# **X:\Family & Therapies\ISCAN_Service\ISCAN Logos\ISCAN CMYK portrait.jpgISCAN Care Co-ordination Service**

## PHASE II (Care Co-Ordination) Guidance for ISCAN teams

The new care co-ordination service starts on 1st October 2018. Each ISCAN sector – North, South and West – will have a Care Co-ordinator (Band 5) and a Family Support Worker (Band 4) join the ISCAN service. These roles are a mixture of full and part time.

Family Support workers will undertake care co-ordination work as agreed by the ISCAN team at the weekly meeting.

Care co-ordinators will undertake complex care co-ordination work and facilitation of IAP work as agreed by the ISCAN Team at the weekly meeting.

Care co-ordinators will screen referrals into ISCAN before the weekly meeting to have some idea of which referrals might be eligible. This will help with discussion and decision making during the meeting.

Referrals will not be accepted into ISCAN for care co-ordination only. The decision to allocate care co-ordination and, if appropriate an IAP (Integrated Assessment and Plan) will be made by the ISCAN team and in respect of referrals received for children and young people with 2 or more developmental needs and those requesting an assessment for ASD / ADHD.

If professionals who are part of the ISCAN team have existing cases that they feel would benefit from care co-ordination they can bring that case back to Part 3 of the weekly meeting for multi-agency discussion and decision making. Some sectors may need to consider how this is done, if a part 3 of the meeting is not already established.

IAP will only be available to new children / young people referred to the service who have complex multi-agency needs.

**A waiting list will not be held for care co-ordination and IAP**. Each sector team must prioritise cases in line with the available capacity of the new Phase II staff.

Cases will only be accepted for care co-ordination once it is clear that the family is not receiving a key working or lead professional service from any other agency.

Once a case is identified as eligible for care co-ordination and, if appropriate an IAP, the Care Co-ordinator or the Family Support Worker will contact the family to see if this is a service which they would like to receive.

It is recommended that the first 5 cases be reviewed by the whole team for evaluation and learning.

# ISCAN Care Co-ordination Service – Questions & Answer Section

**Q. How will referrals be made**?

A. Referrals will not be accepted by ISCAN purely for care coordination or for an IAP. Each ISCAN team will decide whether care co-ordination and or an IAP is required in respect of individual cases referred in whereby the child has two or more developmental needs. However, professionals can refer in for a full multi-agency discussion about how to meet a child’s needs in terms of Part 3 of the ISCAN team meeting structure which has never been implemented fully.

1. **Will CWDT care co-ordinators still be able to be involved if there is an IAP in place for a child?**
2. Yes – care co-ordination will remain in place as long as the family has needs in this regard.

**Q. Should families not be given a choice about whether they want care co-ordination?**

A. It was agreed that the opt-in for families should be implemented following a recommendation from the ISCAN Team. Families will be phoned and asked if they want this service. However in the case of an IAP assessment this is not an option as families will have consented to the referral on the basis that it may result in assessment(s).

**Q. Should the new service consider a baseline of the current status to be able to review / audit as it evolves?**

A. Yes definitely – the care co-ordination service will certainly evolve and be amended if that is required.

**Q. Should the service take into account professional and parent feedback?**

A. Yes, this is a resource for the multi-agency ISCAN teams and the care co-ordination team will take ownership of collating feedback for evaluation and discussion.

**Q. If the family is offered care co-ordination and they have been accepted by several services for an assessment, will the care co-ordinator carry out an initial visit?**

A. Yes – all family information will be collated by the care co-ordinator prior to the IAP to ensure that those services are relevant for the family and they will facilitate the pulling together of the ‘team around the family’. The next step is how to pull together the IAP assessment and co-ordinate appointments from multiple waiting lists. Who is involved from each of the professions will depend upon geographic location and specialty for that specific therapy service. The care co-ordinator will pull the single plan together following the IAP assessment and multi-agency team meeting with the family which the care co-ordinator will book in and chair.

**Q. How will the IAP assessment happen?**

A. There could possibly be an ‘IAP day’ at each of the children’s centres – i.e. a designated day of each week in to which appointments will be templated. Education and social care and care co-ordinators from other services will also be able to have an input. The child will certainly have to have more than one appointment and the IAP process may take place over a period of two – three months. The point is that the assessment is co-ordinated across services and agencies.

