Rethink Mental Illness's Model for Coproduction:

a guide for Integrated Care Systems

Leading the way to a better quality of life for everyone severely affected by mental illness.

Contents


Mental illness.

Introduction

Systems must put people and communities that care at the heart of decision making. How can this be done in a strategic and effective way?

"People and communities have the skills and insight to transform how health and care is designed and delivered. Working with them as equal partners helps them take more control over their health and is an essential part of securing a sustainable NHS." – NHS England, 'Working in partnership with people and communities: Statutory Guidance'

Over the last few years, many systems have made progress in bringing people and communities into decision-making. But we know that this comes with challenges. How do we ensure we are hearing from excluded and marginalised groups? How do we establish sustainable two-way conversation and information exchange channels? How can we organise lived experience information systematically? How can we ensure that all of this data informs insight, has influence and drives action and change? And what are the opportunities for systems to organise around people and communities when this makes a big difference to access, experience and outcomes, addressing inequalities?

In this guide, we outline Rethink Mental Illness's approach to coproduction, sharing how we tackle these questions. The model was developed for coproduction in a mental health context, but can be adapted to be applicable across other conditions.

Why coproduce?

Health and social care services have a legal duty to involve people and communities in commissioning.[1] This is strengthened by the statutory guidance 'Working in partnership with people and communities,' released in 2022, which Rethink Mental Illness contributed to.

The reasons for involving people as equal partners in decision-making go beyond legal obligation. Coproduction puts the priorities of people and communities at the centre of considerations and decisions around access, experience, outcomes and inequalities. In doing so, we believe that Integrated Care Systems (ICSs) can work towards their four statutory aims[2]:

- **Improving outcomes in population health and healthcare.** Focusing on what matters to people, both in finding which issues people prioritise, and finding solutions to problems.
- **Reducing inequalities in outcomes, experience, and access.** Understanding directly from the communities worst affected by inequalities what the barriers are to equal access, experience, and outcomes, and what would remove these barriers.
- **Enhancing productivity and value for money.** Enabling more integrated working across the system, towards collective lived experience priorities and I/We Statements.
- **Helping the NHS support broader social and economic development.** Building community capacity by strengthening grassroots organisations, which become integral to solutions.

1 S.13Q NHS Act 2006, as amended by the Health and Care Act 2022

2 The four aims of ICSs were introduced by NHSE (2020), 'Integrating Care Next steps to building strong and effective integrated care systems across England.' This section elaborates on Rethink Mental Illness's interpretation of the role of coproduction in achieving these aims.

This guide

Since 2017, Rethink Mental Illness has worked with people, community ecosystems and mental health and care systems in places across England to coproduce for better access, experience, and outcomes for people experiencing mental illness. We have facilitated the coproduction of ICS and Provider Collaborative coproduction strategies and frameworks, and codelivering them into practical implementation. Our coproduction staff work closely with both people with lived experience and system leaders to facilitate the best possible outcomes within the known constraints systems are facing such as workforce shortages and funding concerns. By fostering strong connections with national arms-length bodies, such as NHS England, we leverage our comprehensive understanding of the national policy context. This allows us to provide valuable context to the work, ensuring that the influence generated can effectively translate into action.

Through these years of experience, we have developed a model for coproduction alongside a wide range of resources. This guide shares our model with ICSs, Provider Collaboratives, and other systems who are coproducing services or strategies.

We start by introducing our model for coproduction, which is based on the statutory guidance for working in partnership with people and communities. We then go into each part in more detail, explaining how it can work in practice. We explore key challenges in each part, and share solutions where we can. Throughout, we give examples of the impacts that coproduction is already having in systems around the country.

Questions you might have

Whose perspectives matter in coproduction?

There is no single definition or theory of coproduction. In the health and care sector, it is widely accepted that coproduction means people with lived experience working as equal partners with people who work for the organisations providing services.

Rethink Mental Illness's coproduced definition is: Coproduction occurs when people with lived experience of mental health issues and carers work together with staff as equal partners in a way that is meaningful and effective from the outset. It follows a process of cocreation and shared decision making that is reciprocal and jointly owned by all involved. Coproduction achieves a shared vision that transforms the balance of power and resources to a position of equal ownership.

