**Pathway 3**

* Pathway 3 is a discharge to a care home for patients who are likely to require long-term bed-based care.
* Patients who have had a life changing event or have been through other pathways multiple times.

**Process**

* Once the pathway has been identified by the MDT, a member of the hospital integrated discharge team will lead on the completion of the referral utilising the Greater Manchester Supported discharge form.
* Input may be required from extended members of the MDT to support the assessment and/or Mental capacity if required.
* Once complete the referral is sent to the relevant local authority who will lead on the sourcing of a pathway 3 placement.,
* Referrals should be sent to the relevant hospitals' single point of access email address.

North Manchester General Hospital - [noticetoassess@manchester.gov.uk](mailto:noticetoassess@manchester.gov.uk)

Manchester Royal Infirmary- [LL.discharge2assessMRI@mft.nhs.uk](mailto:LL.discharge2assessMRI@mft.nhs.uk)

WTWA - [wythenshawecontactofficer@mft.nhs.uk](mailto:wythenshawecontactofficer@mft.nhs.uk)

**Key communication points to consider prior to completion of a pathway 3 referral.**

The basic for good practise is to involve patients and their representatives in discharge planning from the earliest opportunity. By keeping them informed throughout the discharge journey and confidently explaining the discharge to assess process further choice issues can be avoided.

* All relevant discharge information leaflets should be provided to patients and their representatives at the earliest opportunity, leaflets form a part of the communication but do not replace regular effective, transparent engage with patients from all members of the MDT.
* A pathway 3 bed is for patients who are likely to r**equire long-term bed-based care** who have had a life changing event od have been through other pathways multiple times. It is a temporary move to a discharge to assess bed, based in a care home for a period of up to 28 days, this will likely be one of our contracted D2A beds.
* The choice that patients have is to opt out of D2A, if they opt in then this means they agree that the first appropriate placement found will be accepted.
* During this time, they will be visited by health and social care workers who will assess them to decide what care they need long-term you will be allocated a social worker within 48 hours of discharge to progress from the temporary plan to a long-term plan.
* The temporary bed will be at the first home that has availability and is able to manage the assessed needs, this may be out of the local areas if there are limited bed who can me specific needs.
* Staying in hospital to find a home of choice is not an option because beds in the acute hospital are needed for people who are acutely unwell and the longer you stay in hospital the greater the risk of hospital acquired infections and general deconditioning.
* Once they are in a D2A bed the team will work with the patient and family to find a long-term care home which they will be able to choose that suits all the needs.
* The d2a bed will be paid for by the local authority until all the long-term assessments are completed (usually less than 28 days)
* Local authorities will try and place in home CQC rated as “good” however there are occasions where a “required improvement” home may be considered if the local authority is assured through due diligence wok has been undertaken to ascertain a position appropriate to discharge patients to.