Welcome to the Cheshire and Merseyside Health and Care partnership Self-Assessment Matr
This matrix is based on the Cheshire and Merseyside Place Based Care Framework

What is this matrix for?:
Leaders of Place based care programmes will be asked to self assess themselves against eac
description of "What excellent looks like")
This will allow each Place to identify areas of strength, areas for development, inform best pra
review and collaboration across Places.
Across Cheshire and Merseyside the self assessments will be brought together into a single do
best practice across Places and also help us identify if there are any challenges and barriers

The self assessment can be repeated at regular intervals to enable Places to track progress o

What about the Programmes?
The 19 cross cutting programmes have been asked to contribute to the "what excellent looks
the interdependencies between their work.

How does the self assesment work?
On the "PLACE SELF ASSESSMENT" tab each of the core elements of the Cheshire and Mersey
These are then broken down into "sub elements"
In column F Place leads are asked to use the drop down boxes to describe the extent to whi

In column G Place leads are asked to use the drop down boxes to describe how broadly the
neighbourhoods/PCNs/hospital footprints has a more fully implemented model than others)
When scoring you should take into account the description of "what excellent looks like". To b
your area.
Place leads may want to consider buddying up with another place and using the matrix as a
good ideas/best practice
The sub - elements and the descriptions of what excellent looks like are ambitious - as they sh
care model. It is fully anticipated that places will not have full implementation across many s

References:
The 10 point plan for Place and the sub-element descriptions of what excellent looks like hav
Delivering sustainability and transformation plans: From ambitious proposals to credible plans
Programmes and Dudley Multi-Specialty Community Provider Outcomes Framework (publishe

PLACE NAME: TEST

CORE ELEMENTS		SUB-ELEMENTS	WHAT DOES EXCELLENT LOOK LIKE?	Level of implementation	Level of coverage	Narrative (inc barriers, opportunities, challenges)
Collaborate and integrate	1.1	There is a governance system that supports integrated change and is endorsed by your Health and Wellbeing Board	There is a written MOU or integration agreement that sets out the shared vision and how the partners will work together to deliver this vision. The system has mechanisms that allow providers and commissioners to disinvest and reinvest to support the new care model. This will include methods to make decisions and mitigate risks collaboratively. Partnership includes VCSE representation. Places understand their representation on C&M HCP Programme Boards and have a mechanism for making decisions on their recommendations.			
	1.2	There are pooled budgets to maximise the local £	The local authority and CCG have a pooled commissioning budget to support the delivery of integrated care. This will be wider than the minimum Better Care Fund and will support the true integration of health and social care services. The local authority and CCG have a pooled budget for commissioning care packages for people with Learning Disability and/ or Autism. There will be an integrated infrastructure to oversee this pooled budget with robust analysis of the impact of spend. There is acceptance of the concept of invest to gain and agreement on a mechanism for providers and commissioners to invest back into parts of the system when there are savings. There is an integrated infrastructure to consider where spend can be reduced (eg reduction in costly OOA packages) and look to bring care closer to home. This includes planning for services within local catchment such as Supported Living/ Residential Care to meet more complex needs. Personal health budgets are promoted within this system.			
	1.3	There are joint strategies and delivery plans (agreed between the CCG, Local Authority, and all significant local providers - including the independent, voluntary and third sector)	CCG, Local Authority and all significant local providers have agreed strategies and delivery plans that underpin the vision for place based care. Strategies and plans at place level refelct the priorities of C&M wide programmes and, where appropriate, translate these into local delivery.			
	1.4	There is a collaborative leadership approach that includes mechanisms for staff and citizen engagement	There are mechanisms to make changes and improvements that include input from patients, community, clinicians and non-clinical staff Transformational delivery plans include a comprehensive programme of involvement from relevant service users. All staff with a role in planning, commissioning or delivering services in your Place have an opportunity to 1) understand what your proposals are, how they will impact them and their ways of working 2) engage and influence decisions. There is work with your local Healthwatch and VCSE, building on existing local relationships and the connections you have in different communities to ensure that a diversity of views are captured, including marginalised communities and those groups seldom heard. Places have a plan for using media and social media activity, a series of engagement events and a regular flow of communication updates using the range of channels across the constituent organisations keep people informed about local plans and provide an opportunity to take part and share experience and expertise. There is co-production with people who use services spans service design, decision-making, mobilisation and monitoring. A key element of this is ensuring that representation is found from people with lived experience (eg CYP for CYP projects).			
	1.5	There is a specific plan to develop a collaborative culture	A cultural and organisational diagnostic will have been undertaken. A live development plan will be underway and senior leaders held to account. There is a specific communication and engagement strategy that encourages cross organisational working			