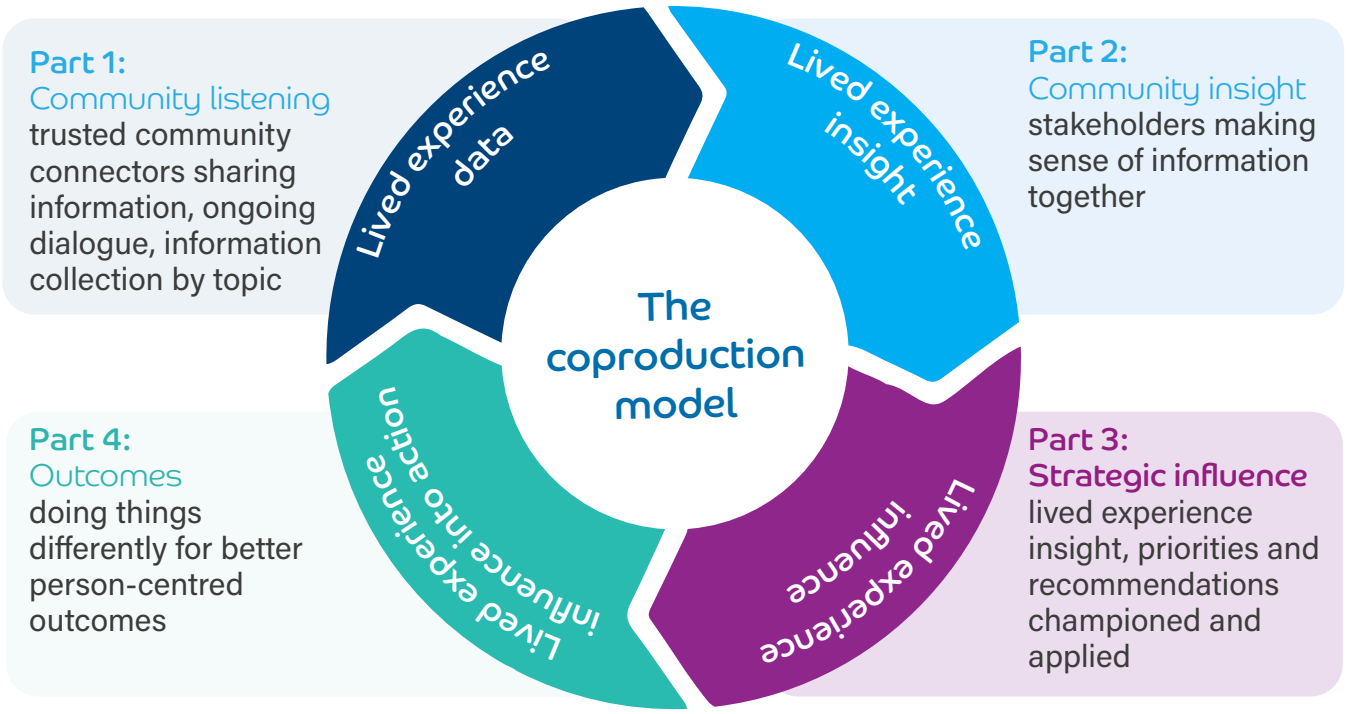
This means that several perspectives must be valued as equally important:

- People who are experts in their own right due to their personal lived experiences, including caring experiences (often called 'experts by experience').
- People caring, supporting, or commissioning within an organisational system (often called 'experts by training').

The perspectives of people caring and supporting people directly and staff who have their own lived experience are very valuable in the strategic shared decision making process. This includes peer support workers who intentionally bring an expert by experience perspective to direct care and support within a system. When gathering these perspectives, it is helpful to know which perspective is saying what – for the best possible sensemaking and decisions based on that.

"I have found coproduction to be a little bit like being an accidental celebrity. All the darkness and pain of mental ill health is suddenly useful, it's no longer an embarrassing, hateful, lonely time; but interesting and helpful and people are respectful of it. Your opinions are sought after and valid and as a result so are you."

Expert by experience leader, Somerset



In the following sections, we go through each stage of the model and tackle some of the practical challenges which can occur at each stage.

Questions you might have

How does the model allow us to understand a wide range of perspectives?

In coproduction, we need to hear from a wide range of people with lived experience. But not everyone can, or wants to, be involved as an expert by experience leader in system improvement and change. As a result, we often hear concerns that coproduction is not truly representative of local people and communities. Our model addresses this by bringing lived experience into decision-making in two distinct ways.

1. **It collects lived experience information from a wide range of people through a process called 'community listening'.** This information comes from many different perspectives – from families and carers as well as people with direct lived experience. It can also collect the perspectives of people who support people in communities, who spend time talking with people and hold considerable knowledge and insights as a result.
2. **It involves expert by experience leaders, who are equal partners with health and care leaders, in the shared consideration and decision making process.** They champion the voice of lived experience within the system, representing the wider lived experience information that has been collected.

It is important to ensure not only that we are hearing from a wide range of people, but specifically from those worst affected by inequalities. We discuss this in relation to people involved in community listening in part 1, and expert by experience leaders in part 2.

