

“ICBs - Partnership Working with People and Communities” Learning Report, August 2024

1. Background

As part of a wider programme of work by the Public Participation Team to support effective partnership working with people and communities, NHS England provided funding to 16 ICBs (Integrated Care Boards) at a level of £7k each, for the period October 2023 to March 2024. The funding was intended to help them:

- Work more closely with Integrated Neighbourhood Teams and Primary Care Networks on their community engagement.
- Form more effective regional networks.
- Share insights across the system.
- Work on cross-border projects around specialised service transformation engagement.

As part of the application process for this funding, each ICB identified a project to which the funding would be applied. The list of projects is set out at Annex A.

NHS England appointed [A Better Way](#) as a learning partner to:

- Offer ICBs expert advice and guidance and support them with their work via a mixture of 1-2-1 conversations, open drop-in sessions, group discussions, targeted workshops on issues/themes identified by the ICBs.
- Produce case studies outlining how ICBs have progressed with this work and the impact it has had.
- Prepare a succinct report for NHSE and the ICBs, which summarises what has been learned from the exercise, including any insights on how to build greater momentum for systems change, and setting out some ideas for what NHSE might like to consider, to build further on this exercise.

2. What have we learned?

2.1 Context

There is a substantial body of evidence that communities have a vital role to contribute to the Health System. As the 2010 Marmot Review concluded: “Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.”

Although our health and care systems are increasingly overwhelmed and inequalities are deepening, it need not be like this. And there is growing recognition of what is needed to make things better: ICBs need to be more preventative, holistic and tackle the social determinants of health, provide care closer to home, be person-centred and relationship driven... ***Above all, the ICB's are extremely clear that they need to work more closely with our communities...***

2.2 What is working well?

1. There are significant examples of partnership working with communities happening across all 16 ICB's. The work is varied and covers all aspects of engagement and partnership.

2. The work is happening at every level:

- I. System level working with Voluntary and Community Sector (VCS) organisations:
 - a. Cross-sector organisational networks – e.g. a neighbourhood health forum or a prevention network.
 - b. Improved collaborative working between community and health system – e.g. Community Multi-Disciplinary Teams with VCS membership.
 - c. Insights banks, CRM databases and sharing of data between the public sector system and the VCS.
- II. Organisational and workforce level:
(Tools to support organisations and professionals to work more effectively)
 - a. Asset maps.
 - b. Toolkits for community engagement.
- III. Community level:
 - a. Parent and carer forums.
 - b. Patient and community forums.
 - c. Listening or engagement surveys and events.

3. There is a substantial 'leadership' group of experts in community engagement across the ICB's that are a wonderful asset to the system. The group involved in this project has:

- I. A wide range of skills, backgrounds and knowledge.
- II. Considerable expertise and experience delivering successful community engagement work within and outside the NHS.
- III. Enormous passion, energy and commitment and drive to make a difference to the NHS, its patients and local communities.

4. There is an increasing group of staff within the NHS that has now taken part in projects working with communities. The collective experience and organisational memory are increasing as more and more investment into community and patient engagement work is made.

5. There is a notable step change in the intention of the NHS to want to engage in community and patient engagement work and that it has become more *"on the agenda"*. There is an increasing recognition of its value and the need for the NHS to invest much more in this work. Statutory guidance has been available since 2012, and was reinforced in 2022 with the publication of ['Working in partnership with people and communities'](#). Community engagement and partnership language is becoming more normalised. A number of leads reflected that *"several years ago, we wouldn't have been able to consider doing the type of work we are doing now"* or *"community engagement in the past would have been seen to be nothing to do with the NHS and something that happened outside the system"*.

2.3 What are some of the challenges?

Despite this fantastic work and the intention of the system to work closer in partnership with communities, there are a number of challenges identified by the Engagement Leads in this project and their colleagues that make this work very hard to do well:

