Attachment 3

Programme Manangement Office
St James Hospital
Ibsley Centre
Room 2, First Floor
Locksway Road
Milton
PO4 8LD
Telephone Number: 02392 684851
Email: pmo@ports.nhs.uk

Personal Health Budgets

Author	**Jason Hope**
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Author:		Jason Hope
Quality Assurer:		PMO
Approver:		Innes Richens

Documents Referenced

Ref.	Title	Location

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3	Update to Risk and Issue Log	JH	07.09.10
4	Update to Risk and Issue Log. Update to Finance work group objectives	JH	19.11.10

Contents

1. Executive Summary

Provide an overall summary of the document

2. Project Brief

Project Brief
Portsmouth Personal Health Budget (PHB) project aims to develop personal health budget implementation arrangements in Portsmouth to the level at which formal DH (Department of Health) pilot status can be awarded. The project also aims provide a PID (Project Initiaition Document, or project plan) for the further implementation of personal health budgets across all areas sanctioned by the DH (Department of Health) by December 2010. The project willl seek to meet its objectives by working with a group of people operating personal health budgets and by using this experience to answer questions set by the project steering group. This project requires no specific funding beyond supporting meeting arrangements and aims to make no specific savings. Some activity that may have been provided within NHS organisations may transfer to private organisations, however it is expected that NHS providers will sub-contract for these arrangements.

3. Business Objectives

3.1. The project will begin in the Financial year 2010/11 and be completed by December 2010. Key Stakeholders are NHS Portsmouth, Solent Healthcare, Rowan's Hospice, Portsmouth Disability Forum, Portsmouth City Council and adults living in Portsmouth.

3.2. To increase the choice and control people in Portsmouth, over the financial year 2010/11, can exercise over the way their healthcare is planned and delivered for the following groups:

- People who will receive Continuing Healthcare (Long Term Care funded by the NHS or NHS and social care)
- People on the Gold Standard Framework (programme of standards) receiving end of life care
- People with mental health needs receiving a stable package of care

3.3. To develop sufficient robustness in pilot arrangements to be awarded Department of Health pilot status by December 2011 and produce an enhancement of this PID to deliver Personal Health Budgets in all areas sanctioned by DH

3.4. To aim to pilot Personal Health Budget arrangements with up to 10 individuals from each group identified in item 2, with no fewer than 5 from each group, during the financial year 2010/11.

3.5. To explore the full range of options available for delivering healthcare as a personal budget including delivery alongside self directed support for social care within the areas defined in item 3.2

3.6. Rationale and Options Analysis


PHB project Appraisal

4. Project Organisation and Approach

4.1. The project will led by a steering group which will advise the NHS Portsmouth executive Director. The Project will be managed within a Prince 2 (project management style) framework with bespoke Agile (complimentary project management style) project management features.

4.2. The steering group will comprise workstream leaders and key advisors

4.3. Working groups will carry out investigations into delivering personal health budgets and feed learning to the steering group

5. Organisation

Please see the glossary at the end of this section

Sponsor

Innes Richens, Director of Strategy and System Reform

Project Manager

Jason Hope, Senior Project Manager

Project Steering Group Members

Person	Role	Group	Area
Ruth White	Rowan Hospice	End Of Life Care	Independent Provider
Richard Curtis	Commissioner CHC	EOL/CHC	Commissioning
Gina Cook	Service Manager	CHC	Commissioning and provision
Jackie Chalwin/Jo Robinson	District Nursing	CHC/EOL	Health Provider
Brian Rains	Service User led organisation	SU Representative	Third Sector, Service User
Lynn Rigby	Director Portsmouth Disability Forum	Service User Led Organisation	Third Sector
tbc	Carer	Carers Involvement	Independent
Mark Rolands	Respiratory Consultant	EOL Care	Health Champion
Heather Smith/ Melanie Froggatt	Finance Management	PCT	Finance
Ian Ross/Angela Dryer	PCC/SDS Link	PCC	Transforming Social Care
Chris Day	Provider Information Systems	PCT	Informatics

Carol Ablitt	Finance direct payments	PCC	Direct Payments
Matthew Hall	MH Provider Lead	Solent Health Care	Health Provider
Jason hope	Project Manager	Commissioning	Integrated Commissioning