	1.6	There is a shared culture of continuous improvement	Monitoring and evaluation is embedded. A learning culture is established with leadership using evaluation to inform decisions There is an agreed approach for change that is recognised and adopted across the system There is a common language for system change and agreed data sources to generate a single version of the truth. Programmes use all opportunities for shared learning at local, regional and national level- with investment in evaluation of programmes to demonstrate improvement			
	1.7	There is a jointly agreed engagement plan for your place	A co-produced place wide plan has been developed, to maximise local capacity. As well as colleagues from CCGs and Trusts, this means working with local authority colleagues, patient groups, charities and VCSE organisations. There is agreement on when engagement is happening, how it will feed into the decision-making process, and how you will feed back on the involvement that has taken place. A substantial plan is agreed with your council to ensure it is fully involved in the development of the Place Plan. Members are regularly informed of your thinking and involved in decisions via agreed channels and early on in the process. There is a process to ensure that the views of people who use services are taken into account			
2	1.8	Health needs of the whole population are understood, through population health segmentation, predictive modelling and wider actuarial analysis working in accordance with relevant information governance	Understanding population health need will include use of JSNA, and aggregated data drawn from all significant local providers. This can be matched with service activity to enable the integrated system to invest resources where it can have the biggest impact. There is a clear focus on reducing health inequalities. The system has access to BI and analytics skills to interpret this data and to undertake population health intelligence and analytics.			
Establish neighbourhood hubs						
	2.1	There are identified hubs/neighbourhoods/primary care networks that broadly cover a population of 30-50k	There are groups of GP practices, working with other providers of care to provide coordinated and anticipatory care. These groups use a multi-disciplinary approach that crosses organisational and professional boundaries. Groups of GP practices have "cancer champions" who are skilled at providing non-urgent care to people affected by cancer and have strong links with MDTs GP practices should have a supportive care register which includes people at end of life. (this should be c. 1% or practice populaton) Personalised support care plans are in place for people on this register. GP Practices making best use of LD Health Facilitators and training around reasonable adjustments, Annual Health Checks and STOMP. GP Practices are working to become autism-friendly			

4	2.2	Neighbourhood Hubs coordinate care delivery spanning physical, mental health and social care.	Standardised protocols are fully implemented across all primary and community services and are operational within the care model. They are evidence based informed by best practice and shared learning across the sites, designed by clinicians and social care professionals across the site footprint. Implementation is supported by rapid feedback cycles and professional governance to ensure timely adaptation and reaction to performance of protocols and pathway GPs, ideally 24/7 incorporating out of hours cover for on the day appointments Primary and community care teams work as one team with fewer boundaries and handoffs and colocation where possible. Health and wellbeing staff including: health visitors, school nurses, social prescribing link workers, youth workers, drug and alcohol staff, social workers, mental health staff, as required, be part of the Primary Care Networks and the Multi-Disciplinary Team model Neighbourhood hubs will provide a route for new primary care roles Nurse and Nurse prescribers picking up the walk in treatment Paediatric early morning and afternoon cover to reduce the 50% unwarranted A&E attends from children Social worker presence to ensure any social needs are covered/guided at source. Third Sector navigators (or social prescribing link workers) to ensure the direct route to social prescribing. Rehab and Physio staff offering community treatment to avoid re admission			
	2.3	Hubs act as a route for delivery of secondary services in the community	There is access to geriatrician support to support direct access avoiding A&E or potential admission (including from care homes) There is a fully interoperable data set meaning clinicians will have access to the summary care record, care plans and patient notes wherever they are treating patients. This will include information on cancer and EOLC treatment and care plans. Streamlined referral pathways into specialties ensure that cases are appropriately triaged and diagnostics are prepared. Hospital specialists have a more holistic understanding of patients by linking into Primary Care Networks and participating in MDTs, offering phone advice, electronic advice and delivering training.			
	2.4	Wider public services are included within networks	Networks are in place which include wider public services like housing, education, employment, fire and police and all combine to support patient self-care			
	2.5	Hubs are supported by fully interoperable technology systems	We have a digitally mature system with shared care records so health issues are identified sooner and people are treated more effectively. Hubs can access an interoperable record to enable seamless care.			
Improve access to primary care resources	3.1	Primary care networks have been implemented	https://www.england.nhs.uk/gp/gpfv/redesign/primary-care-networks/ Links with Primary Care Networks to develop referral pathways, learn from service information to ensure secondary care services are focused on patients with greatest acuity and that primary care are supported effectively to support their patients as much and as long as safe and effective. Appropriate use of Advice and Guidance and eReferrals There is a process for ongoing shared learning on inappropriate referrals and late presentation of disease to secondary care.			
	3.2	People can access a digital first offer from primary care	All GP practices offer patients the opportunity to book online appointments, request repeat prescriptions and have access to electronic records. Using local beta access to national NHS programmes where relevant Reasonable adjustments are in place to support individuals who struggle with digital and telephone access. Patient Portal exists as Patient Control Record			

