

CHAPTER 5 PLANNING AND DELIVERY OF CARE

This Chapter examines and discusses the process of planning and delivery of care for the individual drug user and sets out key principles and elements of effective practice. The key sources of evidence include research studies, consultation seminars and the EIU Working Group. We have also drawn on a qualitative study with service users conducted by SDF to explore their views and experiences of planning and delivery of care (Appendix 3).

This chapter sets out:

- definitions of planning and delivery, their rationale and wider context
- key issues in planning and delivering care
- key principles and elements of practice

What is planning and delivery of care?

The **planning** of care is the process of making decisions about the treatment, care and support that the individual will receive and about who will be involved in providing the appropriate services. It follows from the outcome of the assessment process discussed in Chapter 4 and should produce an integrated care plan.

The **delivery** of care is the process of co-ordinating, managing and providing the care so that the individual receives the 'right' services at the right time and in the right way to match their assessed needs and in accordance with the agreed integrated care plan. It is important to clearly identify the level of intervention required according to individual need and to identify how best to manage care effectively.

The Rationale: Why is planning and delivery of care important?

Effective planning and delivery of care is important in order to ensure that individuals receive services **in an integrated way**. This will reduce duplication and overlap, maximise the benefits of the efforts of all agencies and service providers, and minimise the number of contacts that individuals have to make with different professionals (EIU Consultation Workshops 2001, Type 5).

Twice I got a date, and twice those dates got put back. The person dealing with it was going round in circles. Took about a year to get help

SDF Focus Group Respondent 2002

As the service user focus groups have shown, fragmented or disjointed care can lead to disillusion and frustration (SDF 2002, Type 4). An integrated planning and delivery of care process should reduce the complexities for the individual, provide consistency of care and enhance the likelihood of a positive outcome. However, it is worth noting that there are **few robust evaluations** of integrated care planning and delivery.

What evidence is available suggests that the planning and delivery of care is best provided by **careful co-ordination** of the range of service providers that can address the assessed needs of the individual. It also suggests that it is useful to include family, partners, friends and drug users themselves in the planning and delivery of care. The key requirements are:

- communication between agencies and service providers and the individual
- co-operation and consistency between agencies and service providers
- co-ordination of services and interventions
- involvement of drug users and their families / partners / friends

The Wider Context

As set out in chapter 2, the Joint Future agenda will be a **key driver** for change in community care generally, which is equally applicable to the drugs field. The key principles and ways of working that are particularly relevant to the planning and delivery of care are: joint resourcing; joint management; intensive care management; and information sharing.

It is anticipated that this will result in improved co-ordination, management and delivery of services. This will have a number of **benefits** for service users, providers and carers. These should include the provision of a more consistent, comprehensive and integrated service and an improvement in treatment and care outcomes. This should also have benefits for service providers who (within an integrated care approach) should be working in a supportive, multi-disciplinary team. The survey of NHS services for opiate users in Scotland showed that respondents were positive about working in multi-disciplinary teams (Cameron 2002, Type 3, Appendix 5). The main reasons cited were mutual support and working with enthusiastic, trustworthy and like-minded colleagues.

It is important to recognise that the idea of integrated care is not new. It is **how** integrated care planning and integrated care delivery are defined and described that can vary. Despite these variations, however, there are principles of good practice that cut across a number of fields in health and social care. These are presented throughout this Chapter.

One example that has relevance for drug users is the **Care Programme Approach** in the field of mental health. It promotes a level of integrated practice because it is a '**whole system approach**'. It takes a holistic approach to treatment, care and support. A key element of this 'whole system' approach is effective care co-ordination for individuals with **complex needs**. As with drug users, links need to be made across social work or care services, health, education and employment, housing, criminal justice and voluntary agencies to facilitate access for individuals to the range of services required to meet their needs.