Glossary

CHC – Continuing Healhtcare

EOL – End of life care

SU - Service User

PCT - NHS Portsmouth

PCC – Portsmouth City Council

SDS – Self Directed Support

MH – Mental Health

5.1. Responsibilities

Project Board Role	Person / Title	Responsibility
Sponsor	Innes Richens	Responsible for the successful delivery of the project, supported by the supplier & user. They will ensure the project balances the needs of the business, the user & the supplier.
Senior Supplier	Ruth White Matthew Hall Gina Cook Jackie Chalwin Carol Ablitt Ian Ross Chris Day Lynne Rigby	Represents the interests of those designing, developing, facilitating, procuring and implementing the required products.
Senior User	Innes Richens Brian Rains	Will ensure the requirements have been clearly defined and are fit for purpose; They will provide user resources and ensures user benefits are realised.
Project Assurance	PMO	Will monitor all aspects of project's performance and products independently of Project Manager
Project Team	**Job Title**	**Responsibility**
Jason Hope	Senior Project Manager	Delivering the Project to plan

Matthew Hall	AD AMH	Operational Delivery and Clinical Standards Workstream Lead
Heather Smith	Head of Finance	Finance and Information Workstream Lead
Richard Curtis	Commissioner CC	Governance, Risk Management and Market Development Workstream Lead
Jason Hope	Senior Project Manager	Culture Change and Workforce Development Workstream Lead
Jason Hope	Senior Project Manager	Communications and Stakeholder Management Workstream Lead

6. Quality Plan

6.1. The project will be delivered using the PMO project framework based on PRINCE2 methodology. Project Assurance will be provided by:

PMO (Project Management Office – oversees all NHS Portsmouth projects)

Project Board

The DH self assessment survey for PHB pilots will be used to establish when Portsmouth's implementation arrangements have reached the level necessary for formal pilot status.

The PMO and executive member on the steering group will assess the suitability of the emerging PID for implementation of wider Personal Health Budget arrangements

NHS and Portsmouth City Council ethical approval arrangements will be sought where appropriate to ensure patients or service users are treated properly whilst in the process of learning how to deliver PHBs

NHS Clinical governance (process of ensuring quality standards) arrangements in Portsmouth will provide the framework for ensuring patients or service users are not put at risk by the activities of the project.

6.2. Project Tolerances

The costs have been assessed and agreed to have £100 tolerance

The resources are

Person	Organisation	Project Time Agreed per month
Ruth White	Rowan's Hospice	
Brian Rains	Portsmouth Disability Forum	
Lynn Rigby	Portsmouth Disability Forum	
Richard Curtis	NHS Portsmouth	
Gina Cook	NHS Portsmouth	
Chris Day	NHS Portsmouth	
Heather Smith	NHS Portsmouth	
Jackie Chalwin/Jo Robinson	Solent Healthcare	
Matthew Hall	Solent Healthcare	
Ian Ross	Portsmouth City Council	
Carol Ablitt	Portsmouth City Council	
Jason hope	PCC/NHS Portsmouth	20hours

The planned timescale for project completion is **December 2010** but the deadline is **March 2011** so slippage is **3 months**

7. Scope

Inside the scope of the project

7.1. A range of evidence that can demonstrate it is appropriate for the Department of Health to award of formal Personal Health Budget (PHB) pilot status to Portsmouth.

7.2. Project Initiation Document to support the implementation of Personal Health Budgets across the range of areas sanctioned by DH from December 2010-07-23

7.3. The learning from introducing personal health budget arrangements with between 15 and 30 people receiving healthcare and support because of their mental health need, because they have a terminal diagnosis or need continuing healthcare.

7.4. An operational policy to deliver PHBs as a direct payment after the point when the DH awards formal Pilot status

Outside the scope of the project

7.5. PHBs offered as a direct payment

7.6. PHBs offered outside the groups stated in this PID

7.7. Deliverables (outputs of the projects) offered by other projects aligned with the aims of this project.

8. Impacted Departments

The following areas will be impacted by this project:

People and Departments	Impact	When
NHS Portsmouth Finance	Will need to assess financial risk of delivering PHB's	August to December

