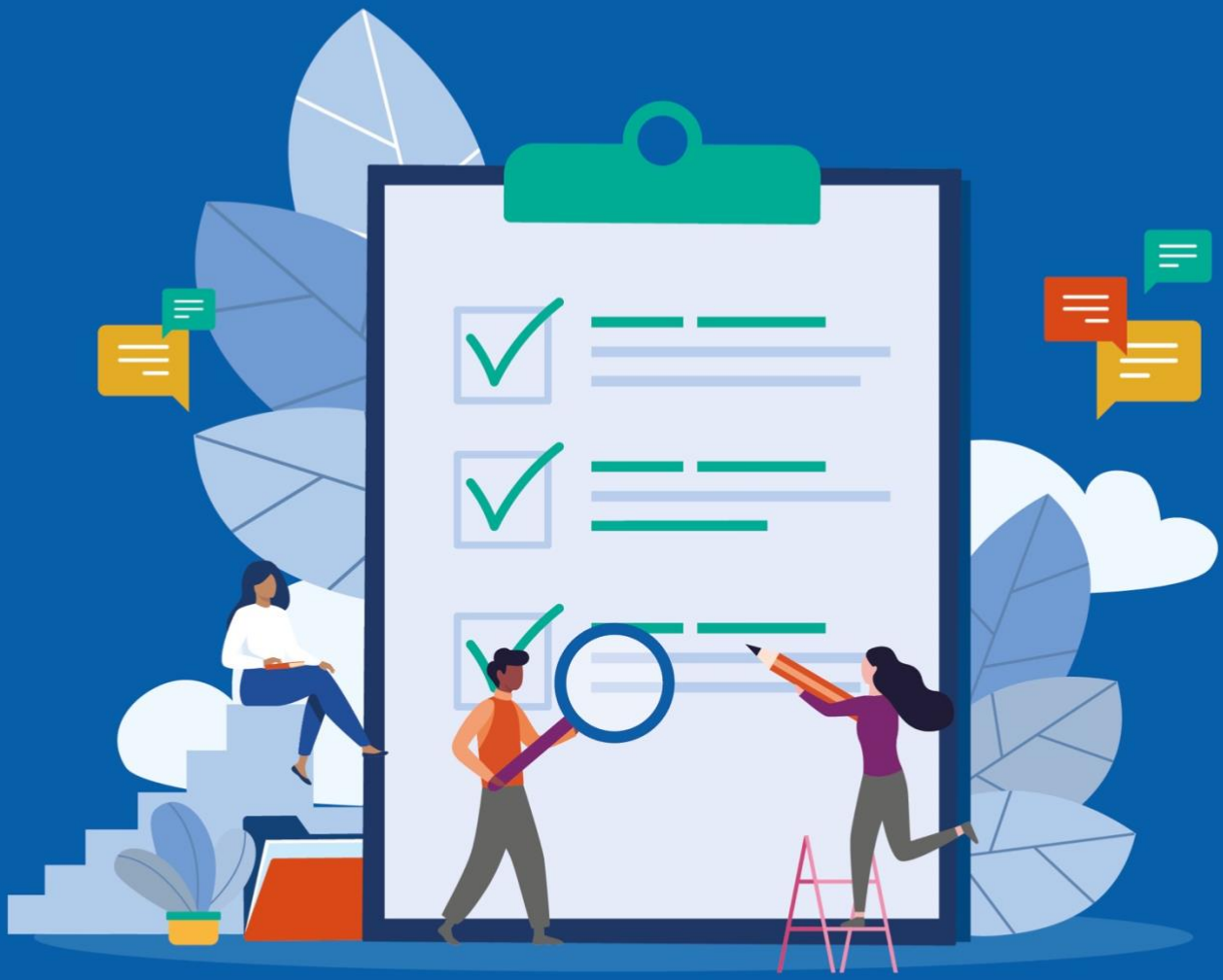
The CQC Handbook



The essential guide to the Care Quality Commission

102 pages covering all you need to know about the CQC

PRACTICE INDEX PLUS

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The CQC Handbook

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1 Introduction

1.1 Aims

The aim of this handbook is to provide anyone involved in managing a practice or primary care organisation (new or existing) with a guidance document that explains in detail the Care Quality Commission (CQC herein) and what organisations are required to do to demonstrate compliance with CQC regulations.

Every primary care practice or organisation is different, and each will operate differently. The vision, values and ethos of individual organisations will be different, yet all will strive to deliver a safe, effective, responsive, caring, well-led service to the patient population.

The CQC Handbook is comprised of five key sections, as outlined below.

1. **Overview of the CQC** – explaining the role of the CQC, associated regulations, fundamental standards of care, regulated activities, service providers, ratings, statutory notifications and warning notices.

2. **Registering with the CQC** – detailed information covering the registration process, including the provider portal, applications, DBS checks, statement of purpose, supporting documentation and pre-registration advice.

3. **How the CQC monitors service providers** – an overview of the CQC's monitoring approach, including collecting information, summary records and the pre-assessment provider information request.

4. **How the CQC assesses service providers** – this section covers the Quality Statements, assessment frequency and how the CQC assesses service providers.

5. **Preparing for an assessment** – a comprehensive guide to preparing the team for an assessment and presenting the organisation at assessment.

The CQC Handbook concludes with a frequently asked questions section, aimed at providing practical guidance to further help an organisation effectively prepare for a CQC assessment.

Throughout the document, there are links to CQC GP mythbusters, relevant policies provided by PI PLUS and links to pertinent eLearning courses available in the HUB through Practice Index Learning.

Organisations such as the CQC, NHS and primary care practices are in a state of constant change and, as such, this document should be classed as a live document and external resources monitored for changes to ensure the correct guidance is being adhered to.

1.2 Status

The organisation will aim to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the Equality Act 2010. Consideration has been given to the impact this policy might have in regard to the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment. Furthermore, this document applies to all employees of the organisation and other individuals performing functions in relation to the practice such as agency workers, locums and contractors.

The CQC Handbook is designed to support individuals in understanding and conforming to the CQC's requirements and regulations. It remains the responsibility of the practice management team to ensure that all staff have undertaken the necessary training to be able to comply with the aforementioned requirements and regulations.

2 Overview of the CQC

2.1 Background

The CQC was established in April 2009, replacing the three former regulatory bodies:

- The Healthcare Commission
- The Commission for Social Care Inspection
- The Mental Health Act Commission

Since its inception in 2009, the CQC has made considerable changes to its monitoring and regulatory approach. This sees the CQC review the information they have on all service providers on a monthly basis (remotely) and helps them target assessment activity where they have concerns. You can read further information about this approach here.

As part of the ongoing development of their approach to regulation, the CQC is in the process of implementing a single assessment framework which will be applicable to all service providers. This single assessment framework is being rolled out regionally, commencing in the South of England in November, with full coverage of England expected by March 2024. Further information regarding the single assessment framework can be accessed here.

2.2 Provider relationships with the CQC

The following are the roles that you will most likely encounter when engaging with the CQC:

Regulatory coordinator: The regulatory coordinator works across various sectors, and they are the main point of contact for any enquires you may have. In addition, they are responsible for:

- Engaging with local groups such as Healthwatch, patient advocacy and participation groups or voluntary and community organisations
- Supporting the assessor and inspector in triaging, assessment planning and evidence gathering
- Making sure our records reflect an up-to-date position on risk and activities for your service

Assessor: The assessor will be a specialist in your sector and is responsible for:

- Reviewing data about your service
- Reviewing information and notifications we have received related to your service
- Deciding when to assess your service, what we will look at and who will take part
- Carrying out off-site assessment activities
- Agreeing scores with the inspector and writing parts of the report
- Handling factual accuracy checks for your report with the inspector
- Publishing your scores and report

Inspector: The inspector is also a specialist in your sector and is responsible for:

- Working with the assessor to monitor the risks for your service
- Planning and carrying out the on-site activities of your assessment
- Agreeing scores with the assessor and writing parts of the report
- Handling factual accuracy checks for your report with the assessor
- Taking enforcement action

Operations manager: The operations manager works across multiple sectors and is responsible for:

- Managing the assessment team responsible for assessing your service
- Having oversight of risk and systems issues in the local area
- Taking some decisions about enforcement action

Contact details for the CQC can be found here.

2.3 Role of the CQC

The CQC is the independent regulator of health and adult social care in England. The CQC ensures that health and social care services provide people with safe, effective, compassionate, high-quality care, and they encourage care services to improve.

The CQC has four key roles:

- To register care providers
- To monitor, inspect and rate services

- To take action to protect people who use services
- To speak with an independent voice, publishing its views on major quality issues in health and social care

It is through its work that the CQC can:

- Protect the rights of vulnerable people
- Listen and act on the experiences of service users
- Involve the public and people who receive care
- Work with other organisations and public groups

The CQC ensures that service providers meet the fundamental standards of quality and safety, as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2.4 Fundamental standards of care

The fundamental standards of care were introduced on 1 April 2015 and are defined as the standards below which care must not fall. The CQC explains that these are the standards that all service users have a right to expect when they receive care. They are:

- Care and treatment must be appropriate and meet people's needs and preferences (Regulation 9)
- People must be treated with dignity and respect (Regulation 10)
- Care and treatment must only be provided with consent (Regulation 11)
- Care and treatment must be provided in a safe way (Regulation 12)
- People must be protected from abuse and improper treatment (Regulation 13)
- People's nutritional and hydration needs must be met (Regulation 14)
- All premises and equipment must be clean, secure, suitable and properly used, maintained and located (Regulation 15)
- Complaints must be appropriately investigated and appropriate action taken in response (Regulation 16)
- Systems and processes must be established and used to ensure compliance with regulatory requirements (Regulation 17)
- Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed (Regulation 18)
- Staff must be of good character, qualified and able to do their job (Regulation 19)

The introduction of the fundamental standards was part of a large-scale change to the CQC's regulatory approach which was prompted by a number of high-profile failures in care, specifically at the Mid Staffordshire NHS Foundation Trust, and an enquiry chaired by Robert Francis QC, often referred to as the Francis Report, which resulted in recommendations for changes to the law.

2.5 Guidance in meeting the fundamental standards of care

To help organisations meet the fundamental standards of care, the CQC has published detailed guidance for providers on meeting the regulatory requirements.

2.6 Acts and regulations

This section contains links to the core acts and regulations that are associated with the CQC:

- Health and Social Care Act 2008
- Care Quality Commission (Registration) Regulations 2009
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Mental Health Act 1983

Any legislation that is linked to the CQC should only be used as guidance and not as legal advice. You can read the terms and conditions for using legislation which are available on the CQC website.

Please note, throughout this document there will be references to other acts, regulations and guidance documents, which will be hyperlinked or inserted as footnotes.

2.7 Regulated activities

It is a requirement by law that a service provider must register for each of the regulated activities that they carry out. The list of regulated activities is listed in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In total, there are 14 regulated activities:

1. Personal care
2. Accommodation for persons who require nursing or personal care
3. Accommodation for persons who require treatment for substance misuse
4. Treatment of disease, disorder, or injury
5. Assessment or medical treatment for persons detained under the Mental Health Act 1983
6. Surgical procedures
7. Diagnostic and screening procedures
8. Management of supply of blood and blood-derived products
9. Transport services, triage and medical advice provided remotely
10. Maternity and midwifery services
11. Termination of pregnancies
12. Services in slimming clinics
13. Nursing care
14. Family planning services

Note: Not all of the above regulated activities will apply to primary care organisations. For detailed guidance on regulated activities, the CQC has produced the Quick reference guide to regulated activities by service type.

2.8 Service types

There are a number of service types, each having its own code. A GP practice may be classified as follows:

Service type: Doctors consultation service (DCS)
Service code: DCS

or

Service type: Doctors treatment service (DTS)
Service code: DTS

It is worth noting that some service providers' activities may cover more than one service type. The full list of service types and codes can be accessed here.

2.9 Service providers

A service provider is the legal entity responsible for the services that they provide, and for upholding quality and safety. A service provider can be:

- An individual
- A partnership or organisation (examples of organisations include companies, charities, NHS trusts and local authorities)

The table below lists the types of service provider and gives examples.

