They will carry out an initial assessment that includes checking bloods, pulse, blood pressure, temperature and urine, as well as other investigations such as ECG or make arrangements for X-rays. The outcome of this is then discussed with medical staff and a plan implemented. The team co-ordinate your care plan and will also assess any nursing or social needs you may have. This may include attending a medical outpatient clinic or day hospital, if this is considered to be a necessary part of your treatment and will make referrals to other services as required.

The specialist team meets daily to discuss treatment and ensure they are doing everything they can to help you stay healthy at home.

This service helps you to stay at home but this may not be possible for everyone. If our specialist team do not think you are well enough to receive care at home, you will be admitted to hospital.

Contact Details

Telephone number for all referrals across Fife is:
01592 729555

e-mail address for electronic referrals is:

Fife.icassreferralsfife@nhs.scot

Alternative Formats

The information included in this publication can be made available in large print Braille, audio CD/tape and British Sign Language interpretation on request.

Integrated Community Assessment and Support Service
(ICASS)

www.nhsfife.org/reshapingcare

What is ICASS?

ICASS is a team of Healthcare Professionals and Support Workers who provide a range of integrated services in your own home, care homes or community settings and is made up of two main parts that work very closely together.

- Intermediate Care
- Hospital at Home

ICASS aims to improve the health and wellbeing of people in Fife by enabling people to stay independent in their own home or in their community wherever this is possible.

Fife Health & Social Care Partnership

Supporting the people of Fife together

Intermediate Care

Intermediate care will provide support and assistance that will enable you to regain independence wherever possible or seek the extra support you may need to stay in your own home.

This is a multi disciplinary team of nurses, occupational therapists, physiotherapists, support workers, home care managers, social workers and other community services who can provide a period of rehabilitation to help you recover. This can be for a few days or a number of weeks depending on your needs.

How does it work?

You will be referred to intermediate care by a GP, hospital or other health and social care staff.

The team will work with you, your family and carers and agree outcomes to achieve an appropriate level of independence in every day tasks and help you to manage your health issues by promoting general health and wellbeing.

The duration of the service will vary according to your individual need, but may range from days to weeks. Visits will be reviewed and adjusted as required. The team will work closely with other agencies including social work and voluntary organisations to ensure your care needs and personal outcomes are achieved.

Hospital at Home

The role of the Hospital at Home team is to treat patients at home or care home by providing the same level of medical care that would be expected should you be admitted to hospital. This team is led by a medical consultant.

How does it work?

Patients are referred to the Hospital at Home team by their GP or hospital medical staff to allow them to continue their treatment in the comfort of their home.

Following referral you are assessed at home by a nurse practitioner to identify your medical needs.