5	3.3	Enhanced primary care that offers convenient access to GP appointments	A range of appointments for patients to access same-day, including telephone consultations, e-consultations and walk in clinics, as well as face to face appointments. No patient is attending A&E because they cannot get an appointment with the GP 100% coverage of GP Extended Access, compliance with all seven core standards, and direct booking available though NHS 111.			
Mobilise community assets						
	4.1	There are established partnerships with schools and workplaces to promote healthy eating and physical activity, using all community buildings and assets such as sports teams, emergency services, housing and local leaders.	Community programmes focusing on healthy eating, physical actvity and health promotion include cancer awareness messgaes and encourgae uptake to national screening programmes. Smoking cesssation is a key priority. We use an assets based approach making the most of local amenities, people, community groups and talents to embed prevention. We are also offering Mobile Health Kiosks the community use. All local places have health improvement services in place that we co create with.			
	4.2	Workforce health charters are in place in your large local employers	Work with local health partners and local Chambers of Commerce to support this			
	4.3	The strategic estates strategy identifies and facilitates the disposal of surplus land and buildings	All assets mapped across each system with a target utilisation of key buildings at 80% by March 2021. Key sites identified for disposal and land disposal opportunities will be actively managed at a system level and in line with our fair shares regional target. Carter targets to reduce non-clinical space in key acute sites will be managed at a system level in line with the Estates Strategy metrics. Place estates plans will be reviewed and updated annually to reflect local priorities and include any planned capital spend or future requirements.			
6 **Promote self care and prevention**						
	5.1	An effective population health framework is embedded in local strategic and delivery plans	The Cheshire and Mersey Population Health Framework provides a detailed and comprehensive approach to delivering Population Health effectively The framework has been adopted by the collaborative leadership group. The framework has been cross referenced with local place development plans to understand where the principles of population health can be adopted. Mental health features highly in health frameworks as a continuing area for improvement in C&M			
	5.2	Make Every Contact Count (MECC) training been delivered to all neighbourhood hub teams	Contractual levers incentivise roll out of MECC training for all staff groups. Brief interventions re; smoking cessation and the importance of screening are included. Trusts deliver Prevention of Ill Health CQUINS.			
	5.3	There is a plan in place to increase % of population who have had NHS Health Check	There is a plan in pace to increase uptake of the 3 national cancer screening programmes There is a plan in place to increase the number of people with SMI receiving physical health checks. Promotion of eye screening All places sign up to Cheshire and Merseyside Prevention Pledge			