Service provider	Example
Individuals	Where an individual is carrying on the regulated activity by themselves (sometimes referred to as a sole trader), they need to register as an individual. Individuals register in their own name as a legal entity and are directly responsible for carrying on the regulated activity or activities.
Organisations	Organisations that intend to carry on regulated activities must register; this includes the following: local authority, NHS trust, registered company or charity, limited liability partnership (LLP), other corporate body.
Partnerships	Where an activity is provided by a partnership, the partnership needs to be registered as the service provider. The CQC do not register each partner individually, but they place a condition on the partnership registration that details the names of each

	partner. If there are any changes to the membership of the registered partnership, the provider needs to apply to vary that condition. Providers that registered as a partnership before 4 February 2013 did not have this condition, but the CQC will add the condition to their registration if they apply to add or remove a partner or make another change to their registration details.
Corporate groups	Where a health or care provider is a subsidiary of a bigger parent company and is the legal entity responsible for the service, it will need to register in its own right, rather than the parent company. For example, if several provider companies all trade under the same brand, each company that carries on regulated activities must register individually. The CQC will manage the relationship across the parent corporate brand and the published assessments will distinguish clearly between the registered provider and the brand.
Franchises	Franchise holders are usually separate legal entities to the parent company and, as such, must register in their own right.
Joint ventures	Where an activity is provided as a joint venture between two providers, the venture will often be a corporate entity in its own right and therefore must register. Where the joint nature of the venture is reflected in contracts or agreements, rather than in organisational form, each party, depending on the individual case, may need to register.
Primary care at scale	A growing number of primary care services are now working more collaboratively. GP practices are working more 'at scale' as part of a federation or a larger primary care network with community health and other primary care teams and services. Collaborative working arrangements also include single provider 'super practices' covering multiple sites. Regardless of whether arrangements are formal or informal, it is important for providers to clearly identify the legal entity responsible for carrying on the regulated activities.
Section 75 agreements	Section 75 agreements enable NHS bodies and local authorities to establish joint funding, delegate functions, and integrate resources and management structures, such as

	integrated community mental healthcare. These do not usually constitute a new, separate legal partnership and each body that provides a regulated activity must be registered for it separately. In general, the body that has the original statutory obligation or power to provide the service is the one that should register for it, as it is the one that retains accountability for it.
Services registered with Ofsted	Regulated activities cannot be dual registered with both the CQC and Ofsted. Where a provider must register with Ofsted, the parts of their service that Ofsted regulates will be exempt from registration with the CQC. This does not mean that a provider cannot be registered with both regulators; it means that there cannot be double accountability for the same activity.
Hosting arrangements	Where an activity is carried on by Provider A but is hosted by Provider B, then Provider A will need to register, regardless of its host. For example, independent providers of healthcare or personal care in prisons must register, not the host prison.
Renting arrangements	Where Provider A rents out its facilities to Provider B, Provider B will need to register in its own right if it provides a regulated activity.
Practising privileges	Practising privileges are a well-established system of checks and agreements to enable doctors to practise in hospitals without being directly employed by them. Doctors sometimes rent consulting rooms to conduct private outpatient appointments in independent hospitals and in private facilities within an NHS hospital. Where these doctors provide a consultation in a service that is managed by the hospital, and the doctors have agreed practising privileges, the consultation may be covered by the hospital's registration.
Subcontracted services	Subcontractors that provide treatment or care services that include the provision of a regulated activity will usually need to register in their own right, although this will always depend on the nature of the subcontracting arrangement. Subcontractors for services other than the direct provision of treatment or care,

	such as providing equipment or support services that do not include provision of a regulated activity (for example, catering or cleaning) will not need to register.
Secondments and service-level agreements	In some cases, a service provider makes use of staff from another organisation who are 'loaned' to it through a secondment or similar agreement for a certain proportion of their time. For example, Provider A carries out surgical procedures and treats disease, disorder or injury. Provider A employs two specialist nursing staff to administer chemotherapy and provide support to patients. When one or both specialist nurses are on leave, Provider A borrows specialist chemotherapy nursing staff from Provider B. An agreement is in place to enable this to happen. The staff continue to be paid by Provider B, but Provider A is the provider who is carrying on the service. This arrangement does not make the delivery of the regulated activity a joint service (which might require both Providers A and B to register for it). Instead, the staff member's original employer is acting as a staffing agency. For the time that the member of staff has been seconded to work for Service A and is managed by Service A, they are part of Service A. In that situation, Service B would not need to register for the service provided by Service A. This is often the case with arrangements for community mental health services.

2.10 Rating a service provider

The CQC rates service providers for the quality of care overall and for the five key questions: Is the service safe, effective, caring, responsive and well-led? Ratings are awarded on a four-point scale, as illustrated below.

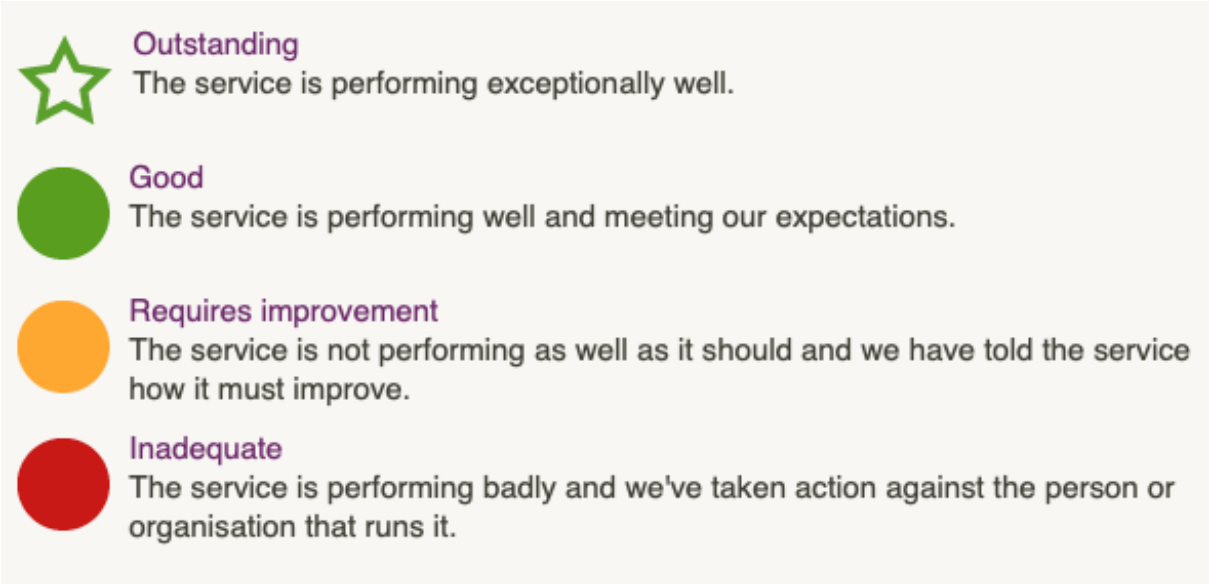

Image source: cqc.org.uk

2.11 Assessing and scoring evidence

When the CQC assesses evidence, it assigns scores to the key evidence categories for each quality statement; this is calculated using the evidence scoring framework. All evidence categories and quality statements are weighted equally and relate to the quality of care in a service:

4 = evidence shows an exceptional standard
3 = evidence shows a good standard
2 = evidence shows some shortfalls
1 = evidence shows significant shortfalls

Each quality statement can have multiple evidence categories; therefore, the scores from each evidence category are combined to gain an overall score.

The example below shows how combining evidence category scores can give a quality statement score. This example uses the infection prevention and control quality statement. This quality statement has four evidence categories:

1. People's experiences
2. Feedback from staff and leaders
3. Observation
4. Processes

Evidence category	Score	Existing or updated score
People's experiences	3	Updated
Feedback from staff and leaders	2	Updated
Observation	3	Updated
Processes	3	Existing
Total score for the combined evidence categories	**11**	

The score is calculated as a percentage as follows:

- Divide the total score by the maximum possible score. (The maximum score is the number of required evidence categories multiplied by the highest score for each category, which is 4.)
- In this example, there are four evidence categories; therefore, the maximum score possible is 16.
- Total score divided by the maximum score, multiplied by 100
- 11 / 16 x 100 = 68.75%

The CQC then converts this percentage back to a score, using the following thresholds:

- 25 – 38% = 1
- 39 – 62% = 2
- 63 – 87% = 3
- Over 87% = 4

In this example, the score of 68.75% equates to a score of 3. This score is then used to determine the score for a key question. The example below refers to the Safe key question:

Quality statement	Score	Existing or updated score
Learning culture	2	Existing
Safe systems, pathways and transitions	3	Existing
Safeguarding	3	Existing
Involving people to manage risks	2	Existing
Safe environments	3	Existing
Infection prevention and control	3	Updated
Safe and effective staffing	2	Existing

Medicines optimisation	3	Existing
Total score for the Safe key question	**21**	

This total score is also calculated as a percentage as follows:

- Divide the total score by the maximum possible score. For this example, this is the total number of quality statements multiplied by the highest score for each statement (which is 4).
- In this example, there are 8 quality statements under the Safe key question.
- 21 / 32 x 100 = 65.6%

At key question level, the percentage is translated into a rating using the following thresholds:

- 25 – 38% = inadequate
- 39 – 62% = requires improvement
- 63 – 87% = good
- Over 87% = outstanding

In this example, the rating for the Safe key question is good.

To calculate the overall rating, the CQC aggregates the scores for each key question to achieve a total percentage which is then translated into an overall rating:

Key question	Score
Safe	21/32
Effective	18/24
Caring	10/20
Responsive	21/28
Well-led	24/32
Total	**94/136**

This score is converted into a percentage, 94/136 x 100 = 69.18%, which gives an overall rating of good.

In addition, the CQC uses the following rules to ensure that areas of poor quality are not overlooked:

- If the key question score is within the good range, but there is a score of 1 for one or more quality statement scores, then the rating for that key question score is limited to requires improvement
- If the key question score is within the outstanding range, but there is a score of 1 or 2 for one or more quality statement scores, then the rating for that key question score is limited to good

2.12 Display of ratings

Once the CQC has rated a service provider, this information must be displayed by law, in accordance with Regulation 20A: Requirement as to display of performance assessments.

This organisation will display their CQC rating on:

- Posters in the practice and at branch sites
- Websites of the practice

Following a rating, the organisation will ensure that the CQC rating is displayed on posters in the practice and on the practice website no later than 21 calendar days after the rating is published on the CQC website.

Downloadable resources such as posters and widgets are available here.

2.13 Statutory notifications

The organisation is required to notify the CQC about various incidents, events and changes that occur; failure to do so is an offence. In accordance with the Care Quality Commission (Registration) Regulations 2009, the 'registered person' must submit notifications. The registered manager usually submits notifications on behalf of the organisation, although this task can be delegated.

Notifications are to be submitted via the CQC Provider Portal.

2.14 Types of notification

The organisation must notify the CQC if any of the following occur:

- Death of a patient
  - Whilst the patient was in consultation with a healthcare professional
  - While at the organisation
  - During a home visit
- Serious injury to a service user
- Abuse or allegations of abuse
- Incidents that are reported to or investigated by the police
- Any event that stops or may stop the registered person from running the service safely and properly

Examples of when and when not to notify the CQC can be found in GP mythbuster 21: Statutory notifications to CQC.

2.15 Warning notices

The CQC can issue a warning notice should the quality of care fall below what is legally required. Legal requirements include:

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Other legislation that registered persons are legally obliged to comply with while delivering the service (see section 3.5)

There are many reasons why the CQC issues a warning notice. The CQC will issue a warning notice when there is a breach of the following:

- Regulations
- HSCA 2008
- An Act with requirements that relate to the fundamental standards
- A condition placed on a registration

Warning notices are issued in writing and sent to the registered person. Detailed guidance relating to the content of warning notices and response times can be read here.

3 Registering with the CQC

3.1 Overview

The registration process is multifaceted and time-consuming; it is therefore essential that sufficient time is allocated to prepare for and complete the registration process. The CQC assesses applications against the assessment framework.

The purpose of the framework is twofold: firstly, it ensures that service providers are aware of the expectations the CQC wants service providers to meet at registration. Secondly, the framework replicates the questions the CQC asks when inspecting a service, thereby helping service providers to prepare for an assessment.

The CQC advises that if an application does not meet the standards detailed in the five key questions, the application will be refused.

3.2 Applying to register

When applying to register with the CQC, there are a number of ways in which this can be done:

- Apply to register as a new provider
- Apply to be a registered manager
- Apply to register as a new provider with a new registered manager

- Apply to register as a new provider with an existing registered manager
- Apply to register as a GP federation

Applications can be made online using the CQC Provider Portal.

3.3 Application timescale

Whilst no definitive timescale can be given, the CQC advises that the process may take several weeks. Once the application has been submitted, the CQC aim to validate the application within five working days. Applicants will receive a confirmation letter once validation has been completed.

Valid applications are then assigned to the registration team for assessment. Assessing the application is dependent on multiple factors, including, but not limited to:**Error! Bookmark not defined.**

- Preparation and readiness
- Availability of nominated individual and manager
- Response to request for further information in support of the application

The CQC may return an application if they are unable to contact the nominated individual to assess the application.

It is envisaged that the CQC will make a decision on an application ten weeks following validation. The decision can be either:

- A notice of decision to register (NoD)
- A notice of proposal to refuse (NoP)

Should a NoP be issued, the applicant has 20 calendar days to make a representation. Detailed information can be found in this guidance.

3.4 Registration process

Prior to applying as either a new provider or a registered manager, individuals must ensure that they:

- Are clear about the application they are making
- Understand the requirements of the legislation
- Can explain and demonstrate how they will follow the regulations

There are a number of documents that a potential service provider must have ready before they apply. They are:

- A countersigned Disclosure and Barring Service check
- The four-part statement of purpose
- Supporting documents (see full list here)

All of the required documents must be included with the application. If they are not, the CQC will return the application. Please note, it can take weeks to compile the necessary information; therefore, this must be taken into consideration during the planning phase of the registration.