Part 1: community listening for lived experience data

In this part of the model, we hear what matters to people in the community as part of an ongoing conversation about system improvement. The listening is guided by categories so that subsequent insights can be effective within influencing scope.

It is vital that community listening is a continuous dialogue. When decisions are made based on lived experience information, we must feed this back to the people who provided this information. The conversation continues as members of the community give further feedback and share ideas.

Working with community connectors to understand and address inequalities

It is important to work with existing community connectors in community listening. These are people who are already trusted by communities, such as people who support people at the grassroots. A culture of humility is vital. Doing this enables the flow of information and understanding between people who plan and deliver care, and people who are severely affected by mental illness. It is important to have a coproduced strategy for equality, diversity, and inclusion and addressing health inequalities at this stage. This strategy can include specific inequalities strategies such as the Patient and Carer Race Equality Framework (PCREF).

We at Rethink Mental Illness support community connectors and leaders to note what matters to people according to categories relating to service development and improvement. These are often called buckets, and are discussed in more detail in part 2 of the model. As the information exchange and shared consideration process develops, specific lines of enquiry can be included and adapted. Different topics that relate to mental health, choices, control and freedom can be included.

The obvious benefit of community listening is the lived experience information people share in relation to systems and services – what is helpful, not so helpful, gaps, and ideas for improvement. We go on to discuss how this information can be turned into insights, influence, and action in the rest of this publication. This benefits the system as well as the people it serves.

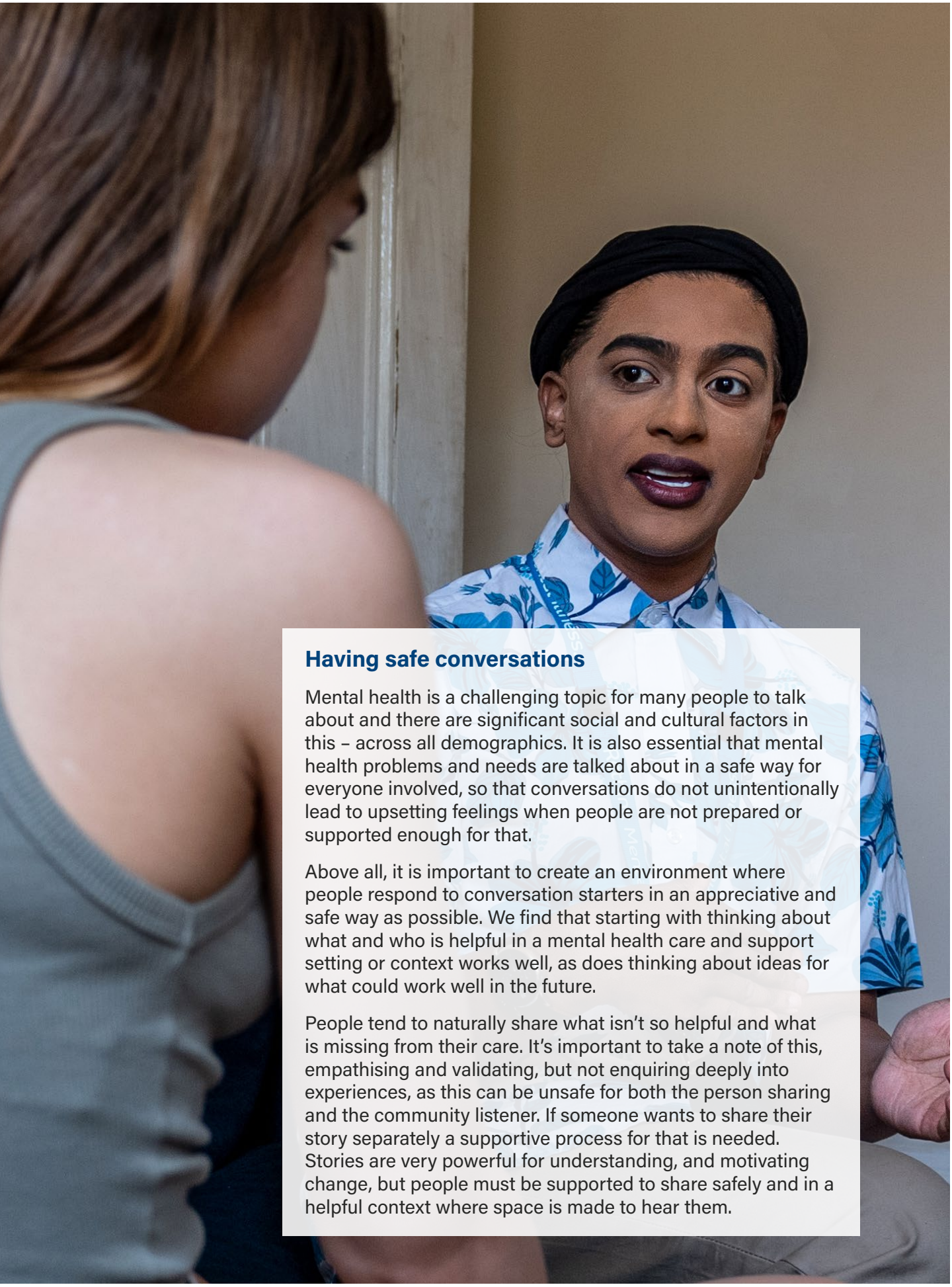
As well as this, community listening, by working with community connectors, has other benefits everyone involved:

- **To community connectors and leaders.** There is a two-way flow of information, allowing community connectors to share their knowledge and understanding of the support available to people to be as well as possible in relation to their mental illness. Sharing meaningful, helpful and locally-relevant information about what options are available to people can help engagement with community listening.
- **To people severely affected by mental illness.** In turn, this information allows people more choice, freedom, and control over their own care. They are able to hear this knowledge from people they know and trust.
- **To the system.** The system gains more knowledge about the support that the grassroots offer, and the value this has in a whole system context. Social mapping of the grassroots ecosystem is particularly helpful here and we've been piloting this in Coventry and Warwickshire. This is particularly significant in terms of wellbeing and prevention of illness, and for people experiencing intersectional inequalities.

Over time, coproductive working will lead to power sharing and service development and improvement will be effectively influenced by lived experience.

"[One of the key achievements of coproduction work has been] changing people's perceptions and assumptions of what someone living with mental health problems can achieve."

Expert by experience leader, Cheshire and Wirral



Having safe conversations

Mental health is a challenging topic for many people to talk about and there are significant social and cultural factors in this – across all demographics. It is also essential that mental health problems and needs are talked about in a safe way for everyone involved, so that conversations do not unintentionally lead to upsetting feelings when people are not prepared or supported enough for that.

Above all, it is important to create an environment where people respond to conversation starters in an appreciative and safe way as possible. We find that starting with thinking about what and who is helpful in a mental health care and support setting or context works well, as does thinking about ideas for what could work well in the future.

People tend to naturally share what isn't so helpful and what is missing from their care. It's important to take a note of this, empathising and validating, but not enquiring deeply into experiences, as this can be unsafe for both the person sharing and the community listener. If someone wants to share their story separately a supportive process for that is needed. Stories are very powerful for understanding, and motivating change, but people must be supported to share safely and in a helpful context where space is made to hear them.

Questions you might have

How can we ensure we engage diverse communities through community listening?

It is really important that we listen to people severely affected by mental illness, including people worst affected by health inequalities. This will involve people with a variety of access and support needs. We know that systems often have questions about how to engage with people in practice.

Some enabling factors in community listening include:

- **Understanding the intersectional inequalities picture,** including ethnic and racial inequalities, Autism and ADHD, other co-occurring needs, younger people and older people. This should be linked to system inequalities strategies, public health data and community ecosystem knowledge.
- **Recognising and funding community connectors** for their grassroots knowledge and insight and expertise in engaging people in their communities. This enables the ongoing conversation with the mental health and social care system. This funding must be sustainable e.g. over years rather than small grants or projects.
- **Enabling people to engage in different ways.** For example, holding a mix of semi-structured in-person group conversations, individual conversations, online conversations, and surveys.
- **Meeting people where they are.** For example by giving people the opportunity to share views based on their experiences while in community spaces they go to anyway, and on what matters to them from their current perspective. It helps when people are in spaces where they feel comfortable and there are people they trust around.
- **Giving people something in return for their time.** This might mean sharing wellbeing and system information, training, or wellbeing activities in exchange for time. If people are offered payment (including vouchers), they must be given information about how their benefits could be affected, if they receive benefits.
- **Anonymity.** Information gathered through community listening is anonymous and aggregated. Explaining this clearly to people can help them feel more comfortable sharing their views. Some people worry that survey responses can be linked to them and it should be explained that this is not the case.
- **Making sessions accessible.** When organising conversations, it is good practice to ask everyone what they need in order to comfortably participate. For example, being able to only listen and then give thoughts later, being able to stop or leave the conversation at any time, or come another time. For online conversations: keeping cameras off, not needing to introduce yourself, breaks, and sometimes written context in advance. Working alongside trusted community connectors makes a big difference to people feeling as safe as possible in conversations and they can often give recommendations about how to facilitate them, group and individual preferences and needs, language needs, etc.