NHS Portsmouth Continuing Health Care	Will need to free up staff time to operationalise PHB choices	August to December
NHS Portsmouth Strategy and System Reform Directorate	Will need to undertake early analyisis of market position and recommend market development strategy. Director time will be required for decisions and chairing group	August to December
Integrated Commissoning Unit	Project management time	August to December
Rowans Hospice	Will require management time ot understand how to deliver services under Personal Health Budget arrangements	August to December
Adult Mental Health service, Solent Health Care	Will need Associate Director, Team Leader and Social Worker time to understand how to deliver personal health budgets	August to December
District Nursing Service, Solent Healthcare	Will need service manager and district nurse time to to understand how to deliver personal health budgets	August to December
Portsmouth Disability Forum	Will need organsiationsal expertise and time to understand how to develop information about PHBs and respond as an organisaiton	August to December
Portsmouth City Council	Will need time from people involved in the self directed support development work to offer advice and align policy and process. Time will be needed from social work staff to help with transition to an oprerational PHB	August to December

9. Constraints, Assumptions, Dependencies

9.1. Constraints

9.1.1. The capacity of the working groups to deliver learning to the steering group will set the pace of the project

9.1.2. The mechanisms to support the development of personal health budgets are largely embryonic, this will make the processs of offering PHBs more difficult at this stage

9.2. Assumptions

9.2.1. The implmementation of the CAF programme will support information sharing across in the longer term, local workarounds should information sharing issues arise will be sufficient for this project

9.2.2. SHA and DH support for the project stays in place until the end of the project

9.2.3. SHA advice to avoid developing a RAS (resource allocation system – allocating an amount of money against a defined need) is sound and an amount of money can be agreed as a budget indicative of what support and treatment for the indivual should cost under present arrangements

9.3. Dependencies

9.3.1. The development of PbR for mental heath will provide indicative budget levels for people with mental health health needs.

9.3.2. Portsmouth City Council's transforming social care programme will provide some of the mechanisms an dsupport to offer PHBs

10. Implementation

10.1. Local

The establishment of working groups to focusing on offering PHBs to a small group of individuals will lead to deliverables beign achieved. The focus of these working groups will be to answer the steering group questions about the process of implementing PHBs producing documentation to outline:

10.1.1. Operational Delivery and Clinical Standards Workstream Lead

10.1.1.1. A design for an end to end operational process to offer a PHB, including:

10.1.1.2. A process for planning the care, support and treatment needed,

10.1.1.3. sign off of plans including reviewing for risk and appropriateness

10.1.1.4. The review process

10.1.1.5. Any benefits in terms of improvements to clinical interventions are documented and applied more widely, as appropriate

10.1.2. Finance and Information Workstream Lead

10.1.2.1. ***Evaluate suggestions for how*** indicative budget level for a PHB will be set

10.1.2.2. How commissioners will be able to understand spend against outcomes

10.1.2.3. How to align PCT and PCC financial processes to ensure payment to individuals or organisations is not a blockage to operating a PHB

10.1.2.4. How to ensure there is transparency in the level of indicative budget set and what appropriate procedures need to be in place to allow people to challenge decisions about their indicative budget

10.1.3. Governance, Risk Management and Market Development Workstream Lead

10.1.3.1. How risks will be identified throughout the developing PHB systems

10.1.3.2. What the approach to risk for individuals should be in planning and signing off a personal health budget

10.1.3.3. What safeguards should be in place to ensure delivery of support does not compromise the wellbeing or identified outcomes for individuals operating a PHB

10.1.3.4. Recommendations for a workforce development strategy for inclusion in the enhanced PID to deliver PHB more widely

10.1.3.5. How the PCT remains in a position to drive the market development for PHB

10.1.3.6. Develop the range of choices available to people for support to plan and operate their PHB

10.1.4. Culture Change and Workforce Development Workstream Lead

10.1.4.1. Recommendations for a workforce development strategy for inclusion in the enhanced PID to deliver PHB more widely

10.1.4.2. Develop a joint approach between health and social care individual budget programes which makes the most effective use of resources to develop the workforce

10.1.5. Communications and Stakeholder Management

10.1.5.1. Ensure that regional resources are focussed effectively in Portsmouth

10.1.5.2. Please see appendix B

10.2. Forward Strategy and External Roll-Out

This project aims to produce a PID to roll out the large scale implementation of Personal Health Budgets

11. Risk & Issues

See Appendix A

12. Communications Plan

See Appendix B

13. Project Plan

High Level Deliverables

Project Stage or Phase	Deliverable (description)	Completion/Delivery Date
1	A range of evidence that can demonstrate it is appropriate for the Department of Health to award of formal Personal Health Budget (PHB) pilot status to Portsmouth.	December 2010
1	Project Initiation Document to support the implementation of Personal Health Budgets across the range of areas sanctioned by DH from December 2010-07-23	December 2010
1	The learning from introducing personal health budget arrangements with between 15 and 30 people receiving healthcare and support because of their mental health need, because they have a terminal diagnosis or need continuing healthcare.	December 2010
1	An operational policy to deliver PHBs as a direct payment at the point when the DH awards formal Pilot status	December 2010

