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

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