1. System issues

- a. **Non-Core** – Whilst there is an overall intention to work more in partnership with people and communities, the reality is that key priorities of the system lie elsewhere. Working with communities still feels on the periphery to the mainstream work of the NHS:
 - i. In particular, the system’s key priority is on meeting the enormous demand and short-term pressure on delivery of current acute medical services.
 - ii. The system is not focused on prevention – *“we are often trying to treat and solve the health issue not the underlying social problems”*.
 - iii. There is a lack of capacity, funding, resources and dedicated time set aside for this work. People are stretched by “business as usual” requirements and have little or no capacity to think and act differently.
 - iv. The system inadvertently disincentivises people from doing this work through short term KPIs and output metrics that are driven by current medical system needs and not longer-term, more holistic and social outcomes.
 - v. *“Why is it we have to sell ourselves?! We are doing all the running bending over backwards to sell comms and engagement work to a system that says it values comms and engagement work!”*
- b. **The scale and complexity of this work** is daunting:
 - i. The NHS is one of the ten largest organisations in the world with a budget of over £150bn and c.2m staff AND is an organisation in crisis that is focused on providing medical care.
 - ii. The starting point for this work is challenging both within and outside the system: restructuring and crisis within the current system and lack of funding and disjointedness in the VCSE and local community.
 - iii. There is no time to tackle systemic issues. *“It is the same people doing the same thing in the same way”*.
- c. **Crisis within the system** – there are increasing health and social inequalities and pressing issues in our health and social care system. This includes unprecedented demand for NHS services, major budget constraints, low staff and practitioner morale and additional mental and physical health challenges ICBs face as they continue our recovery from Covid-19. This makes this work incredibly difficult to prioritise.
- d. **Staff restructuring** – many of the Engagement Leads we are working with are undergoing or have recently experienced significant and sometimes repeated restructuring of their roles and teams and/or major staff and budget cuts. Work that is already challenging is even harder to deliver when those in the key delivery roles are operating in such uncertain conditions.

- e. **Lack of senior buy-in** – While some Engagement Leads feel very well supported by senior leadership within their ICB, this was by no means universally the case. Some Leads commented that, although senior colleagues openly stated their support and commitment to this work, this was rarely backed up by action. It appears that senior people don't believe that making time to build relationships and trust with community partners and to listen to people and communities on a regular basis is a sufficient priority, compared to other more urgent demands on their time. Whilst most NHS strategies and leadership groups make clear statements of intention to work differently and more in partnership with communities, the reality can be very different:
 - i. *“Senior people don't get it. It doesn't seem to connect to the main business of the NHS”.*
 - ii. *“It is so hard to get people out of the office, to prioritise this, to remove the job title and take off the NHS lanyard.”*
 - iii. *“It is very difficult to get people off Teams and out of the office to prioritise meeting people where they are at in our communities. “I managed to get one strategic lead and then the CEO. One by one – but it is very slow and hard work...”*

- f. **Systems and processes** in the NHS are not set up for collaboration with communities or for receiving innovation funding. Consequently many of the projects were very slow to get going and a lot of precious time and effort was consumed by internal procedural negotiations on how the £7k grant should be managed and accounted for, whether it could be passed on to external partners, and if so how::
 - i. That it was very challenging to get these projects started highlights this – eg *“It was slow to get the project off the mark” “It was so hard to get funding out to community. The £7k has got lost and we can't distribute it.”*
 - ii. Simple things like not having contract templates for non-NHS suppliers or having to generate tender documents and procurement processes for non-core activity is extremely time consuming and bureaucratic.

- g. **Funding:**
 - i. The core work of patient long-term relationship building, network formation, listening and engagement is not 'commissioned' and there is no mainstream funding for this.
 - ii. Where funding is made available it is nearly always short term and non-recurring in nature. This makes longer-term system and cultural change and building of trust and relationships much more challenging to achieve.
 - iii. Despite doing this work for many years, consistently referring to this work as innovation and continuing to fund it through “innovation” or “pilot” funding, reinforces the message that this is still seen as non-core activity.
 - iv. What limited funding there is for this work often goes to the same organisations or is funded in such a way that it doesn't create lasting change and just serves the priorities of the existing system.

- h. **Communication rather than engagement:**
 - i. Given the multiples pressures and difficulties described above, it is perhaps not surprising that all too often true community engagement, which requires an investment of time, a wide set of skills, and a willingness to be challenged, gives way to more superficial short-term communication exercises, which fail to generate added value. *“We see a lot of effort on comms, not nearly enough on genuine engagement”.*

- i. **Fragmentation** - The work that is taking place is often not joined up:

- i. While there are examples of excellent practice these remain isolated 'pockets' with little wider consequence.
- ii. Managers tend to advance their particular approach rather than taking time to listen to others and create opportunities for collaboration.
- iii. Self-interest (individual, departmental, organisational) can become a barrier to collective change.
- iv. There is often a single voice championing this work. It is rarely seen as a shared responsibility among leadership teams or groups of managers.

