VISION AND STRATEGY - CMC

Practice Strategy (2026–2028)

1. Deliver Safe, High-Quality Clinical Care

We aim to:

- Maintain robust systems for safeguarding, medicines management, significant event review and clinical governance
- Use regular audits and quality improvement activity to improve patient outcomes
- Ensure patients receive care from the most appropriate clinician within the multidisciplinary team
- Maintain high standards of chronic disease management and preventative care

Evidence for CQC

- Clinical audits
- SEA logs
- Prescribing reviews
- Safeguarding training compliance
- QOF performance
- Learning from complaints

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2. Improve Access While Preserving Continuity

We recognise increasing demand on general practice and aim to balance timely access with continuity of care.

We will:

- Use triage and multidisciplinary working appropriately
- Ensure urgent presentations are prioritised safely
- Promote continuity for complex, elderly and vulnerable patients
- Monitor appointment demand and patient feedback regularly
- Use digital access appropriately without disadvantaging vulnerable groups

Evidence

- Appointment data

- GP continuity systems
- Patient survey results
- Access improvement plans
- Friends & Family feedback

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3. Develop and Support Our Workforce

We believe staff wellbeing and retention are essential for sustainable patient care.

We will:

- Foster a supportive and respectful team culture
- Provide ongoing professional development opportunities
- Use skill mix effectively across GPs, ANP, pharmacists, nursing and ARRS staff
- Encourage open communication and shared learning
- Monitor workload pressures and wellbeing

Evidence

- Staff appraisals
- Team meetings
- Training logs
- Staff survey feedback
- Induction processes

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4. Strengthen Multidisciplinary Team Working

We aim to make best use of the wider primary care team to improve patient outcomes.

This includes:

- Clinical pharmacists supporting medicines optimisation and structured medication reviews
- MSK and mental health practitioners improving direct patient access
- Nursing team leadership in prevention and long-term condition care
- Collaborative working across the PCN and community services

Evidence

- MDT meetings
- Referral pathways
- ARRS role utilisation
- Examples of integrated care

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5. Focus on Prevention and Population Health

We aim to proactively identify and support patients at risk of poor outcomes.

We will:

- Improve uptake of screening and immunisations
- Identify frailty and high-risk patients early
- Support patients with long-term conditions through proactive reviews
- Address local health inequalities where possible

Evidence

- Vaccination uptake
- Screening data
- Frailty registers
- Care plans
- Local population health initiatives

Governance and Leadership

The partners maintain overall responsibility for clinical leadership, governance and strategic direction.

We support:

- Clear lines of accountability
- Regular clinical and operational meetings
- Shared learning from incidents and complaints
- A culture of openness and continuous improvement