	5.4	There is a mechanism in neighbourhood hubs to offer signposting to non-clinical services (social prescribing)	There is a registry or map of community assets to underpin social prescribing Neighbourhoods have people who are able to signpost to services There are clear and easily navigated pathways to link people to the appropriate community assets, developed in partnership with the voluntary, faith and community sector Neighbourhoods have people who are trained in coaching and active listening skills to support people to embed new activities and behaviours. These people have awareness of cancer and are able to identify those with cancer specific needs. There is a plan in place to increase the number of people accessing social prescribing Social prescribing includes access for people with LD & autism with some specific resources for those with more complex needs who may not be able to access the universal offer.			
	5.5	Person centred care has been implemented	People with long term conditions (including cancer) and low knowledge, skills and confidence (activation) are systematically identified and supported to take control of their own health and wellbeing, tailored to their level of knowledge, skills and confidence. People with LD and/ or Autism who have long term conditions are systematically identified and supported to take control of their own health and well being. This is particularly important due to the possibility of premature mortality. There are in house training and education programmes for staff, patients and clients on self-management, health literacy, behaviour change, MECC and specialist topics. The 3 key steps for person centred care are: 1) identifying needs through: • Patient Activation Measure (PAM) or a suitable alternative approach to measure level of activation (eg eHNA) • care and support planning conversation to understand needs and preferences – using for example the personalised care & support planning tool – Think Local Act Personal; A systematic approach, to support early indetification of people in the last 12 months of life, e.g using a clinical search tool 2) providing tailored support through: • self-management education – including generic and condition specific courses, reflecting the needs of the local population. Examples include the			
	5.6	There is a model of anticipatory care - using population health analytics, case finding and risk stratification to identify people at risk of deterioration or exacerbation and put mitigation in place.	The model draws from a wide range of data sources and will use evidence based algorithms or disease registries to identify individuals at risk of a sub-optimal outcome. These systems need to generate lists of individual names that can be considered at hub/neighbourhood or practice level neighbourhoods/hubs need the skills to interpret/tailor this analytics in response to local need. There is systematic use of a supportive care register at practice level to review people at end of life & enables proactive care management There is a clear pathway back to secondary care for patients who relapse or are experiencing consequences of their cancer and its treatment. Safety netting is in place to pick up patints with signs of deterioration whilst on routine surveillance- eg. MyMedicalRecord remote patient management system Clinical audit into high intensity user pathways are carried out There is a clear pathway to community LD teams for people who may require additional support. Neighbourhood hubs have arrangements in place to identify people who miss annual health check/GP appointments and ensure follow up			

7 **Actively support people with long-term health and care needs**	5.7	Patients can access their own records	There is roll out of NHS app or other patient portal.			
	6.1	Integrated care records are in place to ensure effective monitoring and to support decision making	All relevant professionals are able to access a longitudinal health record that brings together treatment information from all providers to enable joined up care. The record contains contemporaneous and as near to real time information as possible There should be a single (trusted) assessor process and a single care plan that all appropriate professionals can access There is a mechanism to bring in information from regional and tertiary providers as well as local orgs. There is a consent model that gives the individual control over what information they want to share There is an Electronic Palliative Care Coordinating System (EPaCCS) which works with all local providers enables a longitudinal health record			
	6.2	Use of technological applications, where appropriate, to prevent or signal deterioration	Digital tool are in place to enable symptom reporting outside of clinical settings eg falls sensors, patient reporting their own symptoms, telemedicine and telemonitoring Digit@LL enhance / empower workstream and EPR/HSLI developments with providers are fully implemented Telehealth, apps and patient portal to assess, record and escalate are explored Digital tools enable and support self care and effective self management			
	6.3	Health and wellbeing staff in primary care hubs and multi-disciplinary team for complex care	MDTs design and deliver shared care plans. They wrap about GPs and provide care for those with long term conditions and those at highest risk of developing a complex condition MDTs are formed at the locality or neighbourhood level preferable at 30,000-50,000 people as this is the most effective unit for these teams to operate across MDTs regularly review patients that have been identified as being at the greatest risk of developing complex needs as well as those who already need high levels of support MDTs have access to mechanisms that facilitate ongoing and unscheduled conversations remotely so that patients cases are discussed in real time and they can access support and advice in a timely and efficient manner. This may include linking hopsital specialists into the out of hospital MDT to enable the team to manage complications, seek advice and change treatments without the need for a hospital referral. MDTs at neighbourhood level are skilled and equipped to deal with the specific needs of people with cancer. Advance care planning and understanding preferred place of care reduces the number of patients in hospital at end of life. Primary care professionals can access specialist advice 24/7 Patients identified as being in the last 12 months of life should be managed through a supportive care register in primary care and have a personalised support care plan. Residents in care homes identified in care homes should have the same equity of review, support and personalisation for their individual preferences and needs to be met and hospitilisation avoide MDTs at neighbourhood level are skilled and equipped to deal with the specific needs of people with LD/ autism, including skills around forensic issues			