2. Organisational and Professional level challenges

a. Leadership skills

- i. There is a need to equip those driving this work with leadership skills to affect system change - *"A lot of the challenges we are faced with come down to confidence to lead this work. For those having a go, we need support to have the confidence to keep doing it, to keep 'nagging', to keep at it. And to celebrate this work when we can..."*
- ii. Support is needed with leadership and influencing skills and learning how to engage allies and champions. How to influence up.

b. Lack of technical skills and expertise to work with communities

Beyond the Engagement Leads, many people in the wider system are very willing to engage in projects working with communities but they often don't know how to do the work or have very little experience. *"There is a considerable knowledge and training gap."*

c. Low level of trust and relationships

- i. The starting point is very challenging – ICBs are often starting projects with a very low-level of existing relationships, historical challenges and mistrust. It makes it very challenging to facilitate good beginnings for community projects. *"Historical bad relationships make it very hard to move forward. We often start thinking the worst of each other rather than the best."*
- ii. Sometimes there is a need for a 'broker' or 'translator' to bridge the gap between the public sector and the local communities – especially those sections of the community that have experienced marginalisation and discrimination.
- iii. Building relationships is not prioritised by the system. Relationships are developed in the long term and need to be invested in but the funding and targets, as noted above, are short term and transactional.
- iv. The work can feel very much like a 'tick box'. It makes it hard for the engagement leads to build lasting trust if they are perceived as the front-piece of an organisation that is not really committed to engage with communities, particularly when that might include sharing power and decision-making, or rethinking strategic direction or shifting embedded practice.
- v. Historically, many engagement exercises have failed to follow through with participants to let them know what changed (or didn't change) as a result of their involvement. *"Better feedback is essential, to close the loop and to ensure people feel valued"*.

d. Culture

- i. People want to change and work differently but culture of both is very different. *"Both sides are very stuck in their ways..."*

- ii. The existing conditions and dominant cultures of both the community and the system are so different to each other that it can be overwhelming and with limited time and resources to invest in culture change, it makes it extremely difficult to achieve the aims of the projects.
- e. **Power**
- i. Projects are often driven by an institutional agenda. This agenda is predominantly determined by system needs, immediate pressures, targets imposed from above, and funding pressures.
 - ii. The power relationship is rarely an equal one – in most (though not all) situations the greater power and influence sits with the large institutions, even though it doesn't always feel like that to those who work inside them. Acknowledging this imbalance and considering together what can be done to mitigate any negative effects, can be a useful step in gaining the trust of smaller organisations and community-based associations.
 - iii. The gathering of information can become a one-sided extractive process. People are fed up with being asked and telling researchers what they feel but seeing no change. Several of the ICBs we have engaged with have been keen to move towards a shared approach to data collection and analysis, where the community is more in control of the information required to shape health policy and planning – but methods to do this well are not yet well-established.
 - iv. It can be a struggle for Engagement Leads to keep the system at arm's length, to find ways to distribute its power to communities, and give the time for this work to succeed. Often, they have to 'bend the rules' to achieve this, they tell us.
- f. **Blockers in and out of the system.** Not everyone is on board with the community engagement agenda. There are individuals who don't see the value in this agenda, or see it as a distraction, or threatening to their role, or are simply stuck in the past and angry/negative about change. Sometimes this manifests itself in passive forms of obstruction – talking the talk but taking no action.

3. Community level challenges

- a. Fragmentation and mistrust within the VCSE sector - there are challenges working with community groups who are sometimes unaware of each other's work and not joined up, often competing for limited resources or where there is a lack of trust and relationships. It is very hard to build 'best beginnings' if this is the starting point.
- b. Historical power dynamics between VCSE and the public sector and feeling the need to control can make it hard to get projects off the line. VCSE groups often don't want to be seen to be siding with the 'other side'.
- c. There are considerable cultural and language barriers between community groups and the public sector system.
- d. There are also considerable differences in levels of governance and risk management systems and processes used by community groups compared to the NHS which makes joint working extremely challenging.
- e. We have seen that some Healthwatch organisations and other established VCSE organisations are playing a very positive and creative role, contributing significantly to energising the approach to community engagement within an ICB area. But this is

not always the case. Some regularly commissioned VCSE organisations have become 'institutionalised' and use very traditional methods in the way they work to satisfy the needs of the system (e.g. use of surveys, clipboards and structured and often transactional tools). This close connection to the system and use of structured processes makes it more challenging for these organisations to engage with communities and hard-to-reach groups.