Policy into practice

Social mapping in Coventry and Warwickshire

In Coventry and Warwickshire, Rethink Mental Illness have facilitated an approach called social mapping to understand the interconnections between different parts of the mental health system and wider ecosystem. The social mapping brings together experts by experience and experts by training from across the system including the NHS Trust, Local Authority, strategic colleagues from the VCSE and community leaders. As a group, we look at elements of the system, such as the non-statutory commissioned or grassroots VCSE, the statutory commissioned VCSE, and the statutory system. We draw up a detailed picture of how these impact across the system. From this, we see where we can influence to create change.

An example of this was the work we and our partners did to understand the effects of the cost of living crisis. Collectively, we drew a detailed picture of how the cost of living impacts people who use services across the VCSE, NHS Trust, Local Authority and grassroots community organisations. We saw a domino effect of how the cost of living impacts people's wellbeing. For example, we saw that the costs of attending appointments meant that many people could not afford to do so, and missed these appointments as a result.

In the VCSE sector, we saw where services were under pressure for funding. For example, the cost of utilities increased while funding levels remained the same. With people becoming more unwell, the VCSE began seeing more complex referrals which were more costly to support (for example, where people previously would have had 10-12 appointments, they now needed 18-24). Staff who were trained in mild to moderate mental healthcare needed training to be able to work with complex needs, which also brought additional costs. All of this led to a 'squeezing of the voluntary sector', which, in turn, impacted the statutory system as it couldn't draw on wider support.

The detail we see from social mapping gives us a detailed picture of the issues. This has changed the narrative in strategic meetings – from anecdotal evidence to a more detailed comprehensive picture of the issues.

Part 2: lived experience insight

Definition

An expert by experience leader is a person with lived experience who is a change agent within the system, making sense of lived experience information and being an equal partner in decision-making.

This part of the model is about making sense of the information acquired in part one of the model. It involves sorting it into themes and, based on this, gaining insights from the information. At this stage, expert by experience leaders have a key role to play.

Using 'buckets' and sensemaking

Coproduced buckets are helpful to collect the views and ideas of people so that this information has the potential to influence service and system continuous improvement, and design and implementation of policies and plans. These buckets are categories of information. They might include:

- **Cultural factors,** such as language, communication, and stigma.
- **Co-occurring needs,** such as ADHD and Autism, drug and alcohol use, or street homelessness.
- **Life stage considerations and differences,** for example for people aged 16-25, or over 60.

The bucket names can be agreed depending on coproduced priorities and lines of enquiry, and can be adapted. They can be based on collective lived experience priorities that have been identified, system programme priorities or on issues with a service or system that are proving particularly difficult to solve. Ideally bucket names are a coproduced combination of all three and should be regularly reviewed by both experts by experience and experts by training.

The contents of the 'buckets' will consist of quotes or snippets of information about each theme, noting which community group these come from. Diversity information is also recorded from aggregated diversity monitoring forms, or from information of community groups visited.