3.5 Registered manager application

To apply as a new registered manager, the individual should follow the 'Apply as a new registered manager' guidance. It is strongly recommended that applicants read the 'final checks and common errors' guidance document prior to submitting their application, as this can prevent applications being rejected.

3.6 New provider application

To apply as a new provider, the 'Register as a new provider' guidance should be followed. For GP practices, the following guidance applies and there may also be a need to complete this additional form.

Should an organisation be operating from more than one location, it will need to ensure that this information is submitted to the CQC otherwise the CQC will return the application.

3.7 Fit and proper persons requirement

All providers who carry out a regulated activity must meet Regulation 5: Fit and proper persons: Directors. Not all practices need to conform to this regulation as it is only relevant to those practices that **do not** form part of the traditional GP partnership model.

However, traditional GP partnerships are governed by Regulation 4 and there is an expectation that their partners must:

- Be of good character
- Possess the right competencies and skills
- Be physically and mentally fit to do the job

For further detailed information, see the organisation's Fit and Proper Persons Policy.

3.8 Registration and DBS checks

Prior to submitting an application, a Disclosure and Barring Service (DBS) check must be obtained. The countersigned DBS check can be completed online; this can be done on the CQC and Post Office shared website.

A CQC countersigned enhanced DBS check (CQC-CE-DBS) is required if an applicant is a:

- Partner
- Sole trader (an individual)
- Registered manager (they can also be the nominated individual or director)

The cost for the CQC-CE-DBS is detailed on the shared website.

CQC-CE-DBS checks, for both managers and providers, submitted for applications can be up to 12 months old.

3.9 DBS portability check

DBS checks can be used for more than one application for registration if:

- The individual is currently working in services regulated by the CQC, and
- They can provide evidence of a CQC-CE-DBS certificate that is less than 12 months old

If the above criteria are met, there is no requirement for a new DBS check.

3.10 Statement of purpose

The statement of purpose requested by the CQC is a legally required document and must include the following information:

- About the provider and any registered manager:
    - Full name or business name
    - Contact details (business address, telephone number and email address), email or postal address where the CQC is to send documents and legal notices
    - Type of business (legal status), i.e., sole trader (individual), partnership, organisation
- Aims and objectives for providing the service
- About the places where the services will be provided (location)
- The types of services that will be provided and the range of care needs that are to be met, including:
    - Any specialisms, such as specialist dementia or learning disability care services
    - The age range of the people using the service, i.e., children, people aged 16-17, 18-64, or 65 years and older
    - The types of service, e.g., domiciliary care, care in supported living, or shared lives schemes
    - The regulated activities that will be provided, i.e., personal care, accommodation for persons requiring nursing or personal care

To complete the statement of purpose, providers can use the CQC statement of purpose templates or they are permitted to create their own document.

There are a range of CQC guidance documents that can be used to help complete the statement of purpose:

- Statement of purpose: Guidance for providers
- Regulation 12: Statement of purpose

- The Care Quality Commission (Registration) Regulations 2009, Schedule 3: Information to be included in the statement of purpose

Providers must ensure that they keep their statement of purpose up to date and review it on a regular basis.

3.11 Supporting documents

The following supporting documents must be included with the application:

Required supporting document	Practice Index PLUS resources
Building completion certificate (if applicable)	
Complaints Policy and Procedure	Complaints Procedure - England
Consent Policy and Procedure	Consent Guidance
Equality, Diversity And Human Rights (EDHR) Accessibility Policy	Equality and Diversity Policy Accessible Information Standard Policy
Financial viability statement	CQC Financial viability template
Fit and Proper Persons Policy	Fit and Proper Persons Policy
Governance Policy	Governance Handbook
Health, Safety and Risk Policy	Health, Safety and Risk Management Handbook
Infection Control Policy and Procedure	Infection Prevention and Control (IPC) Handbook
Information Governance Policy	Governance Handbook DSPT Handbook
List of risk assessments Medical Emergencies Policy	Risk Assessment Toolkit Risk Assessment Guidance Document COSHH Risk Assessment Guidance Document Clinical Guidance Document – Medical Emergencies
Medicines Management and Prescribing Policy	The Health, Safety and Risk Management Handbook Prescribing Policy
Medicines and Healthcare Products Regulatory Agency (MHRA) Policy	Central Alerting System Policy
Planning permission (if applicable)	

Public and employer liability insurance quote or certificate	
Recruitment Policy	Recruitment Policy and Procedure (England and Wales)
Safeguarding Policy and Procedures	Safeguarding Handbook
Staffing structure	
Staff training matrix or plan	Mandatory training troubleshooter Staff development policy – mandatory training guidelines
Statement of purpose	CQC guidance
Training and Development Policy	Staff Development Policy – Mandatory Training Guidelines

The following CQC resources are also available:

Meeting the Accessible Information Standard
GP mythbuster 25: Safeguarding adults at risk
GP mythbuster 33: Safeguarding children
GP mythbuster 49: Consent for minor surgery in GP surgeries
GP mythbuster 64: Effective governance arrangements in GP practices
GP mythbuster 67: Reasonable adjustments for disabled people
GP mythbuster 70: Mandatory training considerations in general practice
GP mythbuster 99: Infection prevention and control in general practice
GP mythbuster 103: Complaints management

3.12 Pre-application advice

Should an individual or organisation want any pre-application advice, they can attain this by contacting the CQC using the online contact form, or by email: enquiries@cqc.org.uk, or by telephone: 03000 616161. These services can be used to:

- Tell the CQC that pre-application registration advice is required
- Advise the CQC of the type of activity the organisation intends to register for
- Advise the CQC of the location where the service will be based

The CQC will respond to such enquiries within three working days.

4 How the CQC monitors service providers

4.1 Overview

The CQC reviews the information they have on service providers on a monthly basis; this approach:

- Helps the CQC to prioritise activity
- Involves publishing a statement on the CQC website for lower-risk services. This lets providers and the public know that the CQC inspectors have not found any evidence that tells them they need to re-assess the rating or quality of care at that service at that time

The information the CQC reviews includes:

- The current rating
- Any ongoing or planned regulatory activities
- Information about safeguarding, whistleblowing, incident reports (statutory notifications)
- Feedback from people who use services and their family and friends
- National data sources where available
- Other contextual information

In addition to the above, the CQC also considers the views of service users, gathering information from:

- Responses to the CQC online giving feedback on care services
- Enquiries to the CQC
- Information received from agencies such as Healthwatch and/or local authorities

If there is no need to reassess, the CQC will publish a short statement on the provider's profile page on the CQC website, advising that a review has been completed and there were no concerns identified. The CQC will advise the provider via email before the statement is added to the organisation's profile page.

4.2 Collecting information

Should the CQC determine that they need to gather additional information, they may opt to call the service provider to ascertain this evidence. This is not an assessment, and the service will not be rated following such calls. The aim of the call is for the CQC to decide whether or not they need to take further regulatory action, i.e., an assessment.

The CQC advises that these calls can take between one and two hours, and usually the call will be facilitated using Microsoft Teams. The CQC inspector will email the organisation with an invitation for the pre-agreed date and time, including a link for the call.

The purpose of the call will be to discuss:

- The questions raised in relation to the quality statements
- Any specific risks that have been identified
- Examples of good practice and/or improvements to the service

During the call, the CQC inspector may also ask for evidence and they may request that you do this using 'share your screen'. However, you may need to send evidence via email. If it is the latter, this must be done within 24 hours of the call.

4.3 Monitoring summary record

If there is no need to carry out an on-site assessment or take any form of regulatory action, the CQC will issue a monitoring summary record. This is not an assessment report and the service will not be rated in this record. Furthermore, summary records are not published on the CQC website.

4.4 Pre-assessment provider information request

The CQC may ask the organisation for information prior to carrying out an assessment. This is to enable the CQC to prepare for the assessment and to understand more about the services provided by the organisation.

5 How the CQC assesses service providers

5.1 Single assessment framework

When the CQC assesses a service provider, they use a single assessment framework that uses the five key questions (Safe, Effective, Caring, Responsive and Well-led) as well as quality statements.

Annex A offers an evidence table detailing the considerations to be taken into account when preparing for a CQC assessment. It is divided into the five areas that align with the CQC's key questions and quality statements. This table can be used to help organisations prepare for a CQC assessment. **Note:** At the time of writing (March 2024), it remains uncertain whether the CQC will produce evidence tables along with reports. However, this has been retained as it is deemed a useful way of preparing for an assessment.

5.2 Frequency of assessments

There is no maximum interval between assessments, based on previous ratings. Instead, for GP practices, the CQC uses a variety of information sources to assess quality and to rate service providers, and it may update a rating without conducting a site visit.

There will be occasions when the CQC will assess an organisation; this includes but is not limited to:

- When monitoring information indicates a potential significant improvement or deterioration in the quality of care
- When a provider is part of a larger or complex provider and the CQC has decided to carry out a coordinated assessment alongside CQC hospital and adult social care inspectors
- When the CQC is undertaking a review of care services in a local area

5.3 Composition of the assessment team

Every CQC assessment team is led by a CQC inspector and it is likely that the team will include:

- Specialist professional advisors (SPAs) – this can include practice managers, practice nurses and GPs
- Experts by experience – i.e., individuals who have experienced care personally or have experience of caring for someone who has received a particular type of care
- A member of the CQC's Medicines Optimisation Team

The advisors and experts who join the team will be appropriate to the type of service being assessed.

5.4 Arranging an assessment

The CQC usually gives two weeks' notice to GP practices. The local CQC inspector will telephone the organisation to announce the assessment, and this will be followed up by a letter sent to the registered manager confirming the date of assessment. Within this letter, the CQC may provide posters and comment cards which are to be displayed prominently within the organisation.

Should the CQC be responding to a practice about which it has concerns or there is deemed to be a risk to patient safety, it may carry out an unannounced on-site assessment. On such occasions, the CQC assessment team will, on arrival, liaise with the senior partner or senior manager present at the time.

The CQC may ask for information prior to assessing; this is dependent on the information available to the CQC, the aim of which is to help the CQC prepare for the assessment and to understand more about the care and service that is being provided.

5.5 Period leading up to the assessment

Once the CQC assessment has been announced, the provider will be asked to respond to a number of emails, and the provider will be requested to:

- Submit (via email) a number of policies and protocols (see Annex B) which will be reviewed, and feedback given
- Submit (via email) additional supporting evidence (see Annex B)

- Give consent to grant access to the clinical system for the GP Specialist Adviser (GPSA) who will run a set of clinical searches, review the results and discuss these with members of the clinical team
- Plan remote interviews with the GPSA for members of the clinical team
- Plan remote interviews with the CQC inspector for members of the non-clinical team
- If requested, plan an interview with a member of the Patient Participation Group (PPG)
- Issue the CQC staff survey, ensure staff complete it within the given timeframe, and return the survey to the CQC inspector for analysis

All of the above, including the interviews, will take place during the two-week period preceding the assessment. Interviews are usually conducted using MS Teams.

5.6 On-site assessment

Usually, it will be a CQC inspector and a specialist professional adviser (practice manager or nurse) who will visit the practice to conduct the on-site elements of the assessment. This will include the inspector carrying out premises checks and looking at HR records, whilst the specialist adviser will review infection, prevention and control.

5.7 Assessing GP practices that are working at scale

For organisations working at scale, the CQC is developing and testing its approach to assessing such services. Should an organisation be rated as 'good' or 'outstanding', the CQC will ask for some contextual information about their way of working and links to other service providers, practices, federations and/or networks.

5.8 Talking to the practice team

Throughout the course of the assessment, members of the assessment team will opportunistically speak to staff from the multidisciplinary team. Furthermore, the CQC may request to talk to current and former whistleblowers. It may also be during the on-site assessment that the CQC request to speak with a representative from the PPG.

For further detailed information, see the organisation's Freedom to Speak Up Policy and Procedure.

See also: GP mythbuster 87: Speaking up and listening well

The following eLearning is available in the HUB: Whistleblowing and Whistleblowing: Listening Well – A manager's guide

5.9 Accessing medical records

Under the Health and Social Care Act 2008, the CQC has powers to access medical records for the purpose of exercising its functions. At all times, the CQC will maintain the confidentiality of any records accessed. The CQC's assessment team members will adhere to the Code of practice on accessing confidential and personal information when accessing a patient's medical records.

Should a provider advise the assessment team that a patient does not want them to look at their medical records, this request will be respected – that is, unless there is an overriding need for the team to review that particular record.

For further detailed information, see the organisation's Access to Medical Records Policy.

See also: GP mythbuster 12: Accessing medical records during inspections

6 Preparing for a CQC assessment

6.1 Preparing the team

To ensure that all members of the multidisciplinary team are fully prepared and understand what happens during an assessment, the management team will brief staff using the organisation's Preparing your team for a CQC inspection – A guide for managers PowerPoint presentation.