The **Care Programme Approach** aims to ensure effective collaboration between agencies so that the individual client receives a fully co-ordinated range of services. It entitles clients to:

- A systematic assessment of health and social care needs
- An agreed care plan
- Allocation of a care worker
- Regular review of progress

(SWSI 1999)

A recent and relevant research review – 'A Review of Care Management in Scotland' - was commissioned by the Scottish Executive in 2001 (CRU 2002, Type 3). The overall aim of the review was to identify how local authorities are using care management to maintain people at home. Although this review did not focus on drug users, some of the conclusions are relevant to effective care planning for this group. The research identified gaps in funding systems, in training, and in the reviewing of cases for service users. The report also highlighted a need for **clearer differentiation between complex and more straightforward cases** in care co-ordination and subsequent levels of intervention.

There are a number of different definitions of care and case management in the health and social care sectors. Overall, a useful distinction can be made between **care management and care co-ordination**. Care management is often described as an intensive approach for individuals with complex, frequent or rapidly changing needs usually requiring complex packages of active, ongoing support. Care co-ordination is described as relating more to individuals with straightforward needs and may revolve around "simple" or single services.

When care management was introduced in 1991, it was intended to be an intensive approach for individuals with complex needs and, therefore, to be carried out by professionally qualified staff. Care co-ordination, on the other hand, was considered to require that staff are suitably trained and supported in their tasks. The **key point is that it is important to match the level of management and intervention with the level of need**. This ensures best use of existing resources.

Key issues in planning and delivering care

When considering how to develop effective planning and delivery of care within an integrated approach, there are a number of key issues to address.

In this section we cover **seven key themes**:

1. Working with the individual
2. The link between assessment and care planning
3. The care planning process
4. Integrated care pathways
5. Advocacy
6. Goal setting
7. Delivery and management of care

1. Working with the individual

The focus groups with service users (SDF 2002, Type 4) suggested that planning their care was largely a negative experience for the individual. Service users **did not feel involved** in the planning of their care nor did they know what a care plan was. Most of the participants were confused about what constituted planning in relation to their treatment care and support, and did not feel that meetings with GPs or other professionals were about planning or changing treatment. Further there was a view that **treatment changes were episodic and reactive**, not planned. No participants had heard of shared care.

In addition to lack of participation, there appeared to be a **lack of trust** between clients and workers made worse by arbitrary decisions e.g. to reduce prescriptions without the client's consent or by the sense of the "luck" involved in getting a 'good' key worker. Service users themselves believe that if they could be involved more in discussions to plan their care it would improve relations with the staff in agencies and lead to better access to services.

It's only really when something happens that's quite drastic – say like if you get lifted or you really fall on your ass – its only then that you can really talk about getting changes in treatment

SDF Focus Group Respondent 2002

The planning of care for the individual in an integrated way will depend on **good communication and liaison** between agencies and service providers. This should help to ensure sharing of information and a smooth transition between services. The service users' focus groups (SDF 2002, Type 4) stated that most participants were in favour of having one person responsible for contacting other people to provide the services required: a lead person. They thought that it would save time, stop confusion and facilitate better relationships and clearer communication between agencies and service providers. However, while the majority was in favour of a single contact, some also felt that it would depend on the person and the kind of relationship that they could build up with them.

Further, many of the service users felt that they had to be at a very serious or crisis stage of drug misuse i.e. injecting, before they could get access to services or a **review of their current care plan**. One of the ways in which service users felt that they could have more of a say in the process was through the help of another person (usually a family member or friend) who could speak on their behalf. The role of an advocate is discussed later in this Chapter.

2. The link between Assessment and Planning

The information generated by the assessment process described in Chapter 4 should form the **foundation** for decisions about treatment, care and support. To be effective, the planning of care should flow from the outcome of the assessment process, including the Action Plan (if one has been produced), that sets out the individual's needs and aspirations, goals and treatment, care and support choices.

The EIU consultation workshops (EIU 2001, Type 5) highlighted that an **integrated care plan** should aim to meet the assessed needs of the individual. However, there may be constraints on the ability of agencies and service providers to match the type and level of services proposed (in the Action Plan). This may arise from the availability of certain services in the local area or problems with access e.g. distance, waiting times (see Chapters 3 and 4).