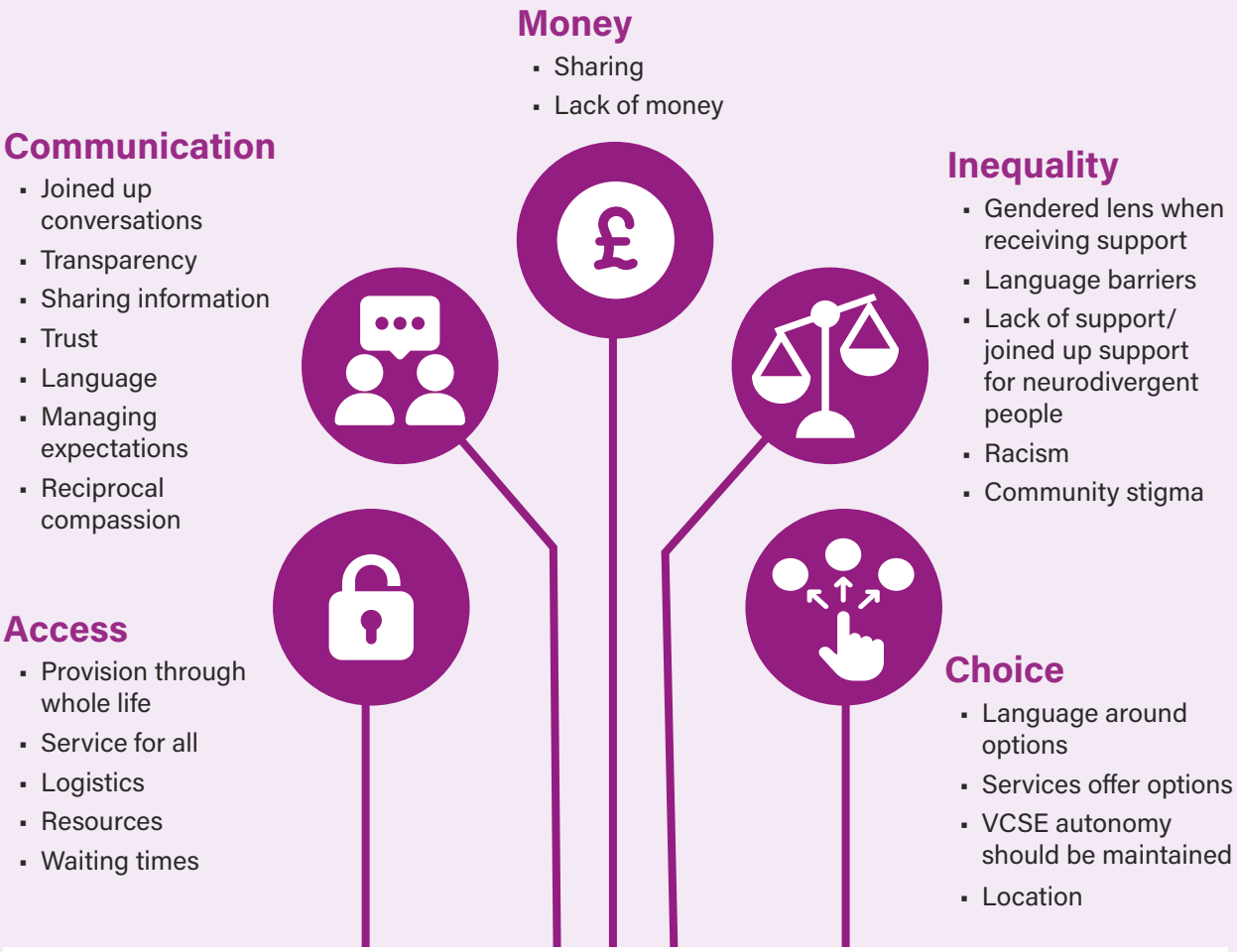
Sensemaking events can then be facilitated to organise the information thematically and to reflect on the insights gathered. This is done collaboratively with expert by experience leaders, community connectors, and experts by training. This process tends to naturally lead to participants thinking of potential solutions.

Community insight examples

To understand how insights can be gained through this part of the model, we can look at examples from community listening we have facilitated in Devon and Norfolk and Waveney Integrated Care Systems.

Community listening in Devon

This is an example of theming from Devon experts by experience and community listeners.



The next stage of the process was to consider the insights that emerged from the themes. One example of this was found within the 'access' theme bucket. Several trends were spotted: many people wanted meaningful earlier help while on long waiting lists. Many people mentioned the value of support that was readily available while waiting for clinical treatment, such as peer support. The insight we can gain from this is that more peer support options could be valuable for people waiting for clinical treatment.

These themes are going forward to inform collective lived experience priorities which will be applied to opportunities to influence in the community provider collaborative.

Insights in Norfolk and Waveney

In Norfolk and Waveney, the Expert by Experience Leader Reference Group were able to form detailed insights around complex and co-occurring needs. The graphic below shows how possible actions can be determined based on these insights.

Complex/co-occurring needs

Insights

- Need to **demonstrate by doing that you are held by the system** (not only say this). The word 'discharge' is not helpful. Practitioner relationships need to be tapered off. If one service is ending e.g. talking therapies, need to **actively connect you with someone else -** and have this action ready so the practitioner is not just saying they will/this will happen
- Need to **really ask 'how are you' 'what's going on for you at the moment'** – to see if there are any stressors/life events that are affecting someone's emotion and mental wellbeing. And have time to listen to understand and connect you with other practitioners.
- Need for **someone to turn to when things are not working**
- Carers being involved (with permission) very helpful, including with personal planning

Possible action (solutions)

- **Training and resources (e.g. map of connections/pathway for practitioners) about how to**:
  - gradually taper off practitioner relationships;
  - phone you if you did not attend to ask if everything's ok;
  - have next phase of care and support ready to connect you with;
  - Avoiding the word 'discharge', as it can have a negative effect
  - how important asking what's going on for you is, empathy and being ready to make connections as helpful/adjust personal plan so this is dynamic.
- Logging on a **personal plan** who is your **turn to person when things are not working.** This person could contact you at intervals as agreed by preferred method
- Training in Triangle of Care and Open Dialogue

The role of expert by experience leaders in sensemaking

Expert by experience leaders have an essential role to play in this part of the model. They champion current lived experience priorities in relation to opportunities to influence in mental health programme workstreams, steering groups and strategic governance. With these in mind, they make sense of the lived experience information coming through from people and communities via community listening.