Increase as necessary

14. Funding

Estimated savings (DO NOT include inflation or general population growth assumptions) - Show as positive numbers			
Key areas of saving (e.g. area of commissioning spend where saving will be generated)	**Financial year 2010/11 £'000**	**Financial year 2011/12 £'000**	**Comments**
Provide a break down of the areas in which savings will be achieved by this project. Separate out savings by Point of Delivery etc.	None	None	Complete with input from the Finance team. Briefly explain how savings will be achieved, how they have been calculated, and how progress can be monitored (e.g. Contract amendment or type of activity to monitor that will prove savings have occurred). Give details of following financial years if known.
Total estimated savings	0	0	

Estimated costs (DO NOT include inflation or general population growth assumptions) - Show as positive numbers			
Costs of development	**Financial year 2010/11 £'000**	**Financial year 2011/12 £'000**	**Comments**
Show all costs associated with this project (including the cost of staff time spent on this project). Show each type of cost separately			Complete this section with input from the Finance team. Split between capital and non-capital expenditure, give details of any matched funding and provide a brief calculation to explain each cost.
Servicing meetings	£100		
Production of Information materials	£50		
Total estimated costs	150	0	
Net total estimated savings	**150**	**0**	

11. Activity

Generated

New Activity that will be generated as a result of project			
Name of Healthcare Provider where new activity will be generated	**Financial year 2010/11 Include UNITS**	**Financial year 2011/12 Include UNITS**	**Comments MUST include: Service** (eg HRG)**; Point of Delivery** (eg Daycase, community etc)**; Currency** (eg contacts, spells); **recurrent or non-recurrent**?
Insert name of Provider Show different Points of Delivery etc separately. **Cannot be established**			Complete with input from Information team. Include a brief explanation for why new activity will be generated, and ensure that the service, point of delivery, and currency are all specified. Give details of following financial years if known.

Deflected

Existing Activity that will be deflected as a result of project			
Name of Healthcare Provider where activity will be deflected from	**Financial year 2010/11 Include UNITS**	**Financial year 2011/12 Include UNITS**	**Comments MUST include: Service** (eg HRG)**; Point of Delivery** (eg Daycase, community etc)**; and Currency** (eg contacts, spells)
Insert name of Provider Show different Points of Delivery etc separately. **Cannot be established**			Complete with input from Information team. Briefly explain why existing activity will be deflected, where it will be deflected to, and specify the service, point of delivery, and currency. Give details of following financial years if known.

12. Escalation Procedures

12.1 Customer, Supplier & User Escalation Procedure

Any member of staff, or supplier, who becomes aware of a suspected problem, must follow the escalation procedure below in order that they can be added to the project's Risk Log, if appropriate.

This is to inform the project manager who will deal with the issue and escalate it, where necessary, to the Project Board via Highlight and/or Exception Reports if outside the agreed project tolerances.

Any formal escalation should be to the Project Manager in the first instance, copying the PMO.

	From	To
Level 1 Little or no impact	From user	Customer Contact
Level 2 Minimal Impact	Customer contact	Customer departmental manager or project stage representative
Level 3 Intermediate Impact	Customer departmental manager / stage representation	Project manager
Level 4 Significant Impact – Project Risk	Project manager	Steering Group via highlight reports and exception reports
Level 5 Extreme Impact – Project Risk	Steering Group	Corporate and Programme Management

13. Authorisation

Please indicate approval and acceptance of this PID by the Project Board to sign off.

Organisation Represented	Role	Name	Signature	Date
NHS Portsmouth	Sponsor Senior User	Innes Richens		
Portsmouth Disability Forum	Senior User	Brian Rains		
ICU	Project Management	Jackie Charlesworth		
Rowna's Hospice	Senior Supplier	Ruth White		

Organisation Represented	Role	Name	Signature	Date
Solent Healthcare AMH Solent Continuing Care Solent District Nursing PCC Direct Payments PCC Transformation NHS Portsmouth – Info Portsmouth Disability Forum		Matthew Hall Gina Cook Jackie Chalwin Carol Ablitt Ian Ross Chris Day Lynne Rigby		
PMO	Quality Assurance			

Appendix A

A. Risk Analysis

To identify, assess and control risks as part of the Risk Management Strategy.