As noted in Chapter 4, this is a difficult issue to resolve for the agencies responsible for the pattern and provision of services in the DAT area, for service providers and for service users. The service users' focus groups (SDF 2002, Type 4) highlight the risk that, if the range of services identified through the assessment process cannot be delivered in the proposed way, the individual will feel disillusioned. However, the agencies who have responsibility for planning services in an area will require the information from that assessment process (and resulting Action Plan) to identify mismatch of provision or lack of availability in order to inform future planning. This should be part of ongoing monitoring to identify gaps in services (see Annex 3B and Chapter 7).

While the focus groups did highlight the frustration arising from unrealistic expectations (as a result of the assessment), it also indicated that there was an understanding among service users of the likely realities and a wish to be told about them. For the service users, the important factors seem to be:

- receiving **good information** about what local services can offer most suitable to meet their assessed needs and what is available to them at the time
- **clear and open communication** with the client and between service providers to choose the most appropriate type and level of services within existing opportunities and constraints
- **full participation** in deciding on the components of the care plan and how it will be delivered.

3. The Care Planning process

There is a growing body of evidence which highlights the importance of **clearly developed treatment and care plans** (BPADIWG 2000, Type 2). While the additions literature on care planning is not extensive, there is much that can be learned from other fields. The fields of education (and in particular) working with children with special needs have highlighted the importance of individual programme planning (a type of treatment plan) (BPADIWG 2000, Type 2).

To ensure that the **integrated care plan** addresses the different type and level of needs of the individual over time, it should be discussed and agreed with all the agencies identified as service providers and the client (EIU consultation workshops 2001, Type 5). As noted above, an important part of the integrated care planning process will be **open dialogue** between the individual, the main contact person (who has taken forward the action from the assessment) and the service providers. The objective is to agree the best possible approach within any existing constraints or opportunities.

The key to establishing better communication between service providers is honesty and openness (EIU consultation workshops 2001, Type 5). They should be honest about the limitations of their own service and open about examining what others may have to offer to complement it. There may be concerns about potentially conflicting priorities. Ongoing communication between service providers is necessary to promote and support the development of a more integrated approach for the benefit of the individual.

For the individual, it is important that they are encouraged to take some responsibility – at a pace that is comfortable – for their part in the treatment, care and support programme and the achievement of the goals (see the section on goal setting later in this Chapter).

Annex 5A sets out ‘Harry’s Integrated Care Plan’ as an example.

4. Integrated Care Pathways

There is an interest in developing the concept of integrated care pathways (ICPs) for drug users among those consulted by EIU. We have presented outline ICPs in Chapters 3, 4 and 5 as a starting point for their potential development in accessibility, assessment and planning and delivery of care.

ICPs use the current best evidence gained from systematic reviews, as well as input from multidisciplinary teams, to outline the optimal course of care for all clients who have a specific condition or who are undergoing a specific procedure. Other common names for these tools include clinical pathways, clinical care pathways, and Care Maps.

ICPs plot out for a particular diagnosis or procedure the optimal sequence and timing of interventions by physicians, nurses, and other professionals. Because pathways prescribe treatment across different care settings and even between different districts, they help ensure that a **consistent, co-ordinated, quality service** is provided over the full continuum of care. Care pathways are designed to minimise delays, make best use of resources, and maximise quality of care.

ICPs that are inter-sectoral, multidisciplinary, and portable between regions or districts have the potential to improve discharge planning and co-ordination, and information flow between professionals, care settings, and districts (Health Services Utilisation Research Commission, 2001). HSURC is online at www.hsurg.sk.ca.

Middleton & Roberts (2001) identify 6 stages to the development of ICPs:

1. Define the **desired outcome** of the activity under investigation
2. Define and **set the start point** of the activity
3. **Agree the boundaries** and identify related issues and departments (agencies)
4. Identify and map the **high level process elements** that you use now to deliver the service objective
5. Identify **failure points** and responsibilities
6. Use the above to **define the project**, data requirements and likely benchmarking partners

EIU will produce a more detailed guide to the development of integrated care pathways for use in the treatment, care and support of people with drug misuse problems later in 2002.

5. Advocacy

Independent advocacy is recognised as an important way of enabling people to make informed choices about, and remain in control of, their own health care. Advocacy helps people have access to information they need to understand the options open to them, and to make their wishes known. There is currently a renewed interest in advocacy as a way of promoting and supporting people to achieve the best outcomes from treatment and care across a number of sectors, including the drugs field.