We know that systems want to ensure that expert by experience leaders are properly valued and supported. This will mean different things to different people. Systems should make it the highest priority to enable expert by experience leaders to be involved in ways that are overall positive for their wellbeing as well for the benefit of systems and ultimately population outcomes, with effective support in their roles. There are several guiding principles that can be used as a starting point.

Take an inclusive approach to finding and developing expert by experience leaders.

Having the energy, time, passion and commitment to being involved over time with system improvement and change is rare and people must be valued for this even if they are involved with the system in other ways or have been for some time. However, it is essential to enable people who would not readily consider the role to consider and try it, and to work with community leaders to encourage people. While the expert by experience leader roles are champion or representative roles, it is vital to reflect on the diversity within lived experience reference groups and enable people from minoritised backgrounds and with lived experience representative across the scope of influence. This involvement activity is not employment and flexibility and choice must be maintained.

Have dedicated staff to support and facilitate.

At Rethink Mental Illness, staff support expert by experience leaders in their roles to share considerations and decision with experts by training, facilitating safely and constructively, with context and scoping of opportunities to influence.

Reward and recognition.

"[Coproduction has] benefits for lived experience advisors [such as] giving me the confidence to apply for my first job in years"

Expert by experience leader, Cheshire and Wirral

Expert by experience leader roles are not employed roles, and people can choose and vary their activity and how long they are involved for. We recommend six-month reflection points. The role is very much like a volunteer role. Payment should be offered but it does not need to be accepted if that is the person's preference. For people who receive benefits, it is essential that they are guided about how to let their benefits agency know before they claim for payment. Payment is not the only form of recognition and expert by experience leaders value reflection on influencing 'wins'; being connected with other involvement; and volunteering, employment, and training opportunities.

"Working side by side with people from all areas and having the opportunity to bring different cultures together is so rewarding, most of all the chance to learn and grow together to create a better future for everyone"

Expert by experience leader, Sheffield


Rethink Mental Illness.
Rethink Mental

Part 3: lived experience strategic influence

The role of expert by experience leaders is to champion lived experience insight (based on information collected from community listening) in shared considerations and decisions with experts by training. This can involve applying potential solutions or recommendations to opportunities to influence or knotty system issues.

"We're involved in strategic planning, which we were never involved in before... We're not just a few EbEs tucked away in the corner... we actually have a real voice and we have a say."

Expert by experience leader, Norfolk and Waveney

Expert by experience leaders find it helpful to have collective lived experience priorities to draw on and reference, rather than always drawing on their own lived experience. These can also be helpful so they can make influencing suggestions during meetings. When the community listening information, themes and insights have been previously shared with experts by training, this can make the lived experience more effective as it can be heard readily in a way that can influence and lead to action. Expert by experience leaders often draw on their own lived experience or what they've heard from others to influence – particularly in considerations where there is more time. However, this is often used to illustrate collective priorities and recommendations, with a constructive, future focus – rather than telling their own story multiple times, which can have a negative effect on wellbeing.

When spaces are hosted with time and psychological safety, and plenty of background information from both expert by experience and expert by training perspectives, the application of lived experience to knotty system issues can be very productive. And this can identify lines of enquiry to feed into ongoing community listening and then bring back to the shared considerations.

We support expert by experience leaders to recognise when they are influencing in meetings and shared considerations, and to keep a note. And we facilitate reflective meetings and offer individual coaching sessions so they can share and learn together. This reflection leads to identifying topics related to opportunities to influence that can be discussed together with experts by training in lived experience reference groups or other spaces. It's important to maintain a balance between the opportunities to influence that both experts by experience and experts by training identify. These are not always the same but are different dimensions or perspectives of the same system issues in relation to access, experience and outcomes.

Policy into practice

Collective lived experience priorities in Norfolk and Waveney

The collective lived experience priorities of the Expert by Experience Leader Reference Group for the Norfolk and Waveney adult mental health programme are informed by community listening. Lived experience insights will also inform the refinement of I/We Statements that in turn will inform system measures and reflective practice. This allows the system to hold itself accountable to people and communities.