**Q. Will the care co-ordinator just be signposting?**

A. The role of the care co-ordination team will be to guide the family and make sense of the direction they are going with their child. Signposting will be part of that but the aim is to avoid referring on to yet more services.

**Q. Will the care co-ordinators be taking a ‘Care Aims’ approach?**

A. Yes, in principle they should, however there is a cost to this and every effort will be made to secure Malcomess Training for the team.

**Q. How will cases be reviewed?**

A. There will be no review of cases. If families need further care co-ordination, the care co-ordinator or individual professionals can request for the referral to be ‘brought back’ to the ISCAN team for further discussion and consideration.

**Q. How will the CC team ensure that families do not feel abandoned once they are discharged from services?**

A. This will depend on the family but the role of the care co-ordinator / family support worker is to ensure that they are fully informed about who to contact should the need arise in the future. Any potential crisis that occurs afterwards will be addressed. The aim of the team is to build relationships with families, empower them and increase their confidence about who to contact to request help. The discharge process will be explained in full to all families and the contact page in the Family File will be highly beneficial.

**Q. How will families benefit from care co-ordination if they do not go through ISCAN?**

A. Any professional can ‘bring back’ cases to ISCAN to request a multi-agency discussion regarding the needs of the child and the family. However, it is essential that the Phase II service is fully embedded as part of the ISCAN process and does not sit as a separate service that professionals can refer to directly.

**Q. How will the Care Co-ordination team increase their understanding of services?**

A. The team are making arrangements to shadow therapists in different therapy teams to fully understand the roles and input that they have with families.

**Q. How will the CC team manage the expectations of families?**

1. It is very clear that the Care Co-ordination team will not ‘set up’ the family with inappropriate expectations and building an excellent knowledge of services available to support the family is definitely a must. It is advised that the team exercise caution in terms of exceeding their roles and creating dependency.
2. There are potentially two types of families:
* Young children with developing complex needs new to all services
* Older children who already have a plan / structure in place in school

It is essential that this information is included in the Family File especially if the child has a statutory ALN plan in place. Any new needs identified must be linked in with the correct educational professional whether this is through the school or the local authority.

**Q. How is demand into ISCAN being managed?**

A. Current demand into ISCAN is one of the biggest issues with education being one of the main referrers. Building an effective ‘gateway’ between ISCAN & Education is essential and this has yet to be implemented effectively. Discussions are underway in terms of the potential to use ALN Transformational funding to enable ALN cluster leads to attend ISCAN team meetings and provide a more effective ‘gateway’ than currently exists.

**Q. What will happen if demand for care co-ordination exceeds expectations?**

A. It is essential that there is no waiting list for care coordination and IAP. Each ISCAN sector team will need to manage their new care co-ordination resource and prioritise within the available time.

**Q. How will information be shared in regard to which families are in receipt of care coordination?**

A. Information relating to the cases being worked will be put onto CWS in terms of any reports and letters from the care coordination service. The outcome reports which are copied to GPs (as standard if they are not the referrer) will state that the family will be offered care coordination.

**Q. Which tasks will the care co-ordinator signpost and which will they undertake themselves?**

A. The aim of the service is to support families without creating dependency. It will be important to identify existing services already known to the family but also develop their resilience by working with them.

**Q. Has the care co-ordination considered technology for their service?**

A. Yes – they are tentatively looking into the use of apps for the future which all agreed would be beneficial for families and young people.

**Q. Will the care co-ordination team have mobile phones for communication with families?**

A. This is currently being considered.

**Q. How will expectations be managed in terms of families who get to hear about the service?**

A. We will need to ensure that all leaflets explain clearly how the service works. Family Liaison Officers will be important here to ensure that the first line needs of families can be met. They can also explain how the service works. If any child and family has needs that warrant care co-ordination and or IAP then they will have professionals involved who can bring that discussion to ISCAN.

**Q. How will the new team receive supervision?**

A. The team will not be working clinically and will receive supervision from within the ISCAN service. However it will be imperative that they have training in regard to case management and also child protection.

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