	6.4	Shared decision making is embedded in all settings	The named clinician or MDT designs the care plan with the patient and carer. This is person-centred and based on positive risk taking. The care plan is shared with providers across the system and implemented by MDTs. The patient will be supported by a single named co-ordinator and a personalised care and support plan developed including anticipatory care ,do not resusitate information, preferred place of care and preferred place of death. The PCSP will be shared using EPaCCS Realistic shared decision making to ensure patients are fully prepared and aware of the benefits and limitations of interventions; to provide informed choice. Hospital specialists and Community Trust specialists increasingly run joint ambulatory clinics in the community and be part of primary care Multi-Disciplinary Teams			
	6.5	The enhanced health in care homes model is implemented	https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf			
8	**Care closer to home - hospitals without walls**					
	7.1	Professionals deliver services at home as an alternative to inpatient care to avoid admission to hospital, e.g. Hospital at Home	Outpatient clinics - assessment, preconsultation and dignostics are available in the community rehabilitation and reablement is available in the community. Specialists, including consultants, are integrated physically and virtually into community teams providing advice without the need for referrals chemotherapy at home continues to roll out as an option. People with cancer can access rehab in the community. Patients can be seen as an outpatient in the local hospice, this includes elective admission as a daycase for symtom management such as blood transfusion Crisis Resolution Home Treatment Teams meet core fidelity The CCG and LA (working with education and providers) use Dynamic Support Databases to identify people with LD/A at risk of hospital admission (all ages). Amber or Red assessment triggers a well-being MDT or C(E)TR. Intensive Support is provided to people at Amber/ Red in their own homes to address escalating needs. This is currently available for adults, and is a development action for CYP. Home treatment such as home dialysis for kidney failure is considered in all projects, supported by telehealth and apps Guidance to staff to share information on clinical and lifestyle risks in referral and discharge summaries to ensure that prevention is addressed at all points in pathways and that patients are included on relevant disease registers as early as			
	7.2	There is access to diagnostic equipment in the community	Use of appropriate diagnostics in primary and community care to support specialty pathways			
	7.3	Interoperable systems linked with Acute settings to ensure speedy results, XRAY, Bloods etc.	C&M Share2Care programme and connect workstream are fully implemented Acute Trusts to be linked by a collborative Picture Archiving Commuication System (PACS) this enables radiology images to be viewed at each Trust regardless of where in the network the image was captured. Digital pathology is implemented that: o Ensure equity of access for all patients in Cheshire and Merseyside to specialist expertise, in whichever hospital the patients have their biopsy and the pathologists work o Facilitate inter-laboratory referrals o Facilitate intra-laboratory consultations between colleagues o Move towards a more standardised method of reporting cancer cases using structured data capture and use o Provide essential infrastructure to allow the implementation of algorithms to assist decision making Interoperability to ensure results are shared across the entire system, between primary / community care and across specialty care to avoid repeat testing. Particularly relevant for haematology, orthopaedics and nephrology Technology systems on site to pick up BP/AF with direct response for treatment or relevant intervention			