6.2 Provisions for the assessment team

The CQC assessment team will need a room where they can base themselves throughout the duration of the assessment. This is where they will conduct any interviews with staff members, PPG members and whistleblowers. **Note:** These interviews are usually conducted remotely where possible, ahead of the on-site assessment.

It is recommended that refreshments such as tea, coffee and water are made available to the team throughout the day. It is in the best interests of the organisation to ensure that this facility is as welcoming as possible.

The CQC acknowledges that it might not be possible to provide such facilities, particularly in smaller practices. This information should be relayed to the local inspector during the call to arrange the assessment.

6.3 Presenting the practice to the CQC

It is no longer a routine requirement for the organisation to present a 30-minute presentation to the assessment team at the start of an on-site assessment.

6.4 Format of an on-site assessment

From the moment the CQC assessment team arrive, they will be in 'assessment mode'. It is therefore essential that the organisation is fully prepared from the outset. The process for an assessment is as follows:

- Assessment team arrive and will report to reception
- Reception staff must ensure that the team members sign the visitors' book
- Reception staff call the registered manager or nominated senior member of staff who will greet the assessment team and show them to their dedicated space
- Assessment team hold a short meeting to prepare for the day
- Then the assessment team will advise the practice team of the format of the day
- The assessment begins
- On completion of the assessment, the team will provide headline feedback before departing

An on-site assessment usually lasts between three and four hours.

6.5 Effective preparation

There is much to do prior to undergoing a CQC assessment, and it is the responsibility of all staff to ensure that the organisation is fully prepared and well presented for an assessment. The following is a list of recommended actions to help organisations effectively prepare.

1. Conduct premises checks using the following templates:

    - External inspection of premises checklist
    - Internal inspection of premises checklist

Please note that the checklists are included in the Health, Safety and Risk Management Handbook.

2. Complete the evidence table at Annex A.

3. Collate evidence to show that staff have read the policies listed at Annex B.

4. Collate the additional evidence as listed at Annex C.

5. Have in place a robust policy library, as listed at Annex D.

6. Complete the CQC checklist at Annex E.

6.6 Evidence collation

There is a requirement to ensure that evidence is easily accessible prior to and during a CQC assessment. One such way to do this is to use the Compliance Package in the HUB. This includes:

- **Policy Manager** – keep policies up to date and ensure staff have read and understood them
- **Safety Alerts Manager** – manage, action and distribute CAS alerts to the necessary staff, with a full audit trail
- **Significant Events Manager** – record, manage, categorise, distribute and add learning to significant events
- **Compliments Manager** – record, manage and share compliments and delegate follow-up actions
- **Risk Manager** – record and assess organisation risks, apply ratings and monitor actions
- **CQC Manager** – effectively collate and present all the evidence required for the CQC in one central, secure place
- **H&S Alerts Manager** – send alerts to relevant teams and highlight any important changes
- **Complaints Manager** – manage the entire complaints process, assign outcomes and create the annual K041b submission
- **Criticisms Manager** – record, manage and assign criticisms, and display past criticisms and outcomes to identify trends or themes
- **Checks Manager** – create custom checks, set checks to repeat automatically, and assign checks to be carried out by nominated staff members

To learn more about the Compliance Package, book a demo here.

Alternatively, it is recommended that all evidence is retained in digital format; this enables it to be shared easily upon request.

6.7 Staff training

Whilst the CQC does not provide a list of mandatory training requirements, CQC GP mythbuster 70: mandatory training considerations in general practice advises that the CQC will expect to see evidence of the following training:

- Basic life support (including AED and anaphylaxis)
- Deprivation of Liberty Safeguards
- Fire safety
- Infection prevention and control
- Learning disability awareness (Tier 1 and Tier 2) (The Oliver McGowan Mandatory Training)
- Mental Capacity Act
- Safeguarding adults and children

Staff must undertake the necessary training in order to enable them to deliver safe and effective care; this must be recorded in the practice's training log and the records retained in accordance with the practice's record retention schedule.

All mandatory training requirements can be completed in the HUB.

7 Post-assessment activity

7.1 Assessment report

Following an assessment, the CQC will publish the report on their website. There will also be a separate evidence table published alongside the report. **Note**: This may change in 2024.

7.2 Checking for accuracy

Prior to publishing the report, the CQC will email the organisation a draft of the assessment report and evidence table, the purpose of which is to give the organisation an opportunity to check the factual accuracy of the documents.

The organisation must submit a response to the CQC on receipt of the draft report either to advise the CQC where information is factually incorrect or to point out where evidence may be incomplete. **Note:** This response must be submitted within ten working days.

The organisation must use either of the following forms when challenging the accuracy of a draft assessment report / evidence table:

- Factual accuracy check form
- Factual accuracy check form with evidence appendix/tables

Should the organisation not wish to submit a response, they must notify the CQC immediately; the CQC can then publish the report.

8 Frequently asked questions

8.1 Overview

This section focuses on a plethora of questions that are often asked ahead of a CQC assessment. Some of the responses provided are intentionally brief and, where applicable, will hyperlink to the relevant organisational policies, training courses and/or GP mythbusters.

1. **Does the CQC look at the external areas of the practice?**

   The CQC looks at all areas of the organisation. To ensure that the external areas are fully prepared, the organisation will complete an external assessment of the premises using the external inspection premises checklist which is Annex V of the Health, Safety and Risk Management Handbook.

2. What information does the CQC expect to see displayed at the entrance to the building?

At the entrance to the premises, the CQC will check that the information displayed is accurate and includes:

- Opening hours
- What to do when the practice is closed
- Information about the partners
- Pandemic/seasonal advice
- Any other relevant information to support service users

It will expect to see this information presented professionally and that it is extant.

3. What reasonable adjustments are we expected to have in place or be prepared to make?

In accordance with the Equality Act 2010, the organisation has a duty to make reasonable adjustments for disabled people, ensuring that they are not disadvantaged compared with non-disabled people.

The organisation will be expected to make reasonable adjustments for:

- People with a learning disability
- People with physical impairment
- People with sensory impairment

Such adjustments include, but are not limited to:

- Adapting or making physical changes to a building
- The provision of additional services
- Reviewing and changing a policy, protocol or procedure

Further information can be found in GP mythbuster 67: Reasonable adjustments for disabled people.

The following eLearning is available in the HUB:

Making your practice inclusive for people with learning disabilities and autism

4. What is the CQC looking for, from a premises perspective, internally?

The CQC will look at the condition of the premises. To ensure that all areas are checked ahead of the assessment, the organisation will conduct an internal inspection of the premises using the internal inspection of premises checklist which is Annex W of the Health, Safety and Risk Management Handbook.

5. What information are we expected to display in the waiting area?

There is a requirement to display a range of information in the waiting area. This includes, but is not limited to, posters and information on the following:

- CQC rating and information on practice performance
- Complaints process – how to complain
- Chaperones – how and when to request a chaperone
- Comments, compliments and suggestions – how to leave feedback
- Translation services including BSL interpreters
- Patient Participation Group
- Emergency equipment – where it is located
- In case of fire
- Fire muster point
- Bereavement – information about local support services
- Mental health – information about local support services
- Local services – information about a range of local support services
- Zero tolerance
- Privacy notices
- Sepsis – recognising sepsis
- Breastfeeding – information about areas available to breastfeed
- Did not attend. -% of patients who attending in the preceding months
- Confidentiality
- Safeguarding
- Prescriptions charges and repeat prescription process
- Domestic violence – information about support services in the locality
- Care navigators – the role of the receptionist as a care navigator
- Social prescribers – their role in general practice
- Accessible information – availability of information in additional languages, easy-read format or Braille
- Health promotion in line with national calendar of events
- Useful information – appropriate to patient demographics i.e., cancer screening services, childhood immunisations, diabetes, mental health etc.
- Waiting time – if you have been waiting for more than 20 minutes, please speak to a member of staff
- Practice website – address of website / link / QR code if applicable
- Online services – how to register and access online services
- Do you need to see a doctor?

For further detailed information, see the organisation's Posters recommended for CQC policy.

6. Is it true that we can't use a fabric noticeboard to display posters?

No. However, if fabric noticeboards are in use, they must be cleaned (hoovered) regularly; this means they must be included in the organisation's Cleaning Standards and Schedule Policy.

7. Do posters have to be laminated?

All posters/information notices must be wipeable or laminated. Ideally, non-fabric noticeboards will be used as they can also be wiped clean.

8. We've been told we can't use drawing pins to affix posters to noticeboards; why?

This is a myth! It is perfectly acceptable to use drawing pins to affix posters to noticeboards. The HSE does not advise against the use of drawing pins.

9. Does the information displayed have to be in a particular style?

Information must be accessible and easily understood by all service users. For additional guidance, see Meeting the Accessible Information Standard. For detailed information, see the organisation's Accessible Information Standard Policy.

10. Does the CQC have a list of mandatory risk assessments?

While there is no definitive guide as to what risk assessments are required, due to every practice being different, it is recommended that the following risk assessments are considered:

- Car park management policy including example risk assessment
- Clinical waste
- COSHH see Section 7 of the Health, Safety and Risk Management Handbook
- Dealing with violent and abusive patients
- Disability access
- Display screen equipment
- First aid (including First aid needs assessment) see Annex J of the Health, Safety and Risk Management Handbook
- Fire risk assessment
- Home visits
- Legionella/safe water
- Locking and unlocking premises
- Lone working see Annex L of the Health, Safety and Risk Management Handbook
- Manual handling see Annex M of the Health, Safety and Risk Management Handbook
- Medical gases (storage/use) see Annex N of the Health, Safety and Risk Management Handbook
- New and expectant mothers see Annex O of the Health, Safety and Risk Management Handbook
- Premises security
- Slips, trips and falls
- Workplace driving risk assessment

Note: This list is not exhaustive; it is aimed at providing topics for consideration when determining what risk assessments are required at individual practices.

11. Where should we keep all our risk assessments and do we need paper copies?

It is recommended best practice to collate risks and issues on an electronic risks and issues register that has separate pages for risks and issues, as well as separate pages for archived risks and issues. Risk Manager is available as part of the Compliance Package, accessible in the HUB.

If the organisation uses liquid nitrogen for cryotherapy, then a COSHH risk assessment must be carried out. Liquid nitrogen is classed as a substance that is hazardous to health:

COSHH Regulation 6(1)(a) requires that employers should not carry out work liable to expose employees to substances hazardous to health until all risks have been evaluated and minimised.

Additional guidance can be found in GP mythbuster 86: Storing liquid nitrogen.

For further detailed information, see the organisation's guidance on risk management in the Health, Safety and Risk Management Handbook.

The following eLearning is available in the HUB:

Risk Assessments including COSHH
Legionella Awareness
Lone Working
Display Screen Equipment

See also: GP mythbuster 27: Legionella
GP mythbuster 71: Prioritising home visits

12. Do we need an electrical safety certificate?

Yes, a valid certificate will be required (certificates last for five years). This is usually in the form of an Electrical Installation Condition Report (EICR).

13. Do we need to display an energy performance certificate?

An Energy Performance Certificate (EPC) rates how energy efficient your building is using grades from A to G (with 'A' being the most efficient grade). You must display an EPC by fixing it to your commercial building if **all** of the following apply:

- The total floor space is over 500 square metres
- The building is frequently visited by the public
- An EPC has already been produced for the building's sale, rental or construction

14. What other health and safety related records will the CQC expect to see?

There are many health and safety considerations that organisations must consider, including but not limited to:

- Mechanical ventilation or air conditioning – records of servicing
- Fire safety – records of fire alarm checks, evacuation drills, fire extinguisher checks and fire extinguisher servicing (this is in addition to the fire risk assessment)
- Emergency lighting checks
- Water temperature checks (depending on the water system)

See the organisation's Health, Safety and Risk Management Handbook and Safe Water Policy.

The following eLearning is available in the HUB:

Accident and Incident Reporting
Fire Warden Training
Health and Safety: Office, Electrical and Fire Safety
Legionella Awareness
Moving and Handling Level 1
Moving and Handling Level 2

15. Does the CQC have a list of mandatory medical equipment that organisations must have?

No, as every organisation is different. All organisations must have demonstrable evidence of safe, reliable systems for the use and maintenance of medical equipment. For detailed information, see the organisation's Clinical Guidance Document – Medical Emergencies.

All staff must know where the emergency medical equipment is located and, ideally, there should be signage throughout the premises to show where the equipment can be found.

See also: the Emergency equipment location poster

16. How often should equipment be checked and calibrated?

The CQC assessment team will also expect to see evidence of portable appliance testing (PAT) and calibration records for medical equipment.

It is recommended that PAT and calibration is carried out in accordance with each manufacturer's instructions, as such instructions are likely to include timescales between calibration and other useful recommendations.

Equipment that is likely to need PAT and/or calibration includes, but is not limited to:

- Examination couches
- Defibrillators
- Vaccine fridges
- BP monitors
- Auroscopes and otoscopes
- Blood glucose monitors
- Smokerlyzers
- Medical/baby weigh scales
- Pulse oximeters
- Thermometers
- Spirometers
- ECGs

For further detailed information, see the organisation's Health, Safety and Risk Management Handbook.

