MPATH SERVICE
The primary and secondary care interface

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URBAN VILLAGE MEDICAL PRACTICE

Homelessness, social exclusion and health inequalities symposium
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WHO WE ARE/WHAT WE DO

* Multi agency team – GPs/nurse/Specialist Case Managers/Housing Worker
* Community based – with in reach service into Manchester Royal Infirmary
* Part of larger health service for homeless people
* Daily routine – symphony search for for a &e attendances/admissions last 24 hrs
* Original CCG funded pilot – currently 12 months 'Better Care' funding

DAILY ROUTINE

* All inpatients regularly assessed/reviewed/care planning and discharge facilitation and follow up in community
* Community presence- assertive outreach/engagement with primary care for frequent ED attenders

PRINCIPAL AIMS/VALUES

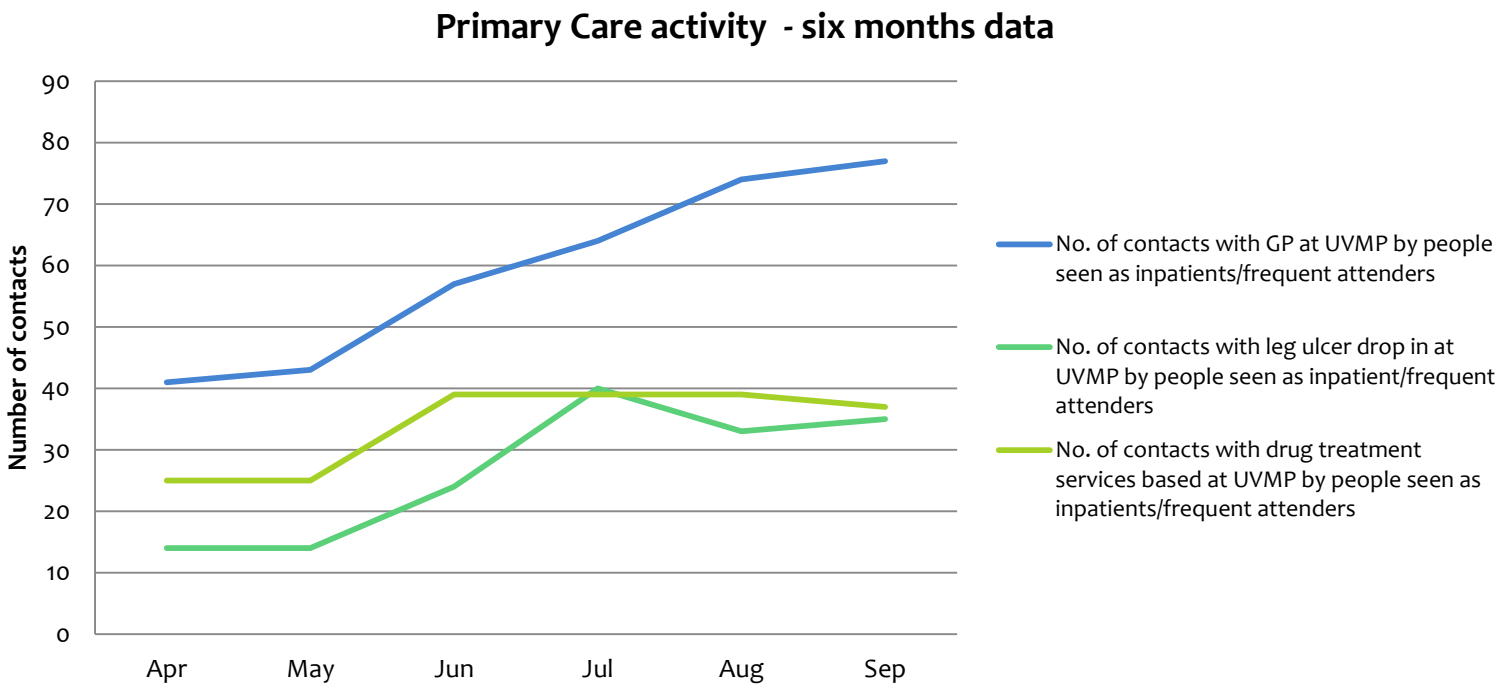
* Entitlement to healthcare
* Engagement and inclusion in appropriate and continuous health care – usually primary/community care
* Improved social outcomes – housing/benefits etc – bringing about an reduction in instability and chaos

OUTCOMES

The mpath service worked with 216 of the 272 (79%) people admitted to Manchester Royal Infirmary during April to October 2014, undertaking 296 assessments.

	Oct 13 – Mar 14	Apr 14 – Oct 14	Outcome	6 month cost saving
No. of A&E attendances overall Based on no. of patients = 216	1089	618	43% reduction	£47,100 Based on £100 per A&E attendance
No. of non-elective admissions overall Based on no. of patients = 216	409	249	39% reduction	£320,000 Based on £2k per non elective admission
No. of Bed days Based on no. of patients = 216	3647	1211	66% reduction	
No. of Repeat admissions within 28 days Based on no. of patients = 216	409	248	39% reduction	

OUTCOMES


Primary Care activity - six months data
Number of contacts
90
80
70
60
50
40
30
20
10
0
Apr
May
Jun
Jul
Aug
Sep
No. of contacts with GP at UVMP by people seen as inpatients/frequent attenders
No. of contacts with leg ulcer drop in at UVMP by people seen as inpatient/frequent attenders
No. of contacts with drug treatment services based at UVMP by people seen as inpatients/frequent attenders

WHAT SEEMS TO WORK

* Continuity of care and consistency – in hospital and community
* Working in collaboration with both hospital and community teams
* Discharge with a social/medical plan
* Engagement in community setting and longer term plans for medical/social care
* Engagement in primary and community healthcare
* Assertive substance misuse approach
* Accommodation plans/aspiring for better

OUR STRENGTHS

* Unique opportunity for collaborative working
* Pragmatic patient care
* Efficient hospital stay
* Effective discharge
* Improved health outcomes for patients
* Improved patient experience

* Majority are registered with UVMP and can be seen within 7 days of discharge or flexibly as required.

WHAT WE HAVE STRUGGLED WITH

* Small proportion of patients who continue to impact on services despite interventions
* People with 'no recourse to public funds'
* Alcohol dependency
* Organic brain damage/capacity issues
* Information sharing – developing cross department plans for frequent ED attenders in MRI

Thank you for listening

ANY QUESTIONS?