	7.4	Proactive case management is in place to provide alternatives to hospital-based intervention in order to prevent unnecessary admissions and ensure earlier discharge	Trusted assessors carry out a holistic assessment of need on discharge Coordinated discharge planning by an integrated team based on joint assessment processes and protocols. The care plans are transferred to community care team Discharge to access is implemented providing short term care and reablement in people's homes or through using "step-down" beds to bridge the gap between hospital and home Trusted Assessors should identify patients at end of life and expedite discharge especially those patients identified as being in the dying phase Person-centred discharge planning is in place for all inpatients, supported by timely Care (education) and Treatment Review for people with LD Up-to-date risk assessments are used to support decision-making, based on positive risk-taking. Transition is carefully planned to suit individual needs, with clearly identified actions to ensure the legal framework, care provider training and any housing adaptations are progressed. Adopt holistic approaches to history taking to address lifestyle and other risk factors and use this information in care planning and include in discharge			
9	**Integrated urgent care and single point of access**	.				
	8.1	An Urgent Treatment Centre (or equivalent) established	UTCs designated, in line with the national requirements for access, providing a clear third option in addition to A&Es and PCHs, with evidence of efficacy being established. These include: access to diagnostics and x-ray third sector support, social navigation and information portal to borough assets A rapid diagnotic centre model for patients with vague symptoms suggestive of cancer is fully implemented			
	8.2	Urgent Care Centres are established to provide integrated services for populations of 100k plus	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres–principles-standards.pdf			
	8.3	A Child Health Hub incorporated into UTC	Community clusters established acting as a bridge from hospital to home, supporting the development of personalised, family centred care through a network of teams working in localities and neighbourhoods.			
	8.4	Integrated discharge and reablement	There is an integrated model of discharge and reablement that supports early appropriate return to normal place of residence.			
	8.5	There is a rapid response service to quickly assess, treat and support patients at risk of hospital admission in their own home, step up services are available as appropriate	There is a rapid response service with advanced skills to assess, provide some immediate treatment, discharge or refer/deliver care to patients in the community, this may include paramedic practioners There is an acute oncology service across the whole Alliance that meets NICE guidelines and provides 24/7 support for people at risk of complications of treatment. This includes support for low risk neutropenic patients to be treated at home. The CCG and LA (working with education and providers) use Dynamic Support Databases to identify people with Learning Disability / Autism at risk of hospital admission (all ages). Amber or Red assessment triggers a well-being MDT or C(E)TR. Intensive Support is provided to people at Amber/ Red in their own homes to address escalating needs. This is currently available for adults, and is a development action for CYP.			

	8.6	There is a 24/7 single point of access to enable appropriate signposting to an on-the-day response to services to keep people well at home.	There is a fully integrated 999, 111 and Clinical Assessment Service offer, with NHS 111 usage at or above the national average This includes: A single phone number to access a triage hub which has real time data showing capacity and utilisation of place based assets clinical triage - through a clinical assessment service access to interoperable patient record to enable safe handovers and prevent people repeating information Hub can access services in GP (inc GP out of hours), adult social care, safeguarding, therapies, third sector and some specialist services (eg acute oncology) A single point of access at locality level for the assessment and triage of cancer related issues. This utilises recognised risk assesssments such as the UKONs triage tool A crisis care model for C&M in development which includes NHS 111. This to be implemented in all places once developed.			
	8.7	Effective signposting to appropriate treatment centres in the event of a crisis	There is a programme of engagement to support people to understand what options are available in the event of a crisis			
	8.8	Patients are directly booked, from the first contact, into the most appropriate service	This includes: out of hours, in hours or at an urgent and emergency care hub or patients are booked into a planned appointment on a future date if their need is not urgent. All people undergoing treatment for cancer have certainty of the next steps in their pathway and access to a named key worker By March 2020, ensure providers: 1) describe and publish all mental health GP Referred Services in the NHS e-Referral Service through a Directory of Service, offering choice of any clinically appropriate team led by a named Consultant or Healthcare Professional, as applicable; and 2) ensure that all such services are able to receive Referrals through the NHS e-Referral Service. 3) make the specified information available to prospective Service Users through the NHS Choices Website, and must in particular use the NHS Choices Website to promote awareness of the Services among the communities it serves, ensuring the information provided is accurate, up-to-date, and complies with the provider profile policy set out at www.nhs.uk			
Engagement Framework to Develop Place 5 Year Plans	9.1	Local Engagement Plan	An engagement plan developed together, as a Place, to maximise local capacity. As well as colleagues from CCGs and Trusts, this means working with local authority colleagues, patient groups, charities and VCSE organisations. You agree when engagement is happening, how it will feed into the decision-making process, and how you will feed back on the involvement that has taken place.			
	9.2	Elected representatives	A substantial plan is agreed with your council to ensure it is fully involved in the development of the Place Plan. Members are regularly informed of your thinking and involved in decisions via agreed channels and early on in the process.			
	9.3	Staff	All staff with a role in planning, commissioning or delivering services in your Place have an opportunity to 1) understand what your proposals are, how they will impact them and their ways of working 2) engage and influence decisions.			
	9.4	Community and patient voice	You work with your local Healthwatch and VCSE, building on existing local relationships and the connections you have in different communities to ensure that a diversity of views are captured, including marginalised communities and those groups seldom heard.			
	9.5	Public	Media and social media activity, a series of engagement events and a regular flow of communication updates using the range of channels across the constituent organisations keep people informed about local plans and provide an opportunity to take part and share experience and expertise.			