Advocacy: A guide to good practice (Scottish Health Advisory Service, Scottish Office 1997) suggests that advocacy is normally considered to have two main aims:

- **protecting** people who are vulnerable or discriminated against or difficult to provide services to
- **empowering** people who need a stronger voice by enabling them to express their own needs and make their own decisions

Advocacy is based on a number of **beliefs and values**:

- the development of a partnership between providers and users of services
- the right of service users to be heard
- empowerment of the individual in issues concerning their care
- ensuring individuals are not excluded from any aspect of the provision of care

The purpose of **Advocacy is not**:

- to create a substitute for making services more accessible or to bypass user involvement in the planning and delivery of services
- to avoid the need to provide person-centred services
- about making complaints, although advocacy may involve supporting people who want to make a complaint and helping them to do so effectively

This good practice guidance has been complemented by the publication of 'Independent Advocacy: A Guide to Commissioners' (Scottish Executive, 2001) which supports the health service and their planning partners in establishing and developing independent and integrated advocacy services in their area.

The Health Plan 'Our National Health: A plan for action, a plan for change' (Scottish Executive, 2000) required all NHS Boards to work with their local authority partners to ensure that independent advocacy is available to all those that require it. Implementation plans have been submitted to the Health Department by all NHS Boards and are currently being turned into practice with the support of the Advocacy Safeguards Agency.

The EIU Working Group (Type 5) highlighted a number of areas of importance when developing advocacy in the drugs field within local areas:

- advocacy in the substance misuse field has not always been the best it can be. For example, anecdotal evidence suggests that GPs often feel pressurised by someone else's presence during consultation

- there can be conflict between the professional and the advocate: for example, between a G.P. providing a prescription and an advocate supporting a change in prescription on behalf of a service user
- advocacy is often used when people are unhappy with services, although it should really be used to put across people's views who cannot or do not do it themselves
- advocacy is about promoting someone's rights, in an assertive, non-aggressive manner

In the service users' focus groups, several users commented on the better outcomes achieved from their perspective when someone else explained their problems and views on treatment options. The value of incorporating information and views from family or friends, is highlighted in Chapter 4 on Assessment. A number of service users felt that they were too 'chaotic' to respond in a coherent way during an assessment process (SDF 2002, Type 4). The study on assessment tools also highlighted the potential value of collateral information (see Chapter 4).

In the light of these findings and in the context of the development of advocacy in their sectors, DATs and partner agencies may wish to consider incorporating advocacy within an integrated care approach.

6. Goal setting

The setting of goals in discussion and agreement with the individual and the agencies identified as service providers is an important part of the care planning process. The goals need to reflect the outcome of the assessment and the individual's current state and motivation. They should include the defined goals of treatment: for example, reductions in drug use or stabilisation, reductions in offending, improvements in physical health. These are often quantifiable and are sometimes known as 'hard' outcomes. It is also important to include 'softer' outcomes such as increased self confidence, motivation and improved relationships with family and friends (EIU Consultation Workshops 2001, Type 5). EIU Evaluation Guide 7 explains the concept of 'hard' and 'soft' outcomes in more detail. It can be downloaded at: www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg7b.pdf.

Goals should be negotiated and should be:

- SMART – specific, measurable, achievable, realistic and timebound
- Service-user directed
- Respectful of service-user's stage of change
- Overall treatment goals to be broken down into their smallest components

Goals should reflect the philosophy of care:

- To reduce the harm associated with the individual's drug use
- To provide alternatives to drug use which are appropriate to the individual's interests and attributes
- To empower the individual to maintain positive changes that are made

The integrated care plan should set out clearly the stages of progress which the individual wants to achieve. Most importantly, **goal setting is a developmental process**. The goals should change as the individual's circumstances change and he/she progresses. (EIU consultation workshops 2001, Type 5; EIU Evaluation Guide 7, 2002).

7. Delivery and management of care

The **delivery of an integrated service** involving a number of service providers with varying levels of input can be complex. As the diversity of services increases the delivery of care will require the establishment or improvement of multidisciplinary teamwork, as well as care management systems. This will require agreement at strategic level by DATs and partner agencies and at operational level supported by locally agreed policies and procedures.