- f. Lack of core funding for community groups makes it very hard for the VCSE (especially smaller groups with only 1 or 2 staff or those which are volunteer-led) to attend meetings and events.
- g. Because of the challenges to build trust and relationships with community groups, the need for scale and a certain standard of governance and structure to work with the NHS and the ability of only certain larger VCS organisations to attend meetings, collaboration and funding often ends up in the hands of the same, small group of organisations. This can have some advantages – for example allowing for long term relationships and trust to flourish. But there are also risks, especially if the organisations concerned become moribund and defensive in their practices, and resist involvement of those in the community who are new, less well-resourced, or less well-connected.
- h. Funding often incentivises wasteful forms of competition – for example we heard of one case where 88 organisations bid for one local contract. Competitive bidding can drive organisations into negative, protective behaviours, rather than encouraging the 'sharing of forces' which are so necessary to make progress in the face of complex health and social care challenges.

3. Insights and ideas – what next?

Despite the considerable challenges to delivering partnership working with communities, the Engagement Leads demonstrated a remarkable sense of positivity and resilience and a desire to continue with the work they are involved in. There was a real belief in the need for this work and considerable determination to find and deliver solutions to these challenges.

3.1 Insights

From discussion with the Engagement Leads and their colleagues, below are some insights on how to build greater momentum for systems change:

1. **Reframing community engagement as an offer** and not as an ask or a drain on a system that has very limited capacity or resources to engage with this work. Too often, it comes across as a request to do or provide something that is additional to business as usual. A key insight is to change the approach and understand from those in the system – "How does our work support you with what you are already doing?" How can this wonderful asset in the community address some of your biggest challenges you are facing?
2. **Making better use of place partners – and letting go more.** In many cases, the ICBs themselves are not best placed to build the direct relationship with their local communities and local citizens. As is widely recognised, including by NHSE, they can achieve most when they are able to work with and through their various place partners – for example the local Healthwatch, the local authorities (including local councillors), the social care providers, the voluntary and community organisations and social enterprises, GPs and other primary care providers, NHS Trusts, housing associations, police and fire services, local businesses, and so

on. All of these are potentially very significant resources to leverage, and identifying those who already have positive and trusted relationships within local communities, including communities of identity, is always a very good starting point. The convening power of the ICBs should not be underestimated, but it is also important to recognise where the energy already is, and where people are already organically engaging communities well. In times of limited resources and stretched capacity, this also avoids duplication and enables ICBs to contribute to others work in this area.

But above all, we heard that the ICBs need to learn to let go more, trust their community partners to do the right thing, avoid requirements that push their partners towards narrow transactional methods, and allow them to unleash the energy and creativity that can come when people know they are working to make things better for their community, rather than simply to meet targets or goals set from above. *“It is tempting to work in a transactional way, but we can do better than this, and there is a growing band of people who really to want to make change happen – we just need to get better at giving up control.”*

3. **Redirecting more efforts internally** – Much of the work to date has understandably focussed on developing partnership working out in communities – listening to the challenges of people and organisations in the community and developing solutions outside or on the periphery of the system. There has been an assumption that the root cause of, and the solutions to, the barriers to greater community participation lie outside of the system. But it is within too. This is something that the Engagement Leads understand very well:

- a. *“What about trying to engage the hard to reach in the system?”*
- b. *“The biggest problem with the NHS is not bed blocking – it’s desk blocking”.*
- c. *“We should be thinking not about how do we work with communities - but how do communities work with us?”*
- d. *“We need to make this work core to the existing system and not something that just happens ‘out there’ in the community”.*

A key insight is that is simply not enough to develop the narrative about the value of community engagement (that is already well known in broad policy terms), nor to produce even more generic toolkits and guidance (there are plenty of those already). Rather, to really move forward, there also needs to be a willingness to change within, a fresh look internally at the ways that ICBs themselves operate, and how, inadvertently, they may be making it harder than need be to bring about the closer collaboration with communities that they know is required, in the face of the accumulating crisis of increased demand and overstretched services.

To put it another way: in order to improve partnership working with people and communities ICBs will achieve most if they can start with changing themselves, not simply demanding change from others.

So, a key task for ICB Engagement Leads (and their allies) is to explain, as clearly and practically as possible, why internal change can help to generate the right conditions for effective community engagement, why this needs to be prioritised, and what methods for this are likely to have the best results.

4. **Creating a collective narrative** – A new place-based definition of community is needed that includes both those working in the system and those working out in the community as one community. They are not viewed or described as separate, but as two parts of the same community. It is helpful to take this collective, holistic approach in all aspects of working with our communities, for example not just referring to engaging with people with lived experience as important but valuing all people's experiences.

