ICS Assessment Services

Rapid Hospital Discharge Services

In response to the huge demand for safe and effective discharge from acute settings, ensuring the ongoing care for patients maintains and prevents further acute intervention, our Rapid Hospital Discharge Services works in partnership with local NHS Trusts, the CCG and Local Authority to deliver expert trusted assessments and discharge from an acute hospital setting back into the community.

We utilise our project teams' comprising expert social work, nursing and occupational therapy assessors to support patients at the point of being medically fit for discharge, to their onward care destination.

Our service includes:

- **Social work and AHP (occupational therapist/physiotherapist) capacity to support hospital discharge;** assessing patients to ensure we move them in a safe and timely manner to their assessed destination:
  - back home without support,
  - back home reinstating their original care package,
  - back home with a reablement package.
- Hospital discharge provided **7 days/week on 9-5 or 8-8 model.**
- **Undertake all 7-day; 14-day and 21-day follow-up reviews** in order to ensure safe and sustainable discharge, ensuring that additional capacity is created and that services are targeted to those that need them most.
- Providing essential link with your residential, nursing and intermediate care units or holding beds to ensure that patients are discharged to the appropriate environment. Building relationships that will instil confidence and enable safe and timely discharges.
- **Occupational therapy and nurse assessor support** provided where identified as part of the team or on an ad hoc (per review) basis.

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How our discharge model works

We integrate with all local guidelines and processes whilst following qualified professional judgments; best practice and government guidance to ensure safe and effective discharge.

Acute Stay

- ICS Discharge Team allocated patient cohort, remote working established.
- Rapid Discharge Assessment carried out, processes agreed following government D2A guidelines and local policies.
- Care homes and community care settings identified.

Discharge

- Patient medically fit for discharge assessment.
- On-going care identified; patient history reviewed and liaison with care provider, family and friends to agree timely discharge.
- Remote telephone and/or F2F (video) assessment conducted as required.

Review

- 7-day, 14-day and 21-day care review conducted to ensure client safety and sustainability of package.
- Onward referrals to OT/Physio or reablement packages in place are followed up.
- Alternative arrangements identified where required.

Case Closure

- Client referred for full Care Act Assessment or conducted by ICS Discharge Team as required.
- Local Authority financial assessment as required.
- Case closed to LA.
- Ongoing case audit and Quality Assurance.

Benefits

- Rapid implementation (2-3 weeks).
- Integration with local GP networks, HomeFirst, Discharge2Assess and Primary Care Networks (PCNs) or other on local discharge and ongoing care processes.
- All patient assessments and transfers managed via remote teams.
- Quality Assurance on all discharges.
- Weekly follow-up reviews conducted.
- Fixed fee per discharge or on a block-capacity model.
- Remote assessments conducted where possible.
- Project teams with access to Local Authority CMS to ensure all patient history is reviewed against existing social care needs assessments.
- Reduction in LoS / DTOC and increased acute bed capacity outcomes.

Call **0161 238 7485,**
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