

CQC Support Programme Webinar Series | Session 1: Introduction to CQC

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Agenda

- Introduction
- The basis for CQC inspections
- Changes at CQC
- Current inspection formats
- Mock inspection overview
- CQC Ardens searches
- Areas of CQC focus
- An overview of the webinar series

Introduction



Background

- Worked as a CQC Inspector for 8 years
- Joined a GP Federation in 2023 providing consulting and support across the country and internal compliance support
- Set up my own business in July 2025 – AD Primary Care Consulting

Services offered

- Mock inspections
- Training
- Targeted support
- Queries and advice
- Intensive support before an inspection
- Support following an inspection
- CQC Registration – not an expert!

The basis for CQC inspections

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

All inspectors base their judgments on the extent to which providers are complying with these regulations.

Key regulations:

9. Person-centred care

10. Dignity and respect

11. Need for consent

12. Safe care and treatment

13. Safeguarding service users from abuse and improper treatment

14. Meeting nutritional and hydration needs

15. Premises and equipment

16. Receiving and acting on complaints

17. Good governance

18. Staffing

19. Fit and proper persons employed

20. Duty of candour

Regulation 12 & Regulation 17

In my experience, 90% of instances where GP providers are found to be in breach of regulation, it is due to non-compliance with **Regulation 12** (Safe Care & Treatment) and/or **Regulation 17** (Good Governance)

Regulation 12: Safe Care and Treatment



12.—(1) Care and treatment must be provided in a safe way for service users.

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include —

(a) **assessing the risks to the health and safety** of service users of receiving the care or treatment;

(b) doing all that is reasonably practicable to **mitigate** any such **risks**;

(c) ensuring that persons providing care or treatment to service users have **the qualifications, competence, skills and experience** to do so safely;

(d) ensuring that the **premises used** by the service provider are safe to use for their intended purpose and are used **in a safe way**;

(e) ensuring that the **equipment** used by the service provider for providing care or treatment to a service user is safe for such use and is **used in a safe way**;

(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

(g) the proper and **safe management of medicines**;

(h) **assessing the risk of, and preventing**, detecting and controlling the spread of, **infections**, including those that are health care associated;

(i) **where responsibility for the care and treatment of service users is shared with, or transferred** to, other persons, working with such other persons, service users and other appropriate persons to **ensure that timely care planning takes place** to ensure the health, safety and welfare of the service users.

Regulation 17: Good Governance (relevant sections)



17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

(a) **assess, monitor and improve the quality and safety of the services** provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) **assess, monitor and mitigate the risks** relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c) **maintain securely an accurate, complete and contemporaneous record in respect of each service user**, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d) **maintain** securely such other **records** as are necessary to be kept in relation to—

(i) **persons employed** in the carrying on of the regulated activity, and

(ii) the **management of the regulated activity**;

(e) **seek and act on feedback** from relevant persons and other persons on the services provided in the carrying on of the regulated activity, **for the purposes of continually evaluating and improving** such services;

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Changes at CQC – A Timeline

- **2019/20:** Transformation begins with aim of introducing:
 - Single Assessment Framework
 - New organisational structure
 - New regulatory IT platform
- **2023/24:** Single Assessment Framework launched
- **2024:** Dash and Richards reports find that all three elements of CQC's transformation have failed.
- **2024 – 26:** Most of the changes made rolled back.
- **2026:** Draft Sector Specific Frameworks created
- **Jun – Nov 26:** Testing the replacement assessment model. Pilot assessments will run alongside - not instead of - existing inspections. Participation in a pilot is voluntary.

Draft Assessment Framework for Primary care and community services

Draft Assessment Framework

- 34 Quality Statements replaced with 28 “new” Key Lines of Enquiry.
- Specific to Primary Care and Community Services.

What’s new for those who have not been inspected since pre-2020?

- Focus on inequalities (patients and staff) & Human Rights throughout
- References to safe use of new technologies including AI as well as cyber security arrangements
- More specific requirements around strategy
- Environmental sustainability
- Requirement to test business continuity plans
- Neighbourhood working

Current Inspection Formats

- **Return to Good and Outstanding**
- **“Enhanced” Return to Good and Outstanding**
- **The way CQC currently Inspects Primary Care**

Return to Good and Outstanding

Began in March 2026. Inspector only. No GP specialist advisor usually present, although could be turned into a comprehensive inspection if concerns identified

Criteria for selection:

- be an NHS in-hours GP practice
- hold a current overall rating of either **good** or **outstanding**
- have had its last inspection report published between **2017 and 2022**
- be considered lower risk
- have no ongoing regulatory activity and not be dormant.