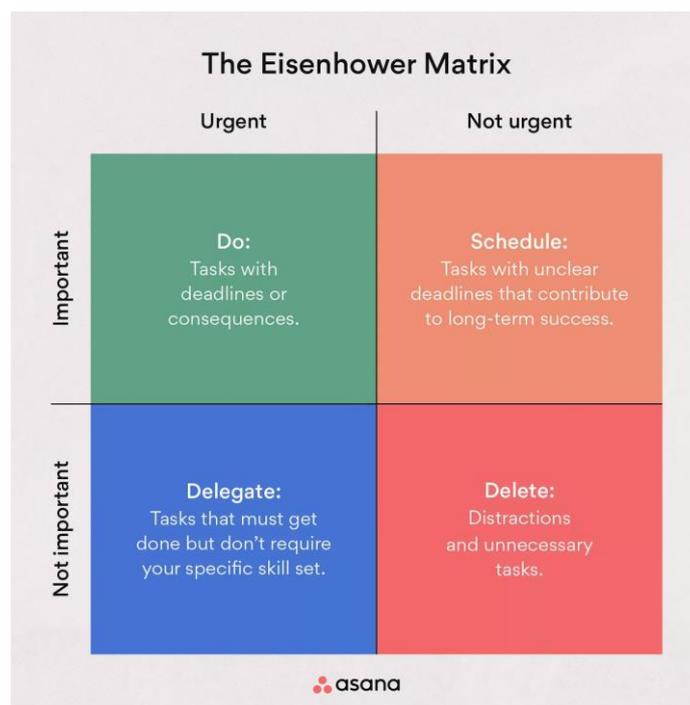
5. **Putting it into practice - Taking a community development approach to systems change** – there are excellent approaches to community development that can be adopted to creating change within the system. For example: Asset Based Community Development, appreciative enquiry or strengths-based working. These approaches focus on building a movement and community within the system that play to strengths and develop long-term relationships. In addition, using these approaches further facilitates partnership working with communities as it is a means of using existing assets in the community to solve system issues.
6. **Culture change** - How ICBs go about this work is as important as what they do. If they want to be person centred, non-hierarchical, relationship based, holistic, preventative, collaborative, community minded etc... they have to behave like it and embrace these core principles at every level and in every interaction.

For example, *“We need to pay attention to language and how we introduce ourselves to avoid creating power dynamics and to build better relationships – for example remove your NHS lanyard and introduce yourself as a person and what you care about rather than as a job title”*.

A Better Way [principles](#) and [behaviour change model](#) were cited by several Engagement Leads as a helpful way of describing the way in which they would like the system and their colleagues to approach their work with communities.

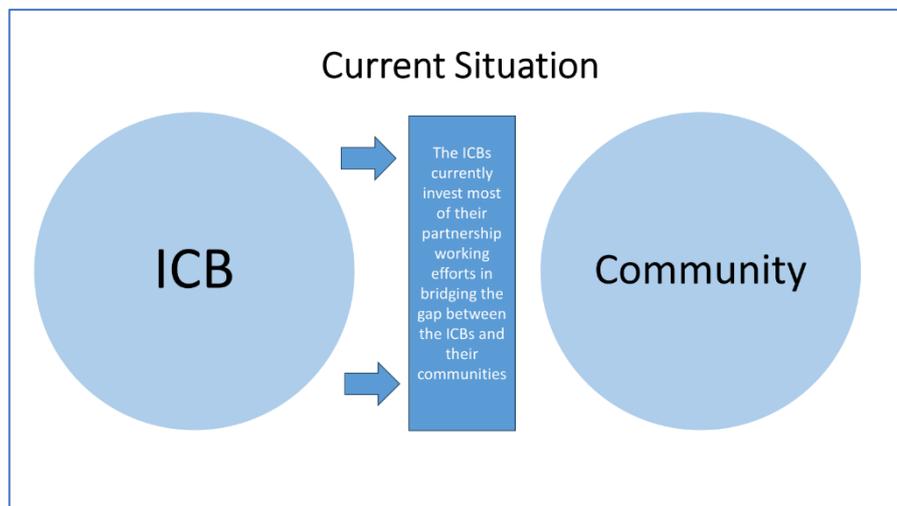
7. **Setting aside dedicated time and resources for this work** – Urgency vs Importance and The Eisenhower Matrix. Partnership working with communities is clearly acknowledged as important for the NHS in achieving its longer-term goals. However, as we have identified earlier in our report, a key challenge for this work is that, relative to tackling current system crises and short-term pressure on acute medical services, it is not urgent.