See also: GP mythbuster 34: Maintenance of medical equipment
GP mythbuster 52: Portable appliance testing and calibrating medical equipment

17. What emergency drugs/medicines are we expected to hold?

The emergency medicines held at practices are dependent on a number of variables including (but not limited to) locality, needs of the population and arrangements for services in the local area such as palliative care, substance misuse, etc.

Organisations must be able to show that they have considered the risk in relation to the decisions made regarding the emergency medicines held (or not held). The associated risk assessment must include the reasons why a suggested emergency medicine is not required.

For further detailed information, see the organisation's Clinical Guidance Document – Medical Emergencies.

See also: GP mythbuster 9: Emergency medicines for GP practices
GP mythbuster 28: Management of controlled drugs

18. Who needs to be trained to respond to medical emergencies?

The organisation must be prepared to deal with an emergency and/or a major incident and have in place robust arrangements to do so. During an assessment, the CQC will look at the arrangements the organisation has in place to respond to an emergency or major incident.

All staff must be aware of their individual and collective roles when responding to an emergency or major incident.

GP mythbuster 69: Business continuity – arrangements for emergencies and major incidents advises that GP practices need to plan for and respond to a number of wide-ranging incidents that could affect health or patient care.
For further detailed information, see the organisation's Business Continuity Policy, Pandemic Management Policy and Pandemic Staffing Policy.

The organisation must also be able to demonstrate that it can respond to a range of medical emergencies that can occur at any time. For further detailed information, see the organisation's Clinical Guidance Document – Medical Emergencies which details the responsibilities of both clinical and non-clinical staff.

See also: GP mythbuster 1: Resuscitation in GP surgeries

In addition to the above, the CQC will expect to see that all staff are trained in recognising and responding to the acutely unwell or deteriorating patient; this includes patients who may have sepsis. GP mythbuster 88: Sepsis recommends that reception staff are empowered to "recognise what doesn't sound right and to raise concerns".

The CQC will also expect to see that sepsis management is discussed at practice meetings and that there is effective 'safety-netting' in place, including giving patients with infections written information about sepsis.

For further detailed information, see the organisation's Clinical Guidance Document - Sepsis.

HUB

The following eLearning is available in the HUB:

Anaphylaxis
Resuscitation – Adult Basic Life Support
Resuscitation – Paediatric Basic Life Support
Sepsis

19. Do we need a responsible person to manage vaccines?

It is best practice to nominate a 'responsible person' who is responsible for receiving pharmaceutical items and ensuring that cold-chain items are placed in the refrigerator immediately. Furthermore, there should be a nominated deputy who will assume responsibility in the absence of the responsible person.

In addition, the Green Book Chapter 3 recommends that there are two named, trained people who are responsible for the ordering and receipt of vaccines (one from the nursing team and one from management). All members of the primary care team should be aware of the importance of good vaccine management and all staff should understand the importance of maintaining the cold chain.

For further detailed information, see the organisation's Cold Chain Policy.

20. Do vaccines/medicines fridges need more than one thermometer?

Fridges should have an integrated thermometer and **ideally** an external maximum and minimum thermometer fitted. To prevent costly errors, the fridge should be wired into a switch-less socket. If this is not possible, the plug should be clearly labelled "Fridge – do not turn off". For security reasons, the fridge should be kept locked or kept in a locked room.

For further detailed information, see the organisation's Cold Chain Policy and Prescribing Policy.

The following eLearning is available in the HUB:

Maintaining the Cold Chain

See also: GP mythbuster 17: Vaccine storage and fridges in GP practices

21. Who needs to know how to respond to a fridge failure?

In the event of a fridge failure, all staff should know what the required actions are and the UKHSA Vaccine incident guidance should be adhered to. Furthermore, Annex A of this guidance contains algorithms for a cold chain breach and for when compromised vaccines have been administered to patients.

22. Can we still use items such as vaccines if they have been stored outside their normal temperature range?

If items such as vaccines have been exposed to temperatures outside the normal range, the manufacturer may advise that the items are safe to use, but it is imperative that the patient or their representative is advised that the item is being given 'off label' and the reasons for doing so. Advice can be sought from the organisation's local 'screening and immunisation team' in NHS(E) and/or the organisation's local PHE health protection team.

23. What do we need to audit in relation to vaccines/fridge items?

The CQC will expect to see evidence of completed audit cycles and PHE suggests that organisations can audit stock/temperature management on a tri-monthly basis. The audit is used to ensure that the processes for stock rotation and storage are in line with extant legislation, as well as checking to see if there are any instances of temperature spikes. See Annex N of the Health, Safety and Risk Management Handbook.

24. Do we need a risk assessment for medical gases?

Gas cylinders have a number of associated hazards; therefore, a risk assessment must be undertaken for the storage area of gas cylinders. This risk assessment must be carried out in accordance with The Dangerous Substances and Explosive Atmospheres Regulations (DSEAR); guidance is provided via www.hse.gov.uk.

For detailed information on storage, training and the transportation of medical gases, including a risk assessment template, see Annex N of the Health, Safety and Risk Management Handbook.

25. Do we need a separate area to store non-cold chain medicines?

There needs to be a designated area for the storage of non-cold chain medicines. For detailed information about storage requirements, see Annex N of the Health, Safety and Risk Management Handbook.

26. Who is responsible for the management of controlled drugs (CDs)?

There should be a responsible person nominated for the management of CDs within the organisation. They should ensure that the guidance in the organisation's Controlled Drugs Policy is adhered to as well as the following:

- The Misuse of Drugs (Safe Custody) Regulations 1973
- GP mythbuster 28: Management of controlled drugs

27. Is it true we have to submit a controlled drugs self-assessment?

Yes. GP practices are required to complete a self-assessment form and complete a declaration on the use of CDs every two years. The regional Controlled Drugs Accountable Officer (CDAO) can provide the self-assessment and declaration form. An example form can be viewed here.

28. What searches will the CQC run on our clinical system?

The CQC will embed and run a number of searches on the organisation's clinical system as they will be used to gather and analyse evidence. This will be done remotely and negates the need for the team to be on-site, thereby reducing the level of disruption for the practice.

The searches the CQC will run include, but are not limited to:

- DMARDs (Azathioprine, Leflunomide, Methotrexate)
- Medicines requiring monitoring
- MHRA/CAS drug safety updates to check that appropriate action has been taken
- Potential missed diagnoses
- Medicines usage
- Medication reviews
- Monitoring of high-risk patients with long-term conditions
- DNACPR or ReSPECT

The full list of searches can be accessed here.

See also:
GP mythbuster 12: Accessing medical records and carrying out clinical searches
GP mythbuster 84: Managing high risk medicines in general practice
GP mythbuster 92: Anticoagulant monitoring in primary care
GP Mythbuster 96: Covert administration of medicines

For further detailed information, see the organisation's Prescribing Policy.

29. What does the CQC expect to see in relation to prescription security?

It is recommended that a designated member of staff has overall responsibility for overseeing the ordering, receipting and storing of prescriptions. Furthermore, a deputy should be nominated to oversee the process in the absence of the designated person.

The CQC will expect prescribers (including locums) and all staff involved in the management of prescription forms to be able to explain how the organisation manages and maintains the security of blank prescription forms.

There are a significant number of CQC expectations that the organisation must meet, all of which are detailed in GP mythbuster 23: Security of blank prescription forms.

The organisation can demonstrate the significance of prescription management by undertaking regular audits that are aligned to the expectations in the aforementioned mythbuster.

For further detailed information about prescription management, see the organisation's Prescribing Policy.

30. Do we need evidence that we process alerts correctly?

The CQC will expect to see that alerts are received and acted upon appropriately. For detailed guidance on how to respond to such alerts, see the organisation's Central Alerting System Policy.

See also: GP mythbuster 91: Patient safety alerts

31. What are the infection, prevention and control requirements?

All providers of healthcare and adult social care should meet or exceed the Code of practice on the prevention and control of infections and related guidance. In addition to the Code, the organisation should take into consideration the guidance detailed in the National Standards of Healthcare Cleanliness 2021.

Additional IPC requirements, including guidance on curtains and window blinds, carpets, healthcare and clinical waste, medicines waste and sharps, are referenced in GP mythbuster 99: Infection prevention and control in general practice.

For further detailed information on IPC, see the organisation's Infection Prevention Control Handbook and also its Cleaning Standards and Schedule Policy.

32. What are our responsibilities regarding the management of clinical waste?

All providers have a statutory duty of care that requires all reasonable measures to be taken to deal with waste appropriately, from the point of production to final disposal. It is recommended that providers conform to the framework for best practice

as detailed in the Healthcare Technical Memorandum (HTM) 07-01 Safe Management of Healthcare Waste.

See also: GP mythbuster 99: Infection prevention and control in general practice

There are specific sections within the organisation's Infection Prevention Control Handbook that covers the safe handling and disposal of waste.

The following eLearning is available in the HUB:

Infection Prevention and Control (Tier 1 Non-clinical staff)
Infection Prevention and Control (Tier 2 Clinical staff)

33. Who is responsible for the occupational health requirements of staff?

The CQC will expect the organisation to be able to demonstrate that:

- All employees are able to have an occupational health assessment
- New employees can have a pre-employment health assessment

For further detailed information on occupational health, see the organisation's Staff Occupational Health Policy and also Staff Induction Policy.

34. What immunisations do staff need?

The CQC expects GP practices to be able to demonstrate that they have an effective staff immunisation programme in place; this includes how this service is arranged and paid for.

All healthcare staff who have direct contact with patients (including reception staff) should be in date for the following immunisations:

- Tetanus
- Polio
- Diphtheria
- Measles, mumps and rubella (MMR). Satisfactory evidence of MMR immunity is either:
    - A positive antibody test to measles and rubella, or
    - Having two doses of the MMR vaccine

In addition to the above requirements, staff in clinical roles will require the following immunisations:

- Bacillus Calmette-Guérin (BCG), if they have close contact with infectious tuberculosis (TB) patients
- Hepatitis B, if they:
    - Have direct contact with patients' blood or blood-stained body fluids, such as from sharps
    - Are at risk of being injured or bitten by patients

- Varicella, if they have direct patient contact and:
    - Cannot give a definite history of chickenpox or shingles, or
    - A blood test does not show they are immune
- Influenza, to all staff directly involved in patient care

Furthermore, all staff should be offered and encouraged to have a COVID-19 vaccine.

For further detailed information on staff immunisation, see the organisation's Staff Immunisation Policy.

See also: GP mythbuster 37: Immunising healthcare staff

35. What are the requirements for staff induction?

In accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18, "*Providers must ensure that they have an induction programme that prepares staff for their role".*

When the CQC assesses, inspectors will look at how an organisation communicates its policies and procedures to staff, and induction is one way in which this can be achieved. Organisations should ensure that all the key features of a good practice induction pack, as highlighted in GP mythbuster 58: Practice induction packs, are incorporated into the induction pack.

For further detailed guidance, see the organisation's Staff Induction Policy.

The following eLearning is available in the HUB:

Induction

36. Does the CQC have a list of mandatory training requirements?

The CQC does not have a list of mandatory training requirements for GP practices. This is due to the fact that training requirements differ from practice to practice, as training needs are dependent on the responsibilities of the practice and the needs of the service users.

The CQC will expect to see examples of the following:

- Infection Prevention and Control (Level 1 & 2)
- Fire Safety
- Mental Capacity Act and Deprivation of Liberty Standards (MCA & DoLS)
- Resuscitation – Adult Basic Life Support (Level 1 & 2)
- Resuscitation – Paediatric Basic Life Support (Level 1 & 2)
- Safeguarding Adults
- Safeguarding Children

For detailed information, see the organisation's Staff Development Policy - Mandatory Training Guidelines.

All mandatory eLearning courses are available in the HUB.

See also: GP mythbuster 70: Mandatory training considerations in general practice

37. What recruitment checks are we expected to carry out?

There are a number of checks the organisation must undertake prior to employment, including:

- ID verification
- Right to work
- Professional qualifications and registration
- Employment history and references
- Occupational health
- Disclosure and Barring Service check
- Registration Authority ID (for smartcard)

The organisation should also check the relevant register for clinical staff:

- General Medical Council (GMC) – The medical register
- Performers List for England (GPs)
- Nursing Midwifery Council (NMC) register
- General Pharmaceutical Council (GPhC) register for pharmacists and pharmacy technicians
- Health and Care Professions Council (HCPC) register for paramedics, physiotherapists, etc.
- Royal College of Physicians – Physician Associate Managed Voluntary Register (PAMVR)

Detailed information can be found in the organisation's Recruitment Policy and Procedure.

In addition, these requirements are detailed in each specific interview pack which also includes job descriptions.

See also: GP mythbuster 82: Physician Associates in general practice

38. Do all staff need a Disclosure and Barring Service check?

An enhanced DBS check is required for all clinical staff.