It will be important to have a **clear system** of planning and delivering of care for individuals who need more than one service throughout the course of their treatment, care and support. The main functions of co-ordination would be:

- to bring individuals together with the service providers that best suit their needs
- to identify a point of contact for both the individuals and the service providers
- to promote and support closer working practices e.g. communication and information sharing to enable joint decision making

There are many different ways in which care delivery can be organised. Currently there is limited evidence on how best this can be achieved within an integrated care approach. What is clear is that it is important to match the level of support with the complexity or severity of individual need. Earlier in this chapter we discussed the relatively simplistic differentiation between a care management approach (for more complex and rapidly changing cases) and a care co-ordination approach for a more straightforward cases.

The EIU consultation workshops offered support for the role of a key worker or **care co-ordinator** to plan and deliver care for an individual. This is probably most appropriate when the needs of the individual are relatively straightforward. There are, however, concerns about the potential for large caseloads and the creation of an extra layer of bureaucracy. An alternative approach would be to establish a **multi-agency team** drawn from the main agencies involved in the care of the individual. This will be essential for individuals with complex needs. A lead co-ordinator would probably still be required, but would work closely with a co-ordinating team that can promote a consistent approach to the client and offer a holistic view of the individual's needs.

One process often used to promote co-ordination is to hold regular **case conferences**. Case conferences are forums of discussion that commonly involve all the parties with a role and interest in the individual's care and progress. As well as service providers, this may include the individual, friends, relatives or an advocate. A chairperson will facilitate discussion. However, the service users' focus groups (SDF 2002, Type 4) highlighted difficulties in this area for service users.

The term 'case conference' had to be explained and outlined carefully to the focus group participants, indicating a lack of understanding about the process. Unanimously, those (and there were several) who had experience of a case conference had found it to be a negative experience (SDF 2002, Type 4, Appendix 3). The service users invariably viewed the case conference as a highly charged affair, with participants feeling intimidated and largely passive. The other participants at the conference were seen almost as adversaries apart from key workers (and not always these). The service users felt that they had no say, control or apparent influence over the course of events, nor who should be in attendance. (SDF 2002, Type 4).

Overall, the delivery of care in an integrated care approach **is a developing area**. The **Models of Care** approach to services for drug users being developed in England is promoting a care management system with the aim of providing **person-centred care** (Models of Care 2001). The overarching aim of care co-ordination is that those who enter into treatment services receive the appropriate level of response by the appropriate service provider.

The **aims** are to:

- Provide a network of care and ensure that drug users have access to a comprehensive range of services
- Ensure the co-ordination of care across all agencies involved with the service user
- Develop, manage and review documented care plans
- Ensure continuity of care and follow the individual throughout his or her contact with the treatment system
- Maximise the retention of service-users within the treatment system and minimise the risk of losing contact with the treatment and care services
- Re-engage individuals who have dropped out of the treatment system
- Avoid duplication of interventions
- Prevent individuals 'falling between services'

In response, eight **Enhanced Treatment Outcomes (ETO) pilots** have been established to explore co-ordination of care. There will be lessons from these pilots in due course. There may also be scope for pilots in Scotland to test out how co-ordination might work in areas with different characteristics e.g. geography and patterns of drug use. The ETO pilots are:

- Screening, referral and enhanced key working in a rural area (Fenlands, Cambridge)
- Treatment system involving multiple agencies in a suburban area (Hertford)
- Co-ordinating service systems across a large geographic area (Kent and Medway)
- Inner city issues and IT links between agencies (Leeds)
- Multiple need clients (Liverpool)
- Screening and triage systems across a large geographic area (West Sussex)
- Black and minority ethnic communities (Bristol)
- Co-ordinating care in inner London (Greenwich)

The screening, referral and triage tools used in these pilots are available from the National Treatment Agency (NTA) on request. Please contact the EIU (EIU@scotland.gsi.gov.uk) if you would like us to access these for you.

Remember Harry?