> *"If we don't meet the 'I statements' that we've produced locally, then we're not doing our job properly."*
>
> **Expert by training, Norfolk and Waveney**

Norfolk and Waveney
Adult mental health system & service transformation/continuous improvement
Collective lived experience priorities at a glance

- Safe and supportive spaces with access to a range of joined up help options, social and clinical (loneliness, peer support, wil be more open to help available)
- Joined up way of sharing information (IT) including physical health needs (holistic view of person, reducing stress for all, better 1:1 shared decision making)
- Being able to get clinical and social support to treat symptoms if you don't have a diagnosis from a psychiatrist
- Feeling held when moving from one expert practitioner to another in the joined up system (no thresholds, discharge, while waiting for clinical treatment if appropriate)
- Feeling cared about, valued, supported and held by the whole system, particularly for people with protected characteristics, experiencing greatest inequalites (communication, resources for access)
- Helpful language and approaches across and throughout system/staff (trauma-informed, protected characteristics, other inequalities. menopause, end of life) Bias and discrimination training
- Joined up fast response to urgent and emergency need (crisis) including Social support 24/7 crisis service next to but separate from A&E space
- Joined up approach to medicine management, reviews and addressing side effects (to avoid conflicting advice/actions/stress/stopping taking)

Part 4: lived experience into action

When expert by experience leaders are in the habit of making a quick note of when they've landed an influencing point that has been heard and leads to some kind of follow up or onward action this is very helpful in tracking influence and seeing what it leads to. These influencing 'wins' can seem small or minor but they are all important and all add up. Tracked influencing into action can be collected, supported by facilitation. This is very helpful when it comes to evaluating the outcomes and impact of coproduction, and feeding back to people and communities. Demonstrating the cycle and impact of lived experience influencing is effective in encouraging the ongoing conversation envisaged in strategies.

"Involvement isn't tokenistic. Action needs to come from what the lived experience advisors are saying"

Expert by training, Cheshire and Wirral

The link between coproduction outcomes and impact and thread back to strategic influencing and insight and data fed by community listening can give the critical path for prioritisation of activity. Our strategies and frameworks often include a logic model which shows the different elements and drivers that can be adjusted depending on the critical path.

Examples of influence into action are:

- System strategies such as inequalities, workforce, eating disorders, and suicide prevention
- Service improvements such as approaches to physical health checks
- Service models and specifications such as rehabilitation, complex emotional needs, crisis spaces, locality wellbeing hubs, talking therapies
- Staff training such as physical health checks approach, trauma-informed care
- System measures such as I/We Statements
- System culture such as locality team working and telling the story of change in ways that are meaningful to people and communities

Questions you might have

How much time does coproduction take?

We often hear concerns about the amount of time that coproduction can take. It is true that it can take some time to get the process up and running and, once it is, continuous further engagement is always needed.

However, systems do not need to start from scratch. Working with VCSE organisations can allow the system to harness the sector's capacity and expertise. Rethink Mental Illness has supported ICSs across the country to codesign strategies, for example.

In the long run, proper investment in coproduction can lead to better and more equal access, experience, and outcomes of care. For example, Somerset ICS is partnered with the Open Mental Health alliance, which coproduced their transformed community model. Between April 2019 and December 2022, the Somerset area saw a 15% decrease in Emergency Department mental health presentations for adults and 24% for older adults. Across all ages there was a 30% reduction in admissions for a mental health need. And, while system-level change may take a while to become obvious, many benefits appear in the meantime, such as

- Ensuring that the system keeps lived experience at the centre of decisions being made and the impact these may have on individuals.
- Challenging assumptions and stereotypes that may influence decision-making.
- Ensuring that decision-making is aligned with the needs of the local community, including those who are most marginalised.

"[I have] seen many professionals change attitudes to mental health and multiply-disadvantaged persons. More training and opportunities are being offered…a more person-centred approach that values people's contributions"

Expert by experience leader, Sheffield

Get in touch – we'd love to hear from you

If your system is interested in coproducing a coproduction strategy or framework, or otherwise needs support with coproduction such as benchmarking or implementation, facilitation and support, please contact us on CMHFSupport@rethink.org.

What can we help with?

We can support with different stages of coproduction, including:

1. **Evaluating** your system's coproduction programme and identifying areas for improvement
2. Translating this model for your local population to create a **coproduction strategy or framework.**
3. Supporting you to get going to **implement** your coproduction plans, including **training and support** for experts by experience and experts by training.

Example of our work: coproduction framework

You can see the draft Norfolk and Waveney ICS Mental Health Coproduction Strategy here: Norfolk and Waveney Mental Health Co-production Strategy - Norfolk & Waveney Integrated Care System (ICS (improvinglivesnw.org.uk)

This diagram shows the elements in our current coproduction framework that we work with systems to co-develop and apply.