Following NHS Employers DBS guidance, certain roles will meet the eligibility to have a standard DBS check carried out. There is no general requirement for non-clinical

staff (for example, reception or administrative staff) to have a DBS check although this does depend on their specific duties and responsibilities.

As a guide, and to determine whether a new member of the team requires a DBS check, or to ascertain what level of DBS check is needed, this organisation utilises the NHS Employers DBS Check Eligibility Tool.

Further detailed guidance can be found in the organisation's DBS Policy.
See also: GP mythbuster 2: Who should have a disclosure and barring service (DBS) check?

39. Will the CQC check to see if staff have had an appraisal?

The CQC will expect to see that there are robust systems in place that enable all staff to receive regular, effective appraisal. The organisation's appraisal schedule is outlined in the Performance Appraisal Policy.

The CQC also expects organisations to have in place effective procedures to deal with poorly performing staff. For detailed guidance, see the organisation's Performance Management Policy.

The following eLearning is available in the HUB:

Appraisals

40. Will the CQC check nurse and GP revalidation?

The organisation must record the date of each GP's annual appraisal and date of revalidation. Revalidation is a legal requirement, with most doctors revalidating through a process of annual appraisals and a five-yearly recommendation for revalidation from their responsible officer or suitable person.

For more detailed guidance, see the GMC Good medical practice framework for appraisal and revalidation.

The organisation must have effective systems in place to ensure that nurses have undertaken the revalidation process. This includes recording the date when revalidation was completed (revalidation for nurses occurs every three years).

For further detailed information, see the organisation's Nursing Staff Revalidation and Appraisal Policy.

See also: GP mythbuster 26: Practice Nurses
GP mythbuster 66: Advanced Nurse Practitioners (ANPs) in primary care

41. How long are we expected to keep records of training, induction and other staff records?

Records must be retained in accordance with the organisation's record retention schedule. The CQC may ask to see any of the documents detailed in this schedule. It is therefore imperative that staff records are readily accessible.

42. Can the CQC access patient records?

Yes, CQC inspectors have powers under the HSCA 2008 to access medical records. If a provider tells the assessing team that a patient does not want them to look at their records, they will respect this request. This is unless there is an overriding need to look at that particular record.

See GP mythbuster 12: Accessing medical records during inspections.

43. What quality improvement activity will the CQC expect to see?

During an assessment, the CQC will expect to see evidence of quality improvement activity (QIA). There are a number of ways the organisation can demonstrate QIA including, but not limited to:

- Data searches
- SEA
- Reflective case reviews
- Reflection and action on feedback/survey results
- Plan Do Study Act (PDSA) cycles
- Audit – clinical and non-clinical

For detailed information, see the organisation's Quality Improvement and Clinical Audit Policy.

See also: GP mythbuster 4: Quality improvement activity

44. Do we have to change the privacy curtains every six months?

No, this is a common misconception. It is not mandatory to change these curtains with any particular frequency. The CQC will want to see that curtains are visibly clean and that they are not stained with any substances.

See GP mythbuster 99: Infection prevention and control in General Practice

45. How often do we have to carry out an IPC audit?

IPC audits should be conducted as detailed in the National Standards of Healthcare Cleanliness 2021. Furthermore, there is a requirement for organisations to complete and display an annual IPC statement. A template for this can be found in the organisation's Infection Prevention Control Handbook.

46. Do we have to have a protocol for correspondence management and/or managing pathology results?

The CQC will expect to see that there is a robust protocol/process in place for both correspondence management and the management of all test results. Furthermore, it will expect to see that the systems and protocols for managing test results include the responsibilities of both clinical and non-clinical staff.

For more detailed information, see the organisation's Correspondence Management Policy and Managing Incoming Pathology Results Policy.

See also: GP mythbuster 46: Managing test results and clinical correspondence

The following eLearning is available in the HUB:

Care Navigation and Correspondence Management Masterclass

47. Is it true that all staff must understand the complaints process?

Yes, CQC assessment teams will seek assurance that staff are familiar with the complaints process and that service users know how to make a complaint and/or raise any concerns they may have.

The CQC will want to see that the complaints process is effective and also that any themes or trends that are identified are used to drive forward continuous improvement and change.

For detailed information, see the organisation's Complaints Procedure.

See also: GP mythbuster 103: Complaints management

The following eLearning is available in the HUB:

Complaints Management

48. Does the CQC check the effectiveness of governance arrangements?

The CQC will talk to staff to ascertain what their role is in the governance framework as well as looking at evidence such as minutes from meetings. The CQC will expect to see that there are systems of accountability in place and that they are effective.

For detailed information, see the organisation's Governance Handbook.

See also: GP mythbuster 64: Effective governance arrangements in GP practices

49. Is chaperone awareness the same as chaperone training?

No. The CQC expects that all staff have an understanding of the role of the chaperone and that they understand the procedures for raising concerns.

Staff who undertake the role of a chaperone must have been trained to do so and have the necessary competencies required for the role.

For detailed information, see the organisation's Chaperone Policy.

See also: GP mythbuster 15: Chaperones

The following eLearning is available in the HUB:

Chaperone Awareness

50. Do all HCAs have to complete the Care Certificate?

The CQC will expect all HCAs employed since April 2015 to have completed the Care Certificate. Furthermore, the CQC expects that organisations employing HCAs will include the Care Certificate standards in the induction process.

See also: GP mythbuster 57: Health Care Assistants in General Practice

The following eLearning is available in the HUB:

Care Certificate

51. Will the CQC ask staff about their role/responsibilities in emergency situations and/or for major incidents?

During an assessment, the CQC will look at the arrangements the organisation has in place to deal with and respond to emergencies and major incidents. It will expect a robust plan to be in place and for staff members to understand their individual and collective roles.

See the organisation's Business Continuity Policy for detailed information.

See also: GP mythbuster 69: Business continuity – arrangements for emergencies and major incidents

The following eLearning is available in the HUB:

Preparing for a Pandemic
Tabletop Exercises (TTX): An introduction

9 Summary

The CQC Handbook has been designed to provide users with the necessary information to be able to understand the functions of the CQC. This handbook also details how users can

effectively prepare for any type of CQC assessment, and how they can remain CQC compliant.

Organisations should aspire to be CQC ready all of the time and the guidance contained within this handbook and referenced policies, protocols and mythbusters will support practices in achieving a state of continued compliance.

Annex A – Evidence table

SAFE

Safeguarding	Yes/No
Safeguarding systems, processes and practices were developed, implemented and communicated to staff	
Partners and staff were trained to appropriate levels for their role	
There was active and appropriate engagement in local safeguarding processes	
Staff knew how to escalate any safeguarding concerns both internally and externally.	
The Out of Hours service was informed of relevant safeguarding information	
There were systems to identify vulnerable patients on record	
Disclosure and Barring Service checks were undertaken where required	
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm	
Explanation of any 'No' answers:	

Recruitment systems	Yes/No
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums)	
Staff vaccination was maintained in line with current guidance and, if relevant, to role	
Explanation of any answers:	

Safety systems and records	Yes/No
Health and safety risk assessments had been carried out and appropriate actions taken	
There was a fire procedure	
Date of fire risk assessment:	
Actions from the fire risk assessment were identified and completed Date of completion:	
Explanation of any answers/comments:	

Infection Prevention and Control		Yes/No
Staff had received effective training on IPC at a level appropriate to their role		
IPC audits were carried out Date of last IPC audit:		
The practice acted on any issues identified in IPC audits		
The arrangements for managing waste and clinical specimens kept people safe		
There is an IPC statement displayed on the organisation's website or within the waiting area		
Explanation of any answers/comments:		

Risks to patients (questions)	Yes/No
There was an effective approach to managing staff absences and busy periods	
There was an effective induction system for temporary staff tailored to their role	
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures	
Clinicians knew how to identify and manage patients with severe infections including sepsis	
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients	
There were enough staff to provide appointments and prevent staff from working excessive hours	
Explanation of any answers:	

Information to deliver safe care and treatment (questions)	Yes/No
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation	
There was a system for processing information relating to new patients including the summarising of new patient notes	
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment	
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals	
There was a documented approach to the management of test results, and this was managed in a timely manner	
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff	
Explanation of any answers:	

Appropriate and safe use of medicines	

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit				
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set)				
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients				
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit				
Number of unique patients prescribed multiple psychotropics per 1,000 patients				

Medicines management	Yes/No
The practice ensured medicines were stored safely and securely with access restricted to authorised staff	
Blank prescriptions were kept securely and their use monitored in line with national guidance	
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions)	
The practice could demonstrate the prescribing competence of non-medical prescribers and there was regular review of their prescribing practice supported by clinical supervision or peer review	
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines	
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services	
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing	
The practice monitored the prescribing of controlled drugs (for example, the investigation of unusual prescribing, quantities, dose, formulations and strength)	
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer	
If the practice had controlled drugs on the premises, there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines which were in line with national guidance	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance	
For remote or online prescribing, there were effective protocols for verifying patient identity	
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held and a system was in place to monitor stock levels and expiry dates	

There was medical oxygen and a defibrillator on-site and systems to ensure these were regularly checked and fit for use	
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective	
Explanation of any answers:	

Significant events	Yes/No
The practice monitored and reviewed safety using information from a variety of sources	
Staff knew how to identify and report concerns, safety incidents and near misses	
There was a system for recording and acting on significant events	
Staff understood how to raise concerns and report incidents both internally and externally	
There was evidence of learning and dissemination of information	
Number of events recorded in the last 12 months:	
Number of events that required action:	
Explanation of any answers:	

Safety alerts	Yes/No
There was a system for recording and acting on safety alerts	
Staff understood how to deal with alerts	
Explanation of any answers:	

EFFECTIVE

Needs assessment, care and treatment	Yes/No
The practice had systems and processes to keep clinicians up to date with current evidence-based practice	
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing	
Patients presenting with symptoms that could indicate serious illness were followed up in a timely and appropriate way	
We saw no evidence of discrimination when staff made care and treatment decisions	
Patients' treatment was regularly reviewed and updated	
There were appropriate referral pathways to make sure that patients' needs were addressed	
Patients were told when they needed to seek further help and what to do if their condition deteriorated	
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	

Population group – people experiencing poor mental health	
Findings:	

Management of people with long-term conditions
Findings:

Childhood immunisation	Practice	CCG average	England average	England comparison
The percentage of children aged one who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e., three doses of DTaP/IPV/Hib/HepB)				
The percentage of children aged two who have received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster, PCV booster)				
The percentage of children aged two who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster)				
The percentage of children aged two who have received immunisation for measles, mumps and rubella (one dose of MMR)				
The percentage of children aged five who have received immunisation for measles, mumps and rubella (two doses of MMR)				

Any additional evidence or comments

Cancer indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical screening at a given point in time who were screened adequately within a specified period (3.5 years for women aged 25-49 and within 5.5 years for women aged 50 to 64				
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %)				
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %)				
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within six months of the date of diagnosis				
Number of new cancer cases treated (detection rate: % of which resulted from a two-week wait referral)				

Quality improvement activity	Yes/No
Clinicians took part in national and local quality improvement initiatives	
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements	
Findings:	

Effective – Staffing	Yes/No
Staff had the skills, knowledge and experience to deliver effective care, support and treatment	
The practice had a programme of learning and development	
Staff had protected time for learning and development	
There was an induction programme for new staff	
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation	
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates	
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable	
Findings:	

Effective – Coordinating care and treatment	Yes/No
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved	
Patients received consistent, coordinated, person-centred care when they moved between services	
Explanation of any answers and additional evidence:	

Effective – Helping patients to live healthier lives	Yes/No
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers	
Staff encouraged and supported patients to be involved in monitoring and managing their own health	
Patients had access to appropriate health assessments and checks	
Staff discussed changes to care or treatment with patients and their carers as necessary	
The practice supported national priorities and initiatives to improve the population's health, for example, stopping smoking campaigns, tackling obesity	
Explanation of any answers and additional evidence:	

Effective – Consent to care and treatment	Yes/No
Clinicians understood the requirements of legislation and guidance when considering consent and decision-making. We saw that consent was documented	
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision	
Do Not Attempt CPR (DNACPR) decisions were made in line with relevant legislation and were appropriate	

CARING

Staff treated patients with kindness, respect and compassion	Yes/No
Staff understood and respected the personal, cultural, social and religious needs of patients	
Staff displayed understanding and a non-judgemental attitude towards patients	
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition	
Explanation of any answers:	

National GP Survey Results

Practice size	Surveys sent out	Surveys returned	Survey response rate	% of practice population

Indicator	Practice	CCG average	National average
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them			
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern			
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to			
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice			
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment			

Patient survey/feedback	Yes/No
The practice carries out its own patient survey/patient feedback exercises	

Staff helped patients to be involved in decisions about care and treatment	Yes/No
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given	
Staff helped patients and their carers find further information and access community and advocacy services	
Explanation of any answers:	

FFT feedback

Staff helped patients to be involved in decisions about care and treatment	Yes/No
Interpretation services were available for patients who did not have English as a first language	
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations	
Information about support groups was available on the practice website	
Explanation of any answers:	