Risk Appetite – Medium *What is the organisations attitude towards risk taking and what is the amount of risk that is considered acceptable?*

A.1. Risk Management

This section documents the known risks at this stage and these will be managed within the project risk log after project initiation.

Table to grade the RAG in the Risk Log. Probability/Impact

Risk assessment criteria:		Project Consequence Level				
		Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Project Likelihood Level	**Certain (5)**	Low (1 x 5 = 5)	Moderate (2 x 5 = 10)	High (3 x 5 = 15)	High (4 x 5 = 20)	High (5 x 5 = 25)
	Likely (4)	Low (1 x 4 = 4)	Moderate (2 x 4 = 8)	Moderate (3 x 4 = 12)	High (4 x 4 = 16)	High (5 x 4 = 20)
	Possible (3)	Very Low (1 x 3 = 3)	Low (2 x 3 = 6)	Moderate (3 x 3 = 9)	Moderate (4 x 3 = 12)	High (5 x 3 = 15)
	Unlikely (2)	Very Low (1 x 2 = 2)	Low (2 x 2 = 4)	Low (3 x 2 = 6)	Moderate (4 x 2 = 8)	Moderate (5 x 2 = 10)
	Rare(1)	Very Low (1 x 1 = 1)	Very Low (2 x 1 = 2)	Very Low (3 x 1 = 3)	Low (4 x 1 = 4)	Low (5 x 1 = 5)

Please complete the below Risks and Issues Log, following the above Key

A.2. Risk Log

Example risks include (but are not limited to): Stakeholder engagement issues, Inter-dependence with other projects, Political considerations, Lack of staff / financial resource, Quality of outcome and Clinical considerations.

Risk (not yet occurred)	Date risk identified	Likelihood (1-5)	Consequence (1-5)	Risk Rating (Total 1-25)	Proximity	Mitigating actions	Risk owner	Date risk notified or amended
Ethics approval cannot be granted in line line with project timescales	23.07.10	3	3	9	Near	Complete research proposal as priority	JH	Closed 14.10.10 not necessary
People cannot be identified in sufficient numbers to make the learning effective	23.07.10	2	4	8	Medium	Start identification of potential volunteers asap	JH	14.10.10 formal pilots working with fewer than 20
PCT systems are not sufficiently flexible to deliver any PHB options	23.07.10	1	5	5	Medium	Examine what the PCT is already doing that resembles PHB	RC	Section 75 allows PHB's as a direct payment 1.11.10
There are difficulties in setting an indicative budget level	23.07.10	3	4	12	Medium	Examine unit cost modelling with provider finance	JC	PLICS will provide MH 25.10
Buy in cannot be established from across systems workforce	23.07.10	2	4	8	Medium/Far	Develop opportunities for staff to see the benefits	JH	
Momentum cannot be established in the steering group	23.07.70	2	5	10	Near	Issue signed PID at earliest opportunity	JH	
Financial and reputational risk issues present blockages to delivery	23.07.10	4	3	12	Near	Facilitate regular risk discussion at senior level	JH	DH business plan indicates national roll out 19.10.10
Lack of clarity about what a Personal Health Budget can be used for prevents staff from opffering PHB	20.9.10	5	2	10	Medium	Collect stories about what PHB's have been used for and disseminate	JH	
Information about	20.9.10	4	2	8	Medium	Raise to CAF2 board	JH	

previous support and treatment cannot be accessed as patients come into CHC, bad planning ensues						and investigate bringing together systems		
Patients plans may not achieve outcomes intended, 'usual' service would need to be offered still	22.9.10	2	5	10	Medium	Build picture of effective reviews from existing work	JH	
Risks associated with a pilot might dissuade patients from getting involved	20.9.10	4	4	16	Medium	Work with user groups to develop independent advice and literature	JH	
Tools to support a brokerage model are not available	1.10.10	2	3	6	Near	Review what is under development	JH	
There is little evidence of good practice to help decide the brokerage model	1.10.10	3	3	9	Far	Develop commonality between health and social care personal budgets mechanisms	JH	
There is little support for an indivual who chooses to develop and/or manage their own plan	1.10.10	4	3	12	Medium	Explore what exisiting support in Social Care personal health budgets might be accessed		
GP Commissioners will not prioritise project	22.10.10	2	3	6	Far	Develop GP engage aspect of comms plan	JH	
MH pilot work cannot be established without double running costs	22.10.10	4	3	12	Near	Update commissioning plan to include request for funding to trial MH PHB	GR	
Process to establish mental capacity will be too time consuming to establish budget before needs escalate	19.10.10	3	3	9	Medium	Select people where mental capacity will not be a issue at pilot stage	Leads	
A way of establishing indicative budget levels is a shared task, operationally and financially. Completing this task cannot be	22.10.10	3	3	9	Near	Adjust finance workstream to evaluating ways of setting individual budgets	JH	