Harry attended a specialist drugs service and participated in a comprehensive assessment. He was able to talk about various difficulties in his life and his partner had a chance to discuss her concerns about the children. The result was a profile of his needs, family situation, attributes (the things he has going for him) and an Action Plan identifying goals and proposed services. He is now going to talk about **putting together an integrated care plan**

Planning & Delivery Pathway

Harry's Action Plan sets out his assessed needs, proposed services and an agreed set of goals.

Processes

Dialogue between Harry, his care co-ordinator, service providers, taking account of opportunities and constraints e.g. distance, waiting times, availability.

This outline Integrated Care Pathway is designed to assist all agencies in developing a local multi-agency system for the planning and delivery of care for clients accessing services in their area.

Outcomes

Which services best fit my needs?

Decisions are made about treatment, care and support services with Harry as a full participant.

Care planning ensures that the most appropriate services are utilised and arrangements are made for the co-ordination of Harry's care.

Harry has an integrated care plan including a prescription, motivational support, housing advice and access to a New Futures project. Health visitor involved.

Service providers work together to ensure that there is a clear information exchange regarding the processes and outcomes of Harry's care.

Harry and his family receive the treatment, care and support that they need.

What happens next?

How do we know if it is working?

Arrangements are put in place to monitor Harry's care, ensuring that it is effective and that it remains appropriate as his needs change.

Harry takes part in reviewing his integrated care plan at regular pre-arranged intervals. His partner comes too.



KEY PRINCIPLES AND ELEMENTS: PLANNING AND DELIVERY OF CARE

From our review of the research literature, the evidence that we have gathered through consultation, focus groups and the EIU working Groups and the developments within Joint Future, we have identified the following key principles and elements of effective practice:

1. **Use the outcome of the assessment process as the foundation for decisions on treatment, care and support.**

This requires an effective assessment process with agreed mechanisms for sharing information between service providers (see Chapters 4 and 6). The production of an Action Plan (from the assessment) should be agreed with the individual. This would set out their needs, attributes and aspirations and would support and enable service providers to design and deliver treatment, care and support in a consistent and integrated way. The data collected in the Action Plan will also – and importantly - aid the needs assessment and 'gap' analysis exercises set out in Annex 3B.

2. **Involve all relevant agencies, service providers and the service user to formulate an Integrated Care Plan.**

It is important to agree **how, when and by who** services will be delivered. An integrated care plan will set out how the agreed goals are to be achieved and how treatment, care and support are to be delivered. To create an integrated care plan, detailed individual service plans should be brought together through case discussions between staff in the various service providers. With the agreement of the service user, copies should be given to all relevant staff. An integrated care plan should cover:

- an individual's needs as identified from assessment

- the goals of treatment and milestones to be achieved

- the interventions and services planned to achieve the goal and the support required

- which service provider and/or professional is responsible for carrying out the interventions

- timing – when, how often, frequency of attendance and expected length of duration

- explicit reference to risk management, risk management plans and contingency plans

- arrangements for information sharing between service providers

- arrangements for monitoring and review with dates

3. **Include the service user in planning their care, including goal setting.**

This requires regular, clear and open communication. There should be openness about constraints to delivering aspects of the services as proposed in the Action Plan and good information about the services available and best suited to meet their needs as part of an integrated care plan. The individual should have the opportunity to participate fully in making decisions about the most appropriate services for them.

4. **Ensure that all involved understand the role of the advocate** (if there is one).

Advocacy should help to ensure that individuals and their families have access to information, understand the options open to them, and to make their wishes known. Advocacy should enable the individual's opinions and concerns to be articulated through:

informed consent: individuals should be advised of treatment and service protocols, particularly in the sharing of information. An advocacy service could promote individual's awareness of service procedures and information sharing.

informed choice: clients should have an awareness and an understanding of the range of services available to them, and the relative merits of each with regard to the achievement of their individual goals.

informed decision making: advocacy can enable clients to have an active influence in the decision making process regarding the planning and evaluation of care.

