NHS
Eastern Cheshire
Clinical Commissioning Group

Caring Together Contract for General Practice in Eastern Cheshire

Summary of Requirements Specification for £2m investment in General Practice

Phase 1 from 1st January 2016 Chapter 1-Access to General Practice	Chapter 2a-Health promotion and disease prevention	Chapter 2b-Long term condition management	Chapter 2c-Community based procedures	Chapter 2d-Community based investigations	Chapter 3a-Complex care coordination
Patients can send an electronic message to reception.	Practices will use every opportunity to proactively identify patients with a BMI greater than 30 and signpost them to advice and support.	Practices will provide an enhanced level of support for patients with long term conditions, e.g. diabetes, asthma, chronic obstructive pulmonary disease and cardiac conditions through the introduction of long term condition	Practices will deliver an enhanced /maintained level of procedures to avoid the need for onward referral. These include; ring pessary fitting/change;zoladex /prostap injections; routine dressings; uncomplicated post op dressings/stitch or clip removal. Hormone injections.	Practices will provide ambulatory blood pressure monitoring; ECG reading and interpretation.	Practices will provide an enhanced level of support for patients with complex health problems.

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		clinics.			
Patients can book an appointment between 2 to 6 weeks in advance following a clinical consultation.	Practices will develop a pre diabetes service to identify, counsel, support and manage through lifestyle advice.	Other conditions such as problems with the bladder, gynaecology, skin conditions and bowel disease will be better managed and investigated before referral on to hospital.			Practices will take a more proactive approach to management by using proactive care administrators and linking into the wider multi-disciplinary team.
Patients can have an enhanced level of online information in relation to their care if registered at the practice for online access.		Practices will provide a service for drugs known as DMARDS. These drugs will be initiated and maintained			

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		following hospital assessment.			
The out of hours service can book ring fenced appointments with a patient's own practice following a clinical assessment.		Practices will provide a bridging service for patients with mental health problems.			
Practices will keep their websites up to date and sign post patients to self-help options.		Practices will manage patients in practice when a referral to a consultant may not be necessary following agreed protocols. GPs will communicate			

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		with consultants for advice and support.			
Following triage, the practice will ensure that a patient is called back by a clinician within 2 hours if urgent.		Practices will provide an enhanced level of support for patient s at the end of life including identifying the preferred place of care in their care plan.			
If assessed to be non-urgent, an appointment will be available within 3 weeks after initial contact.					
Clinicians will reduce the number of unnecessary referral steps and					

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inappropriate hospital referrals					

Phase 2 from 1st April 2016 (unless an early adopter) Chapter 2a – Health promotion and disease prevention	Chapter 2b – Long-term condition management	Chapter 2c – Community-based procedures	Chapter 2d – Community-based investigations	Chapter 3a – Complex care coordination	Chapter 3b – Community coordination
Practices will provide a more comprehensive service for patients who are obese and/or diabetic, including working with the integrated community teams.	For stable patients with a severe enduring mental health illness, in liaison with the mental health team, practices will administer injectables and provide physical healthcare.	Practices will work with the district nurses to develop leg ulcer clinics.	Practices will able to administer D-dimer near-patient testing as part of a deep vein thrombosis pathway.	Proactive care/visits will be undertaken to support the top 5% at-risk patients. Proactive care planning and work with the integrated community team will support the development of individualised care plans.	GPs will actively support patients post discharge, and work with integrated community teams to prevent admission.
To provide a more comprehensive sexual	Practices will identify the top 5% at-risk		Practices will offer a vascular Doppler		Practices will undertake pre-op investigation

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health service, and work with team chlamydia	patients using the risk stratification tool and follow up after hospital admission. Practices will work as part of an integrated community team to support these vulnerable and frail patients.		service.		and management where appropriate. Practices will also provide ongoing post-op management.
					Clinician-to-clinician communication will be improved to prevent patients being referred back to the GP for another referral to be generated to a different consultant.

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