Carers	Narrative
Percentage and number of carers identified	
How the practice supported carers (including young carers)	
How the practice supported recently bereaved patients	
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice	
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment	

Privacy and dignity	Yes/No
A private room was available if patients were distressed or wanted to discuss sensitive issues	
There were arrangements to ensure confidentiality at the reception desk	
Explanation of any answers:	

RESPONSIVE

Responding to and meeting people's needs	Yes/No
The practice understood the needs of its local population and had developed services in response to those needs	
The importance of flexibility, informed choice and continuity of care was reflected in the services provided	
The facilities and premises were appropriate for the services being delivered	
The practice made reasonable adjustments when patients found it hard to access services	
There were arrangements in place for people who needed translation services	
The practice complied with the Accessible Information Standard	
Explanation of any answers:	

People were able to access care and treatment in a timely way	Yes/No
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice	
The practice offered a range of appointment types to suit different needs (e.g., face to face, telephone, online)	
Patients were able to make appointments in a way that met their needs	
There were systems in place to support patients who faced communication barriers to access treatment	
Patients with the most urgent needs had their care and treatment prioritised	
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	
Explanation of any answers:	

Complaints	Yes/No
Number of complaints received in the last year	
Number of complaints we examined	
Number of complaints we examined that were satisfactorily handled in a timely way	
	Yes/No
Information about how to complain was readily available	
There was evidence that complaints were used to drive continuous improvement	
Explanation of any answers:	

WELL-LED

Leadership capacity and capability	Yes/No
Leaders demonstrated that they understood the challenges to quality and sustainability	
They had identified the actions necessary to address these challenges	
Staff reported that leaders were visible and approachable	
There was a leadership development programme, including a succession plan	
Explanation of any answers:	

Vision and strategy	Yes/No
The vision, values and strategy were developed in collaboration with staff, patients and external partners	
Staff knew and understood the vision, values and strategy and their role in achieving them	
Progress against delivery of the strategy was monitored	
Explanation of any answers:	

Culture	Yes/No
There were arrangements to deal with any behaviour inconsistent with the vision and values	
Staff reported that they felt able to raise concerns without fear of retribution	
There was a strong emphasis on the safety and wellbeing of staff	
There were systems to ensure compliance with the requirements of the duty of candour	
When people were affected by things that went wrong, they were given an apology and informed of any resulting action	
The practice encouraged candour, openness and honesty	
Staff had undertaken equality and diversity training	
Explanation of any answers:	

Governance	Yes/No
There were governance structures and systems that were regularly reviewed	
Staff were clear about their roles and responsibilities	
There were appropriate governance arrangements with third parties	
Explanation of any answers:	

Managing risks, issues, and performance	Yes/No
There were comprehensive assurance systems which were regularly reviewed and improved	
There were processes to manage performance	
There was a quality improvement programme in place	
There were effective arrangements for identifying, managing and mitigating risks	
A major incident plan was in place	
Staff were trained in preparation for major incidents	
When considering service developments or changes, the impact on quality and sustainability was assessed	
Explanation of any answers:	

Appropriate and accurate information	Yes/No
Staff used data to adjust and improve performance	
Performance information was used to hold staff and management to account	
Staff whose responsibilities included making statutory notifications understood what this entails	
Explanation of any answers:	

Governance and oversight of remote services	Yes/No
The practice used digital services securely and effectively and conformed to relevant digital and information security standards	
The provider was registered as a data controller with the Information Commissioner's Office	
Patient records were held in line with guidance and requirements	
Patients were informed and consent obtained if interactions were recorded	
The practice ensured patients were informed how their records were stored and managed	
Patients were made aware of the information sharing protocol before online services were delivered	
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services	
Online consultations took place in appropriate environments to ensure confidentiality	
Explanation of any answers:	

Engagement with patients, the public, staff and external partners	Yes/No
Patient views were acted on to improve services and culture	
The practice had an active Patient Participation Group	
Staff views were reflected in the planning and delivery of services	
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population	
Explanation of any answers:	

Continuous improvement and innovation	Yes/No
There was a strong focus on continuous learning and improvement	
Learning was shared effectively and used to make improvements	
Explanation of any answers:	

Annex B – List of policies the CQC may request to see

The following is a list of policies the CQC may request are provided ahead of an assessment. Please note, this list is not exhaustive.

- Access Policy (Managing Access and Demand)
- Access to Medical Records Policy
- Appraisal Policy
- Business Continuity Plan (and/or Major Incident Plan)
- Central Alerting System Policy
- Chaperone Policy
- Clinical Supervision
- Cold Chain Policy
- Complaints Policy (including complaints leaflet)
- DBS Policy
- Duty of Candour Policy
- Failsafe Policy (Safety netting policy)
- Freedom to Speak Up Policy and Procedure
- HCA Handbook
- Home Visits Policy
- Induction Policy
- Infection Prevention and Control Handbook
- Locum Policy
- Medical Emergencies Guidance Document
- New patient registration and health check policy
- Online Services Policy
- Recruitment Policy (incorporating employment of PCN staff)
- Safeguarding Handbook
- Significant Event and Incident Policy
- Staff Development Policy

Annex C – Supporting evidence

The following is a list of supporting evidence that the CQC may request is provided ahead of an assessment. Please note, this list is not exhaustive.

- Audit log/record including summary of audit activity for the preceding 24 months and evidence of two complete, full-cycle audits including actions taken and outcomes
- Care home manager details (if the organisation looks after patients in care homes)
- Emergency lighting checks/servicing
- Evidence of how the organisation has addressed issues from previous CQC assessments, where applicable
- Feedback process
- Fire alarm testing log
- Fire evacuation log (including actions taken)
- Fire extinguisher log (evidencing checks and servicing)
- Fire risk assessment and action log
- Fridge temperature log
- Health and Safety Risk Assessment (including any action log)
- ICO registration certificate
- Infection Prevention and Control audit and action log
- Infection Prevention and Control evidence showing that the IPC lead is appropriately trained for the role and their details
- Legionella / safe water testing
- List of staff, including specific roles, i.e., safeguarding lead, cervical screening, immunisations, etc.
- List of risk assessments undertaken in the preceding 12 months
- Minutes of meetings (to include MDT meetings, meetings during which IPC, premises, cleaning of premises, significant events have been discussed)
- Mission statement, vision and values
- Number of staff by role and hours worked (WTE)
- Patient Participation Group (PPG) contact details (including consent)
- Patient survey, results and action log (own survey)
- Provider liability insurance
- Record / log of emergency medicines and equipment checks
- Record of quality improvement activity within the last 48 months
- Record of staff feedback and action(s) taken (within the last 12 months)
- Referrals process including details for tracking urgent referrals
- Risk register (including issues register)
- Safeguarding risk register (names redacted) and sample of minutes of any meetings where safeguarding concerns were discussed
- Staff HR matrix (to evidence CV, interview notes, contract of employment, photo ID, references, DBS, qualifications, registration, Performers List, immunisation status, induction)
- Staff immunisation matrix (supported by evidence of immunisation status)
- Staff training matrix (incorporating all mandatory and necessary training)
- Statement of purpose
- Summary of complaints (within the last 12 months) and actions taken

- Summary of compliments received (within the last six months)
- Summary of quality improvement activity undertaken (within the last 24 months)
- Summary of significant events (within the last 12 months) and actions taken

Annex D – Recommended polices and protocols

The following are in addition to those policies listed in Annex B.

- Accessible Information Standards
- Accident Reporting Policy
- Allergy, Intolerances and Sensitivities Guidance Document
- Anti-bribery and Counter Fraud Policy
- Audio Visual and Photography Policy
- Bomb threat and suspect packages
- Bullying and Harassment
- Caldicott and Confidentiality
- Cleaning Standards and Schedule Policy
- Communication Policy
- Confidential Waste Policy
- Consent Guidance
- Dealing with Unreasonable, Violent and Abusive Patients
- Death of a Patient and Bereavement Policy
- Did Not Attend (DNA)
- Disciplinary Policy and Procedure
- DNACPR
- Dynamic Lockdown Procedure
- Environmental and Sustainability
- Equality and Diversity
- Female Genital Mutilation Guidance Document
- Fit and Proper Persons
- Fire Safety
- First Aid Policy (incorporated in the Health, Safety and Risk Management Handbook)
- Friends and Family Test
- Gender Identity Toolkit
- Guidance for a New Joining Clinician
- Health, Safety and Risk Management Handbook
- Home Working Policy and Procedure
- Lone Working Policy
- Management Policy and Procedure
- Manual Handling Policy
- Mental Capacity Act
- Modern Slavery and Human Trafficking Guidance
- Palliative and End-of-Life Care Policy
- Pandemic Management Policy
- Pandemic Staffing Policy
- Partnership Guidance Document
- Patient Participation Group
- Patient Social Media and Acceptable Use
- Patient Text Messaging (SMS) Policy
- Portable Appliance Testing (PAT)

- Privacy Notice (Practice)
- Privacy Notice (Employee)
- Privacy Notice (Children)
- Privacy Notice (Applicants)
- Quality Improvement and Clinical Audit Policy
- Recording of Drug Allergy
- Removal of Patients
- Responsible Persons List
- Safe Water Policy
- Sepsis Guidance Document
- Shared Decision-Making
- Sickness Absence (Reporting Rules)
- Smartcard Policy
- Staff Occupational Health
- The Use of NICE Guidance
- Translator and Interpreter

Annex E – CQC checklist

Safe

Title	Guidance	Reference(s)	Lead	Date completed
Access Policy	All staff should understand the organisation's approach to managing access and meeting patient expectations. Organisations are to be aware of comments, the contractual requirement and that they are to explore smarter ways to manage access such as technology and also manage expectations and a wider spectrum of clinicians.	Managing Access and Patient Demand Policy		
Access to Medical Records Policy	Staff should be aware of the procedure allowing access to medical records, including the arrangements for access by third parties and clinicians working at the practice. Detail the arrangements for allowing access by patients to their own manual and online computer-held records. Demonstrate GDPR compliance. Ensure that the organisation website has been updated to reflect Access to Medical Records, including prospective record access.	Access to Medical Records Policy (including SAR template) Detailed in the above policy UK GDPR Policy		

	Have all staff completed the annual Information Governance training? Is a child who requests their healthcare record permitted to do so? Are they competent? Ensure that staff are aware of Gillick competency. The following eLearning is available in the HUB: UK GDPR Information Governance and Data Security	GP Mythbuster No 8		
Business continuity	The organisation is to have a Business Continuity Policy/Plan and this is to be reviewed annually or when there is a significant change of the team. All key members of the team are to be forwarded a copy of the plan. Where reasonable, all eventualities should be considered with emergency contacts being listed that include NHS E and ICB. The following eLearning is available in the HUB: Tabletop Exercises (TTX): An introduction	Business Continuity Policy GP Mythbuster No 69 Core Standards for Emergency Preparedness, Resilience and Response		

Caldicott and Confidentiality Policy	All staff should be familiar with the organisation's Caldicott and Confidentiality Policy. Staff contracts should detail the need to maintain confidentiality. There should be a named Caldicott Lead. Staff should also be aware of the need to afford patients privacy and to respect their dignity. Reception staff may be observed when dealing with patients. Have all staff completed the annual Information Governance training? Has the organisation completed the Data Security and Protection Toolkit by 31st March annually? The following eLearning is available in the HUB: Caldicott and Confidentiality Information Governance and Data Security	Caldicott and Confidentiality Policy Data Security and Protection Toolkit Handbook		
Clinical audit	The organisation should be able to provide evidence of regular clinical audit. The organisation will be asked to provide audit evidence for the preceding 24 months. Second-cycle audits are essential and any audit not followed up after 12 or 18 months will usually be commented on.	Quality Improvement and Clinical Audit Policy The Governance Handbook GP Mythbuster No 64		

		GP Mythbuster No 65		
Cold chain	The organisation should have records of the temperatures of the vaccine fridge(s) with stock rotation a consideration, with the shortest expiry date placed at the front and used first. Have a lead person and deputy been nominated? Staff should be aware of the actions that need to be taken should the cold chain fail to be maintained. Staff must understand what to do in the event of a fridge failure. HUB The following eLearning is available in the HUB: Maintaining the cold chain	Cold Chain Policy Dispensary Delivery Protocol GP Mythbuster 17 Distribution and disposal of vaccines (The Green Book - Chapter 3) The Health, Safety and Risk Management Handbook (Annex N).		
Complaints	The complaints process is to be understood by all staff, as any staff member could at any time be requested to assist a patient who wishes to make a complaint. All staff must know who the Complaints Manager is and the Responsible Person (note, they can be the same person).	Complaints Procedure GP Mythbuster 103		