Consequently, this work has not been prioritised. The Eisenhower Matrix below helpfully illustrates the need to carefully schedule dedicated time and resources for this important but not urgent work to make greatest use of existing resources.



3.2 Moving towards an ICB-community interface?

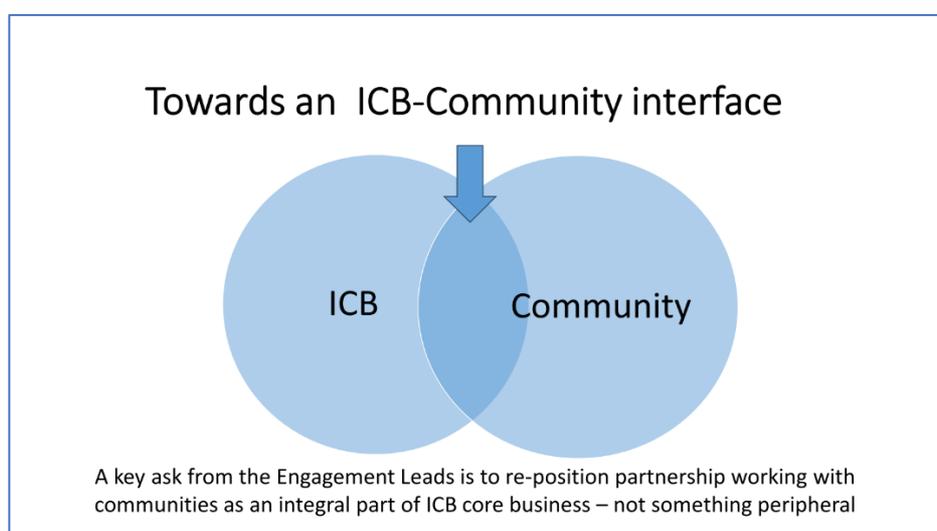
As indicated in insight 2 above, the current situation is that most of the efforts by ICBs to improve partnership working with their communities are externally focussed, attempting through various activities to bridge what is often seen as a gap between the ICBs and the communities in which they operate. This is illustrated in the diagram below:



While this outward-looking approach can of course produce important benefits (for example generating data which can inform ICB practice and policy), they will be limited because there is a core difficulty – this form of community engagement will tend to be seen as marginal to the core business of the ICB, and therefore Engagement Leads will too often find themselves isolated and working ‘against the grain’ of core ICB operations.

So, a key question is whether this situation can change. Would it be possible for ICBs to create the conditions where **a shared interface** with their communities is established? In other words, where the public sector health and care systems and the full range of community-based agencies and associations are working well together to generate better health and care outcomes – and that this interface is recognised as **integral to the core business** of the ICB.

If a move in this direction is regarded as desirable, one thing is clear from the work to date - it will require **internal-facing not just external-facing efforts** by ICBs.



The ideas set out below include some practical suggestions, for how a shift in this direction could be achieved.

3.3 What might come next?

Building on the insights from the Engagement Leads, and the good work which is already happening, the following ideas are set out for consideration by the ICBs and NHSE:

1. **Develop a wider community of practice for those doing community engagement, both within ICBs and equivalents from elsewhere, for example the Start with People network, and the PPV (Patient and Public Voice) network, that:**
 - a. That recognises and celebrates the important and skilled role of those specialising in community engagement. *"I see my role as a Universal Adapter!"*
 - b. Builds on this existing work and enhances the opportunities for Engagement Leads to learn from each other's practice.
 - c. Learns from good practice outside the NHS and connects to other communities of engagement and engagement leads based in our place-based partners.
 - d. Has regular meetings of "our tribe" (of community engagement leads) but is importantly not an echo chamber - where they are challenged enough to feel uncomfortable but not stressed.
 - e. Is a community where practitioners can present work to others and build on work they are doing and go to both seek and provide inspiration.
 - f. Shares practical resources for community engagement – e.g. toolkits, templates, case studies, evidence and evaluation.
 - g. Shares ideas for innovation or community development funding.
 - h. Shares existing insights, outcomes and learnings from community work better with each other and with the system.
 - i. Learns from best practice elsewhere, for example the Bromley By Bow Centre or from the New Local report on community centred approaches in the NHS.
 - j. Holds sessions to share not just intelligence and ideas but the struggles and challenges. *"Not just sharing or a PowerPoint parade of praise! But somewhere to connect at a human level, vent frustration, learn from each other... give courage and confidence to keep going, do more, learn skills etc..."*
 - k. Connects the dots, join up the work that is already taking place. *"We need to find ways to collaborate better across the ICB areas"*.