5. **Introduce a clear system of co-ordination for delivery of care.**

This involves being clear about who is doing what, when and how. It is also important to decide whether there should be a **lead care manager (or co-ordinator) or a multi-agency team**. To be effective, co-ordination requires a person and/or persons who are knowledgeable about services and have good links to the range of services required. Effective co-ordination of care delivery requires that:

the individual knows who they are working with and why

staff are aware of the parties involved, their role and responsibilities

communication is open and information shared (with individual's consent)

service providers offer a consistent approach

regular formal reviews take place to monitor and evaluate joint progress

a co-ordinator is identified if required

a co-ordinating team is identified if required

contact in emergency situations is clear and agreed by parties

NAME: Harry Smith

M/F: Male

D.O.B: 03.12.68

Ethnic Origin: White UK

ADDRESS: Flat G, 38 Roxburgh Drive, Edinburgh, EH2 3IU

Referrer/Location/No. Dr Bryce, Health Centre, 0131 123 4567

Reason for Referral: Mr Smith requested help for his heroin problem, appeared to have complex level of needs requiring assessment.

Family Group

Name	Relationship	D.O.B.	Address
Clare Jones	Partner	14.02.71	As Above
John Smith	Son	23.04.97	As Above
Jackie Smith	Daughter	05.11.99	As Above
Ronnie Smith	Father	12.03.50	Not given

Professionals involved

Name	Position	Date involved	Address/Tel/Email
Dr Bryce	G.P.	20.06.94	City East Health Centre
Joyce Well	Drugs Worker	(referral-12.07.02)	EAS Drug Project
Brian Kerr	Social Worker (childcare)	At case discussion 24.07.02	SWD, Edinburgh
Bill McPhee	Social Inclusion	24.07.02	SIP, Edinburgh
Rose White	Housing	24.07.02	Housing Department

Substance Misuse Profile

Primary Substance	Secondary Substance	Other substance use	Length of Use
Heroin for two years, injecting, daily, had no health checks	Cannabis, been smoking for fifteen years	Valium and alcohol on sporadic basis	Poly-use for eighteen months

Integrated Care Plan

Assessed Need	Action/ Service Required	Contact Person	Evaluation/ Review date
Drug Use	1. Methadone maintenance 2. Specialist intervention	1. Dr Bryce 2. Joyce Well	At next case discussion 24.11.02
Living Arrangements	1. Partner doesn't use drugs, request support with childcare	1. Brian Kerr	As above
Physical Health	1. Full medical required	1. Dr Bryce	As above
Disease Prevention	1. One to One discussion pending medical results	1. Dr Bryce 2. Joyce Well	As above
Mental Health	No concerns reported at this time		
Social Functioning	Supportive family, support requested to remain in employment	Bill McPhee	Individual contact to be arranged.
Legal Situation	Support in maintaining home	1. Rose White	Meeting with Housing next week
Service-users perspective	High motivation to reduce drug use/ stabilise home		
Collateral Information	Partner concerned for children's welfare, planning to leave if not change	1. Brian Kerr	1. Ongoing, visit two weekly
Biological Measure	To be established	1. Dr Bryce	Appointment for next week
Readiness to Change	High Motivation		
Risk and Safety	1. Welfare of children monitored and parenting skills supported. 2. Individual does not appear aware of injecting risks/ information required	1. Brian Kerr 2. Joyce Well	1. Ongoing, visit two weekly to c/d 2. Weekly appointments for first month, initial review thereafter

Co-ordinate by _____

Confidentiality agreement (see attached)

Notes on use of Integrated Care Plan

Information is collated from data from single shared assessment. The assessment of need is based on the subsections within each category of the core data sets i.e. living arrangements looks at household composition including children, status of residency, accommodation type, carer issues, other drug users, housing support needs, benefits, heating.

The Integrated Care Plan is designed to highlight specific needs to be addressed. The next column establishes how this is going to be done; by what action or service. We suggest that this form be completed following a full, comprehensive assessment and discussion with all relevant parties, when roles and responsibilities are clarified.

At the end of this table is the option for identifying a co-ordinator or co-ordination system, if there is a particular person to link people together or a specific team that is dealing with majority of service provision.

Consent to share information may be on a separate pro-forma where the individual has provided informed consent for information to be shared across agencies (details of this process in Information Sharing, Chapter 6)