# Change 3: Care transfer hubs and multi-disciplinary working to co-ordinate discharge

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| Stage | Not yet established | Plans in place | Established | Mature | Exemplary |
| **Care transfer hubs – organisational set up** | Siloed working between acute, adult social care, community healthcare. No shared vision, clear Senior Responsible Owner (SRO) or routes of escalation. | Some multi-disciplinary practices in place with plans to develop a core multi-disciplinary team.  Plans to establish a SRO or SRO in place but not yet operating effectively. | Core multi-disciplinary team spanning health and the local authority, with strong links to care providers, community, and voluntary sector. SRO is established with clear, formal escalation where required. | ‘One team’ jointly owned by health and the local authority, with strong links to care providers, community, and voluntary sector. SRO feels join responsibility and swift and effective escalation of issues. | Co-located core hub with strong links into wider services, out of area partners and community services for urgent response and admissions avoidance. Data regularly consider by health and local authority leadership teams jointly. |
| **Care transfer hubs –  operations** | All patients are flagged to the hub after they are medically optimised. No processes to track patients. Hub does not operate seven days. Limited data sharing. | Hub teams usually involved before patients are medically optimised.  Pathway and case management in place. A clear roadmap is in place to achieve seven day working. Work underway to improve and formalise data sharing. | Hub teams routinely involved before patients are medically optimised and take a lead role in prescribing care packages. Pathway and case management in place with daily system tracking calls. Hub operates seven day services. Effective data sharing in place. | Hub team routinely involved in planning from admission.  Pathway and case management in place with daily system tracking calls with all partners. Hub operates seven day services with some of the broader operating context able to support discharges over seven days. All relevant partners have access to relevant data systems. | Hub is involved in planning from admission, considering ongoing care from a reliable expected date of discharge. Discharge planning tracked through daily system calls involving all partners including key out of area contacts, based on a live data system available to all. Hub operations and the broader operating context supports discharges over seven days. |
| **General principles of multi-disciplinary team (MDT) working** | Health and adult social care work in silos. Risk averse culture. No shared ways of working established. | Emerging MDT working, involving acute, adult social care, community health and voluntary, community and social enterprises (VCSE). Plans in place to develop shared ways of working and objectives. | Work underway to foster collaborative working. Commitment to attend regular MDT discussions from acute, adult social care, community health and VCSE. Some emerging shared objectives and ways of working. | MDT members work together well, leading to more effective discharge and better outcomes for people. | Team working with an agreed, shared vision, shared patient-centred objectives and formally agreed ways of working. |