2. **Invest in a pan-ICB Leadership Group and/or a leadership academy programme for leaders in people and partnership working:**
 - a. We have a great asset for the system- 16 mobilised, skilled and experienced community Engagement Leads motivated for change.
 - b. This wonderful group of leaders are experts in their field – they are not just a group of comms and engagement managers in the system.
 - c. There is an opportunity to co-create a leadership programme involving this group as well as reaching out to other ICBs who share motivation for this work - It's an opportunity for them to lead the change.
 - d. In addition, develop a leadership programme/academy that draws on best practice for doing things differently and can affect culture change. There is considerable willingness to apply different ideas and ways of working but it is difficult – we need to give these leaders the time, confidence and skills to lead this work.
 - e. Create a leadership "bubble", to build the movement of community engagement leaders and experts – with action learning sets or equivalent so that participants can apply the insights they gain directly to the practical challenges they face

3. **Transformation spaces within local ICBs** – there is a need to invest in a protective space for transformation. It needs to be a space that prioritises system change (not innovative incremental changes to the current system or to tackle urgent issues such as demand on existing services) and this needs to be committed to over the long-term. A new independent, informal and free space where this engagement work is core and is ring-fenced from business as usual (see Eisenhower Matrix above):

- “What we actually need is space, protected time (a bubble) with freedom to be creative, to build trust and relationships, long-term, outcomes (not outputs), positive space not fail safe and risk orientated and transactional, very different behaviours, non- hierarchical, free from single agenda, distribute power and solutions and activity (trust and decentralized)”
- “We need a leadership bubble/space for venting frustration but then we also need a space to learn, grow, be creative, be honest and move positively forward...”
- “Needs a big mindset/culture shift to prioritise this work. And this will take time! We need to sustain this in the long term and invest in it. Don't be restricted by financial year ends and by project deadlines etc.”

Time, space and capacity needs to be invested in both at grassroots and in the boardroom:

- a. To drive the change from below we need to start with *establishing protected spaces on the ground in every ICB*:
 - Where small multi-disciplinary teams of people can operate outside the mainstream of rules and targets imposed from above.
 - Where funding for these teams is maintained on a long-term basis (e.g. through a small but fixed percentage of NHS budgets).
 - “We are so busy doing today's job, we need to find a way to make time to think about the really important stuff, tomorrow's job”.
- b. To drive the change from above we need to start with *growing a culture and practice of participative policy making in every ICB leadership group and at national NHS England level*:
 - Where people who experience poor health and who need care support have opportunities to co-design the policy agenda in favour of health creation with senior managers and politicians (Poverty Truth Commissions and Citizens' Assemblies provide examples of how to do this).

We recommend introducing these transformation spaces in one or two forerunner ICBs to trial and lead the way before rolling out to all ICBs.

4. **Building a movement** – mobilise a group of champions to embrace and spread this work to other ICBs, and other parts of the health and well-being system:
- a. Take this report and go on a roadshow to share the learnings and build the movement
 - b. Don't spend time trying to persuade those that don't want to change - go with energy and focus on building a coalition of the willing.
 - c. Support people to put this work into practice and “not just read another report”
 - d. Invite others to 'join' us', rather than attempting to impose practices or behaviours.
 - e. “We are not alone.” There are lots of people doing this work and lots of very positive people who are up for it.
 - f. Relationships do already exist - leverage them.
 - g. How do ICBs share this work more widely and engage others through a champions network? Present what they are doing, build on what they are doing and inspire them with the work.

5. Develop an insight bank for working with and within the system

- a. Develop a guide for the system around how to do community engagement within the NHS. Instead of producing yet another a guide for how to engage with communities, produce a practical guide for how to engage with the system to work in a more community minded way - how to put this into practice, for example, how to schedule time for this work, how to identify and nurture allies within the system.
- b. Need to apply the successful patient and public engagement activities and projects to/for people in the system. Building community and engaging people – the only difference is that the people just happen to be in the system.
- c. Need to invest in time for this in the system. So rather than investing only in community connectors or community builders invest in system convenors and internal community builders.
- d. Support people to have difficult conversations with the hard-to-reach and seldom heard voices in the system.

Annex A: ICBs working with people and communities - project outlines

1. Cheshire and Merseyside

Working with PCN leads across the region, to understand how they engage patients, to identify opportunities for improvement, with a view to producing a toolkit.