agreed								
Infrastructure costs cannot be easily dissagregated and individuals choose PHB's. Extra expense cannot be sustained	22.10.10	4	4	16	Far	Raise issue with action learning set	JH	
Difficulty in keeping steering group and associated workstreams focussed around the purpose	22.10.10	5	5	25	Medium	Develop business and other process maps to establish shared vision	JH	Draft completed 16.11.10
				0				

A.3. Issue Log

Issue	Date Issue occurred	Issue Type	Potential impact/ Status	Mitigating actions	Issue owner	Date issue addressed
Description of the issue that has occurred.		Request for Change/ Off Specification/ Problem/Concern	1 = minimal impact 5 = significant impact	Actions to be taken/being taken	Name	
Carer was unable to continue with the Board	07.07.10	Problem	3	Further carer beign recruited	JH	
New ICU lead for the project appointed	01.06.10	Concern	2	Strong project documentation being drawn up	JH	
Agreement with solent Healthcare to develop implementation does not have a no cost caveat	07.09.10	Concern	5	Disucssion of Commissioning impact as soon as possible	JH	

Appendix B

B. Communication Plan

B.1. Purpose

To ensure that effective communication about the development of Personal Health Budgets is widely disseminated within Portsmouth.

To understand and analyse stakeholder and end users views of Personal Health Budgets in Portsmouth's PHB project. This will in turn feed into an enhanced PID for the development of the Personal Health Budgets more widely in Portsmouth.

B.2. Project Description

The project aims to develop the personal health budget implementation arrangements in Portsmouth to formal pilot status. A number of working groups are being establish to understand how to implement personal health budgets, the learning from these will feed into an enhanced PID to deliver PHBs more widely. A number of volunteers will be offered the opportunity to operate a personal health budget. These will be people with mental health needs, people need continuing care or people with a terminal diagnosis on the gold standard framework.

B.3. Communication Objectives

1. Undertake a stakeholder analysis and consider the arising requirements for communications and stakeholder engagement.
2. To identify key stakeholder groups and understand the specific communication needs of each group.
3. To develop public engagement and formal consultation exercises as required.
4. To facilitate two-way flows of information which can be recorded and which demonstrate listening and exploring possibilities.
5. To provide a full report on the outcomes of the engagement activity for the use of the pilot steering group
6. Provide initial feedback to all those who contributed to the process.
7. Provide feedback after the implementation of the project to show how views were taken into account and influenced the final outcome of the project.

In undertaking the above, the project team will work to the following overarching aims:

- To develop in stakeholders and staff a sense of ownership of and support for the project.
- To provide clear and consistent messages and information.
- To raise awareness of key issues and communicate the impacts as appropriate.
- To balance negative perception and concerns.
- To ensure that the principles of patient and public engagement as described in the NHS Act 2006 section 242 (1B) are adhered to.

Key messages

Whilst the communication messages will vary according to the audience, the PCT must ensure consistency of the core messages to all stakeholders.

The key messages are:

The development of Personal Healthcare budgets will:

- improve the choice, control and independence of individuals and their family/carers when they become eligible for services within the scope of the project
- improve the delivery and access to care
- personalise care to individual need
- develop the provider market within the county to provide high quality care in an affordable framework for the population
- further build and strengthen partnership working across health and social care in the city to benefit the whole population

C – Communication Management Strategy

To be developed when PID agreed

Name of Person	Information Req	To whom	Method type	Frequency
Name of person providing information	*Data/. Information required from party*	*Who will information be provided to?*	*How will this person communicate? I.e. report/Email/Phone*	How often will this communication occur?

C.1 Contact details *Please state all points of contact as part of the communication plan.*

Name	Job Title	Organisation	Telephone No	Email
Name of contact				

Appendix C

D. Project Plan

Insert latest plan here