Avoiding Unplanned Admissions (Enhanced Service) - This incorporates Risk Profiling
Establish the case managaement register (monthly), completed by risk profiling tool which will identify 2%
Inform patients that they are on the register and of their named accountable GP and care co-ordinator
Put care plans in place for patients on the register
Offer a bypass number for care providers to discuss patients requiring a potential hospital admission
Offer same day telephone access to patients on the case register with an urgent medical problem
Make contact with patient on the case management register following discharge from hospital, to ensure co-ordination and delivery of care

Named GP: Over 75s (Contractural)
Patients to be notified of their accountable GP by 30/06/14. Newly registered, turning age of 75 must be notified with 21 days of either registration or DOB. It is acceptable to notify patients in consultation. Pts can request a preferred GP
Accountable GP to work with associated health & social care professional to deliver a multi-discilinary care package that meets the needs of the patient
Ensure the patient aged 75 years and over has access to a health check as set out in section 7.9 of the GMS contract regulations

Regularly review emergency admissions and A&E attendances of their patients from care and nursing homes
Undertake monthly reviews of all unplanned admissions and readmissions and A&Eattendances of patients on the case management register
Complete a quarterly reporting template for the Area Team

Action plan: Named GP for over 75s & Avoiding Unplanned Admissions DES

	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Over 75s	Pts Notified by 30/6/14	2 weeks searches of newly registered pts and pts turning of age of 75, must be notified within 21 days / access to health check as set out in section 7.9 of GMS contract regulation (member of the admin team to take on responsibility of letters: KB to discuss with Sandra) / amend AUA care plan template to suit over 75s - get uploaded to EMIS web - correct coding for EMIS								

AUA: Risk Access 2%	Identify case management register, 2% / inform patients they are on the register and inform them of their named GP & care coordinator	Put care plans in place for patients on the register (1st 2% identified)	Review of 2% on case managements register each month, for new patients identified, they need to be informed of their named GP & care coordinator (within 21 days) / a care plan put in place
		Undertake monthly reviews of all unplanned admissions and readmissions and A&Eattendances of patients on the case management register	

Di, care coordinator to work with Lydia and named GPs
Care plan - final draft to be agreed and uploaded to EMIS web, so it will merge with patient record data when created
Quarterly reporting to be completed and submitted to CSU
Offer a bypass number for care providers to discuss patients requiring a potential hospital admission