Partner:

- NHS Cheshire and Merseyside ICB

2. Derby & Derbyshire

To establish a community-led 'bank' of data, asset maps and human stories in the former coalfields town of Heanor, where local people will own and manage the insights on their terms, whilst partnering with and supported by statutory and non-statutory stakeholders.

Partners:

- NHS Derby and Derbyshire ICB
- Make/Shift
- Understory

3. East of England

To arrange a launch event for a regional engagement network across six integrated care partnerships – bringing together engagement practitioners across the NHS, Local Authority, and VCFSE.

Partners:

- NHS Bedfordshire, Luton and Milton Keynes ICB
- NHS Cambridgeshire and Peterborough ICB
- NHS Hertfordshire and West Essex ICB
- NHS Mid and South Essex ICB
- NHS Suffolk and North East Essex ICB
- NHS Norfolk and Waveney ICB

4. Herefordshire and Worcestershire

To undertake a series of community action network meetings, supported by Healthwatch, to help PCNs improve wrap-around support for frail patients including non-clinical support available within communities.

Partners:

- NHS Herefordshire & Worcestershire ICB
- Healthwatch Herefordshire

5. Kent

To develop residents' forums for INTs, starting with a forerunner PCN which has set up a community stakeholders forum.

Partners:

- NHS Kent and Medway ICB
- West Kent Health and Care Partnership
- Working alongside NHS Sussex ICB which is doing something similar

6. Lancashire and South Cumbria

To work with the Lancashire BME Network to run a series of focus groups across Lancashire focusing on the needs of unpaid carers from the BME population, and their experience of hospital discharge, backed up with an online survey and deliberative interviews.

Partners:

- NHS Lancashire and South Cumbria ICB
- Lancashire BME Network

7. Leicester, Leicestershire and Rutland

To expand the newly established online library (the Insight, Behaviour and Research Hub) to include insights from the ICB Voluntary, Community and Social Enterprise Alliance (VCSE).

Partner:

- NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB)

8. Lincolnshire

To arrange a series of 'Meet & Greet' events across the county with GPs and local communities, to improve understanding on both sides, and to identify influential community leaders who can act as trusted information channels.

Partner:

- NHS Lincolnshire ICB

9. Shropshire Telford and Wrekin

To produce a rural health strategy informed by engagement with community stakeholders, with an initial focus on Bishops Castle and Ludlow.

Partner:

- NHS Shropshire Telford and Wrekin ICB

10. Somerset

To arrange tailored engagement activities with parents/families and other stakeholder groups, to inform the development of a VCFSE collaborative service delivery alliance for improving mental health support for children and young people.

Partners:

- NHS Somerset ICB - Children and Young People's Mental Health Commissioning Team
- Collaborating with Public Health, Somerset Council, Healthwatch, Somerset NHS Foundation Trust and the Voluntary, Community and Faith Sector (VCFSE) in Somerset.

11. South East London

To enable a VCSE partner, Mabadaliko, to produce an accessible consolidated insight report and recommendations on health inequalities experienced by diverse communities, building on their previous research.

Partners:

- NHS South East London ICB
- Mabadiliko CIC

12. South West

To provide training across the region for health sector practitioners in children's palliative care, led by a newly established Voice of the Child parent and carer forum.

Partners:

- South West Children's Palliative Care Strategic Clinical Network (SW CPC SCN)
- SW Voice of the Child Parent and Carer Forum

13. South West London

To conduct a meta-analysis of health and care insight from Healthwatch, voluntary and community sector organisations, NHS Trusts, local councils, and place-based public and patient engagement teams, to contribute to a central repository of insight data, and to identify gaps in the data.

Partner:

- NHS South West London ICB

14. South Yorkshire

Working with a VCSE partner, to further develop an Insights Bank, including qualitative data and 'softer' insights, particularly from underserved communities.

Partner:

- NHS South Yorkshire ICB

15. Sussex

To establish a neighbourhood Community Panel which will draw together groups of local residents to support co-productive processes – as a model for other INTs across the ICB area.

Partner:

- NHS Sussex ICB
- Working alongside NHS Kent ICB which is doing something similar

16. West Yorkshire

To review a range of involvement toolkits for underserved communities, with people from those communities, and prepare a guide to getting involvement exercises with underserved communities off to a best possible start.

Partners:

- NHS West Yorkshire ICB
- NHS South Yorkshire ICB
- NHS Humber and North Yorkshire ICB
- NHS North East and North Cumbria ICB