BIAN - Developing and Reviewing the Interagency Care Plan

When to use: An Interagency Care Plan should be developed when two or more agencies are working with a service user. This will ensure that only one overarching care plan is developed and provide more focus for the service user ensuring that goals are set progressively and care plans build upon each other while potentially conflicting goals are avoided.

1. Interagency Care Plan is developed with areas of need identified
2. Actions and interventions on care plan are agreed between service user and all service providers involved
3. Case Manager and Lead Agency identified
4. Keyworker/point of contact in each service responsible for an action is identified
5. A timeline is agreed for each action
6. A regular review date of at least every 6 months is set for the care plan
7. The Interagency Care Plan is updated reflecting the service user's current needs and detailing the supports being provided
8. Enhanced service user involvement
9. Enhanced inter-agency working

Key Steps

Outline of the Interagency Care Plan

Step 1: The care plan is a collaborative process between the service user and the services involved in their care. The agencies currently involved will be identified with the service user during the assessment process. When developing the Interagency Care Plan it is essential, at this stage, that other relevant services (required to meet agreed goals) are identified.

Step 2: The Interagency Care Plan will outline the interventions agreed, referrals required and timeframe outlined to review the intervention/issue/action identified. A care plan should be developed with realistic goals and address the physical, psychological, social and legal needs of the person. The Case Manager should provide a copy of the Interagency Care Plan to the service user and agencies involved when agreed. All actions and timescales should be clearly outlined on the plan.

Step 3: Any referral or interagency meeting at this stage should be carried out in line with the Referral Protocol or steps outlined for an Interagency Care Plan Meeting.

Determining the Lead Agency and Case Manager

Step 4: The Lead Agency will be responsible for coordinating the care of the service user. Service users are asked if they are currently attending another service as part of the assessment process.

Step 5:

Criteria for Determining Lead Agency

If the service user is attending more than one service, then the criteria for determining the most appropriate Lead Agency, should include:

- Intensity and regularity of contact/future contact with service user

- Capacity of service provider
- Service user preference

*All agreements should be noted on the care plan

Step 6: Once a service is established/agreed as the Lead Agency, then the role of Case Manager should be appointed from within the agency. The preference of the service user should be met where feasible.

The Role of the Case Manager
Case Manager Outline and Duties

1. The Case Manager is generally appointed from within the Lead Agency, but both positions may change over time, by agreement at the Interagency Care Plan Meetings.
2. The Case Manager assigned to the service user will manage and co-ordinate the implementation of an Interagency Care Plan agreed at the Interagency Care Plan Meeting and act as the contact point for other agencies and the service user.
3. The Case Manager will arrange Interagency Care Plan Meetings and invite the agencies involved. Service users and agencies can also request a meeting through the Case Manager.
4. The Case Manager should prepare the service user for the meeting and outline the purpose and aims of the meeting to all the services involved.
5. The Case Manager takes responsibility for both chairing the meeting and recording care plan actions.
6. The Case Manager should maintain a full case file for the service user containing assessment, care plan and any updates/agency reports
7. As soon as possible after a meeting, the Case Manager should enter decisions and actions on the care plan, and circulate the updated Interagency Care Plan to participants.
8. The Case Manager is responsible for monitoring and following up on referrals and general goals and responding to issues or blocks as these arise. Any identified gaps and blocks should be sent to their line manager and the Chair of BIAN via a Gaps and Blocks Form.
9. The Case Manager is responsible for ensuring the Interagency Care Plan is reviewed with the service user at agreed intervals of at least every 6 months and updated as required. All changes will be circulated to the service user and other agencies involved.

Interagency Care Plan Meeting

Step 8: An Interagency Care Plan Meeting is any meeting which takes place between two or more agencies involving the service user in relation to the development, progression or review of the Interagency Care Plan of a service user.

Step 9: The general purpose of an Interagency Care Plan Meeting is to support service user involvement, review progress and ensure clarity in relation to the Interagency Care Plan and to foster a co-ordinated approach among agencies, ensuring sufficient supports and reducing duplication. The specific purpose(s) of an Interagency Care Plan Meeting should be outlined such as:

a. Referral,
b. Change of Case Manager,

c. Care Plan Review etc.

Step 10: While not all interactions between services may require an Interagency Care Plan Meeting or the involvement of the service user, there are some circumstances in which it is essential:

a. there is a transfer of case management roles between services

b. the service user has requested it

c. a Lead Agency/Case Manager cannot be agreed*

d. there is a divergence of views on progressing the Interagency Care Plan or appropriate interventions cannot be accessed*

***It is recommended that services try and address contentious issues (such as where services have divergent views on progressing care plan or determining the Lead Agency) without involving the service user at first.

Step 11: The Case Manager should organise and chair the meeting, provide a brief overview of what has taken place to date and outline the purpose and aims of the meeting. Agencies involved should confirm their attendance and identify their agency representative prior to the meeting.

Step 12: Persistent lack of engagement by any service with the Interagency Care Plan process should be managed through the Troubleshooting for Local Issues Protocol.

Step 13: Participating agencies and their staff will comply with Data Protection legislation throughout the process. In addition, BIAN agencies should respect the BIAN Confidentiality Policy at all times to ensure that information provided has been consented by the service user.

Step 14: As soon as possible after the meeting the Case Manager should circulate the updated Interagency Care Plan.

Note: If the service user disengages, then the relevant agency should notify the other agencies involved in the care plan as soon as possible.