Cork Kerry - Interagency Care Plan Protocol

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.

Protocol Outcomes
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 3 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.

Interagency care plan meeting/Case management meeting.

- 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.
- 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.

- 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[1]
    b. the service user has requested it
    c. a Lead Agency/Case Manager cannot be agreed*

[1] This should be formally recorded in the care plan and documentation will be transferred accordingly- see C.M Transfer form pg 56.

* 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.

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