	For verbal complaints, all staff should attempt to placate any complainant at the time of any complaint and the complaints manager is to be informed. All complaints, verbal and written, are to be logged and will form part of the annual complaints review where analysis of complaints' outcomes is detailed with any actions or learning points discussed. The complaints leaflet explains the two-stage process for dealing with complaints: Stage 1 – the organisation or the Integrated Care Board; Stage 2 – the Parliamentary and Health Service Ombudsman (PHSO). This information is also available on the practice website. The procedure should clarify the mode of complaint, time limits, consent and rights of appeal. Complainants should be made aware of the right to raise a matter with the PHSO (if they are dissatisfied after Stage 1), whose contact details must be provided in the final letter, should the original complaint not be dealt with satisfactorily. It should be clear as to whom complaints should be made relating to health professionals not employed by the organisation but who might have been working in the organisation previously. Complaints will almost certainly be examined in depth by the CQC team, with copies of correspondence reviewed. This also applies to minutes of meetings where complaints			

	are discussed. Lastly, evidence that monitoring and learning have been implemented and reviewed will be required. The following eLearning is available in the HUB: Complaints Management Customer Care			
Controlled drugs	There should be a clearly defined policy setting out the management of controlled drugs. Evidence must be provided to ensure that the process, from ordering to destruction, is being monitored and adhered to. Whilst non-dispensing practices rarely have controlled drugs on their premises, dispensing practices will have numerous supporting Standing Operating Procedures (SOPs) that detail the management of controlled drugs.	Controlled Drugs Policy GP Mythbuster 28		
Duty of Candour	Should there be any concern, complaint or significant event raised, then there is to be a thorough investigation with any findings being reported under the organisation's duty of candour. There is to be a policy relating to the duty of candour and this is to be explained on the website.	Duty of Candour Policy GP Mythbuster No 32		

	The following eLearning is available in the HUB: Duty of Candour			
Emergency equipment	All staff are to undertake mandatory refresher training such as Basic Life Support (BLS), Automated External Defibrillator (AED) and anaphylaxis to ensure they can support a medical emergency. In addition, staff will be aware of sepsis and posters should be placed throughout the organisation to ensure all staff and patients can recognise the symptoms. Staff should be aware of where the emergency equipment is located and this should be clearly signposted. Are there appropriate checks on the emergency equipment and have these been signed? Is the stock in date? Are all emergency drugs checked on a regular basis to confirm any expiry date? **Note:** Oxygen also has an expiry date; likewise, confirm the date of any cylinder and, if fitted, the separate regulator as these both also have expiry dates. The following eLearning is available in the HUB:	Medical Emergencies Guidance Document Sepsis Guidance Document Sepsis poster Emergency equipment poster GP Mythbuster No 9 GP Mythbuster No 88		

	Anaphylaxis Resuscitation Adult Basic Life Support Resuscitation Paediatric Life Support Sepsis			
Equipment care	The organisation is to provide records of equipment calibration, maintenance and PAT of electrical equipment. Ensure that emergency equipment and doctors' bags are included in any testing.	The Health, Safety and Risk Management Handbook (Annexes D and Q) GP Mythbuster No 52 GP Mythbuster No 34		Equipment care
FGM	Staff are to be aware of their responsibilities in relation to female genital mutilation (FGM) and how to raise concerns.	FGM Guidance Document GP Mythbuster No 80		
Fire precautions and evacuation procedures	A fire risk assessment is to be conducted and is to remain in date (see HSE link). The practice is to have nominated fire marshals and they are to remain in date for specific training in this role. Regular evacuation drills are to be conducted. Fire extinguishers are to be regularly checked and a log is to be kept. Annually, they are to be serviced and are not to	The Health, Safety and Risk Management Handbook (Annex H)		

	have passed their expiry date. Anti-tamper tags are to be present. Fire call points are to be regularly checked throughout the building and all fire exits, signs and emergency lights are to be serviceable. The fire evacuation point is to be appropriate and clearly marked. Fire exits are not to be blocked and surfaces should be clear to allow egress as required. Wheelchair users should be able to move around the building and exit it with ease and, if exit routes require them, any key is to be clearly available. A sign is to be placed in or near the lift(s), highlighting that it/they must not be used in a fire. HUB The following eLearning is available in the HUB: Health and Safety: Office, Electrical and Fire Safety Fire Warden Training			
Health and Safety	The practice is legally required to have a Health and Safety Policy and a nominated individual who leads on HASAW matters. This person is to be aware of their responsibilities and this is to be detailed within the job description.	Health, Safety and Risk Management Handbook		

	As per the HASAW Act 1974, the Health and Safety Policy is to provide and maintain a healthy and safe workplace by ensuring that a safe system of work is provided for all employees at the practice. The practice is to ensure that the working environment and provision of equipment is safe, and that suitable and sufficient information, instruction and training are provided to employees to ensure their health and safety. The Health and Safety Executive's poster is to be displayed and this identifies the HASAW lead for the practice. The Employer's Liability Insurance Schedule is also to be current and displayed. For further information, the Health and Safety Executive (HSE) provides guidance material. HUB The following eLearning is available in the HUB: Health and Safety: Office, Electrical and Fire Safety	www.hse.gov.uk		
Infection Prevention and Control	The Infection Prevention and Control Lead should be available to meet the inspectors and this person must be trained to fulfil this role.	Infection Prevention Control Handbook		

	An annual audit is to have been completed, and an IPC statement completed and added to the practice website. See HSCA 2008 Code of Practice (Annex D) An annual statement, for anyone who wishes to see it, including patients and regulatory authorities, should be prepared by the IPC lead for each registered provider which should provide a short review of any: • Known infection transmission events and actions arising from this • Audits undertaken and subsequent actions • Risk assessments undertaken for the prevention and control of infection • Education and training received by staff • Review and update of policies, procedures, and guidance Any outcomes following the IPC audit should have an action plan to address these issues. Are COSHH substances maintained and controlled? Is this the role of the IPC lead? Is this written in their job description? Are all COSHH items supported by a safety data sheet?	GP Mythbuster 99 Health, Safety and Risk Management Handbook		

	The following eLearning is available in the HUB: Infection Prevention and Control – Tier 1 Infection Prevention and Control – Tier 2 Risk assessments including COSHH	Safety data sheets		
Medical emergencies	The organisation has a policy on how to respond to a medical emergency. Should there be a significant emergency, or business continuity is interrupted, then the Business Continuity Policy/Plan should be implemented. Staff should be aware of these policies, and they should be discussed as part of the annual training programme. The following eLearning is available in the HUB: Anaphylaxis Resuscitation – Adult Basic Life Support Resuscitation – Paediatric Life Support Sepsis	Medical Emergencies Guidance Document Business Continuity Policy www.england.nhs.uk GP Mythbuster No 69		
Name badges	To help identify staff, name badges would be useful, although this is not mandatory in general practice.	NHS England Staff Identification Badge		

	A consideration is that name badges are commonplace throughout industry, including the wider NHS, so why not in general practice? Dr Kate Granger, MBE highlighted the need for the introduction of name badges when she was a terminally ill patient with her 'hello my name is' campaign.			
Patient Group Directions and Patient Specific Directions	Patient Group Directions should be kept centrally and evidence should be available that all PGDs have been read by the appropriate nursing staff. All documentation is to have been read and signed by nursing staff and supervising clinicians. Should the supervising clinician who agreed and confirmed the PGD be on an extended absence period from the organisation, the CQC would expect another supervising clinician to be nominated and, in this instance, PGDs would be required to be re-signed by all involved in their use. PSDs are required for all invasive procedures carried out by non-registered health workers. The authorising clinician must sign off the procedure before it is done in respect of every patient individually.	GP Mythbuster No 19 NICE guidance		
Patient safety alerts	An alert system is to be adopted within the practice which supports the spectrum of CAS Alerts, be it for medical, drugs, equipment or safety.	Central Alerting System Policy GP Mythbuster No 91		

	There is to be a named individual who receives and disseminates all alerts then places them into the CAS Log. All appropriate staff are to be forwarded alerts and a process is to be established to ensure that all alerts have been acted upon as required.			
Prescribing and prescription security	The Prescribing Policy sets out the procedures for issuing, monitoring and reviewing repeat prescriptions. Staff may be asked about the timescales involved in patients receiving either an urgent or a routine prescription. The organisation must ensure that measures are in place to prevent and tackle prescription form theft and misuse.	Prescribing Policy GP Mythbuster No 23		
RIDDOR	The accident book should be available with evidence of actions taken for any entries. This is to ensure that any RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) actions have occurred. All staff are to be aware of where the accident book is kept and who the available certified first aiders are. Has a First Aid Needs Assessment been conducted?	Health, Safety and Risk Management Handbook www.hse.gov.uk		

	The following eLearning is available in the HUB: Accident and Incident Reporting Health and Safety			
Risk assessments	The CQC will request evidence of risk assessments during assessments. Examples of specific risks include, but are not limited to, the following: ● Car park risk assessment ● Clinical waste ● COSHH (see Section 7 of the Health, Safety and Risk Management Handbook) ● Dealing with violent and abusive patients ● Disability access ● Display screen equipment ● First aid (including First aid needs assessment) (see Annex J of the Health, Safety and Risk Management Handbook) ● Fire risk assessment ● Home visits ● Legionella / safe water ● Locking and unlocking premises ● Lone working (see Annex L of the Health, Safety and Risk Management Handbook) ● Manual handling (see Annex M of the Health, Safety and Risk Management Handbook)	Health, Safety and Risk Management Handbook		

	• Medical gases (storage/use) (see Annex N of the Health, Safety and Risk Management Handbook) • New and expectant mothers (see Annex O of the Health, Safety and Risk Management Handbook) • Premises security • Slips, trips and falls • Workplace driving risk assessment The CQC will expect the organisation to have an up-to-date risk and issues register. HUB The following eLearning is available in the HUB: Risk assessments including COSHH			
Safeguarding	There should be clearly defined policies for dealing with vulnerable patients (children and adults). Staff must complete the relevant level of safeguarding training, know who the organisation's safeguarding lead is, and to whom they should report any concerns. Children who fail to attend their appointments can be considered as being at risk of neglect. Staff should be aware of the "Was Not Brought" aspect of the Safeguarding Policy.	Safeguarding Handbook GP Mythbuster No 25 GP Mythbuster No 33 Clinical Disengagement Policy		

	Clinical disengagement could be a concern with capacity and should be read in conjunction with the Safeguarding Policy. The following eLearning is available in the HUB: Safeguarding Adults Levels 1, 2 and 3 Safeguarding Children Levels 1, 2 and 3			
Safe water	The organisation should provide evidence of undertaking a risk assessment in relation to ensuring that water is safe. Legionella is a problem in both water systems and air-conditioning units. The following eLearning is available in the HUB: Legionella awareness	Safe Water Policy Health, Safety and Risk Management Handbook GP Mythbuster No 27 www.hse.gov.uk		
Significant events	Significant events are to be a core part of the governance infrastructure. All staff are to be aware of the process and be involved in raising significant events as appropriate. The CQC will require to see any SEAs that have been recorded within the past 12 months and that actions arising out of these have been acted upon. This could include audit amendments, policy updates or training implementation.	Significant Event and Incident Reporting Policy Duty of Candour Policy GP Mythbuster No 24		

	Evidence of an open and honest culture is to be considered as per the duty of candour requirements. Not all raised SEAs should relate to negative aspects, as best practice should also be identified as a significant event. These are known as positive events. Significant events that have a patient safety impact should be reported to the Learning from Patient Safety Events (LFPSE) service.			
Stock control	As well as vaccines, drugs and dressings will often have an expiry date. Therefore, all items within clinical areas, including any doctors' bags and fridges, are to be checked.	Health, Safety and Risk Management Handbook		
Visitors	All visitors should sign into the premises to ensure that, in the event of a fire, all persons in the building can be accounted for. There are other benefits such as litigation, security and chaperoning as per the Lampard recommendations. Consider the need for visitors to have their name visible on a badge or lanyard, especially if given access to sensitive areas. **Note:** Whilst GDPR rules state that only relevant information can be held, consider the HASAW rules on making any claim against an organisation.	Third party confidentiality agreement incorporating fire safety and risk awareness for visitors		

Whistleblowing	Staff should not fear reporting irregularities during their employment and should be aware of whistleblowing and who the Freedom to Speak Up guardian is. The Freedom to Speak Up Policy and Procedure should be available to all staff and detailed within the Employee Handbook. The CQC will ask staff questions about this subject. Brief staff as to whom they should talk to about any concerns regarding performance, activities undertaken or the associations of personnel working at the surgery. Ensure that the contact details (email and telephone number) of the Freedom to Speak Up guardian are freely available and that all staff know where to find this information. HUB The following eLearning is available in the HUB: Whistleblowing Whistleblowing: "Listening well"	Freedom to Speak Up Policy and Procedure Employee Handbook GP Mythbuster 87: Speaking up and listening well		
Waste disposal	The Infection Prevention and Control Handbook details at Annex C the requirements for disposing of business and clinical waste including "sharps". Evidence of the regular collection of clinical waste by the licensed collection contractor must be retained.	Infection Prevention Control Handbook		

	Clinical waste awaiting collection must be secured. The following eLearning is available in the HUB: Infection Prevention and Control – Tier 1 Infection Prevention and Control – Tier 2			

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