*Assessments in this programme **run alongside our usual assessment activity** and will follow our established approach and methodology. But importantly, they will **enable us to gain additional assurance from lower-risk services that have not been inspected for some time.***

Return to Good and Outstanding Quality Statements Assessed

Safe:

Safe environments: Premises

Safe and effective staffing: recruitment checks

Infection prevention and control: IPC audits, cleaning

Effective:

Supporting people to live healthier lives: Health promotional activities & screening uptake

Monitoring and improving outcomes: clinical auditing

Caring:

Kindness, compassion and dignity: patient and staff surveys to evidence

Responsive:

Equity in access: access arrangements and support for those with reasonable adjustments

Equity in experience and outcomes: tackling health inequalities

Well-led:

Shared direction and culture: Vision, values and staff wellbeing

Governance, management and sustainability: Policies and procedures, leadership structure

“Enhanced” Return to Good and Outstanding Inspections

Enhanced assessments will include a routine clinical review by carrying out the usual clinical records reviews.

The local inspection team will decide whether to carry out either a standard assessment or an enhanced assessment.

Quality Statements Assessed:

Safe: Medicines optimisation

Effective: Delivering evidence-based care and treatment

How? **CQC Ardens Searches!!**

The way CQC currently Inspects Primary Care

Announcement

- Two weeks notice still provided for comprehensive, five days for “return to good and outstanding”. No notice for unannounced inspections - when CQC has serious concerns about risk
- Pre inspection return varies in size depending on inspector.
- Request access for a CQC GP advisor to access your clinical system – CQC Ardens searches – comprehensive inspections or “enhanced return to good and outstanding”
- Evidence gathered from staff may be done via:
 - Questionnaires
 - Remote interviews
 - On site interviews

Mock CQC Assessment Overview

Mirrors the process for comprehensive inspections

- One day reviewing documentation requested in advance of the on-site visit
- One day on site visit primarily focusing on anything you can't email:
 - IPC
 - Recruitment
 - Vaccine Fridges
 - PGDs
 - Emergency medicines and equipment
 - Interviews – PM will always need to be available ☹
- One day drafting action plan listing findings and recommended actions to take.
- Provide lists of questions staff may be asked on inspection.

Information requested in advance of a mock inspection

- Policies and procedures including:
 - Safeguarding
 - Infection control
 - Complaints
 - Significant events
 - GDPR
- Premises and infection control documentation
- Clinical Audits
- Staff and patient feedback
- Overview of complaints and significant events
- Staff overview including roles, training and appraisal dates
- Meeting minutes
- Risk register and business plan

CQC Ardens Searches

- A suite of searches free to download from Ardens. Primary method CQC uses to assess clinical safety and effectiveness
- **Areas of focus:**
 - MHRA alerts
 - High Risk Drug Monitoring & DMARDS
 - Medication Reviews
 - DNACPR
 - Medicines Usage
 - Long term condition management – **all searches under this heading looked at**
- Relevant to Safe, Effective, Responsive and Well-Led Key questions
- Problems identified by the searches are more likely to lead to poor ratings and enforcement action
- Unlikely to be “fixed” within the announcement period

CQC Ardens Searches

Top tips

- Run monthly
- Ensure you are using the latest version
- Put in place a tracker or action plan for work done to reduce numbers of patients flagged by the searches
- Delegation e.g. to pharmacists is okay but GP leadership should still have oversight
- Discuss in clinical meetings
- Consider if associated processes e.g. recalls are adequate, are you doing enough to encourage attendance e.g. short scripting?
- Do not rely on similar searches
- There must be a documented rationale for prescribing high risk drugs in absence of monitoring
- **Get on top of this NOW!!!!**

Doing the above will provide evidence of systems to manage areas of risk which will be viewed positively if any issues arise from the review of records.

Oversight of Non-Medical Prescribers (NMP)

Nurse prescribers, prescribing pharmacists and any other non-GP role that can prescribe medicines

What you need to have/do

- Obtain evidence of prescribing qualification – including externally employed (e.g. PCN) staff
- Conduct standard recruitment checks including of the relevant professional register
- Clearly defined scope of practice
- Access to a GP supervisor daily
- Monthly documented supervision sessions with a GP
- Audits of prescribing to ensure these align with scope of practice and to check quality of prescribing and note keeping - does this align with guidance and best practice?
- Protocols for reception staff to work to when booking patient in with NMPs

Use of new digital tools in Primary Care

New area of focus at CQC including AI receptionists, triaging tools and document management software

Points to note:

- Be very careful with “off shelf” digital products
- Digital Clinical Safety Officer - Trained
- DCB129 & DCB160 risk assessments
- Audit and review of product safety – by practice?
- GDPR implications
- Consider how to deal with this – practice, PCN, Federation

Provision of Flus and B12s by HCA under a PSD

PSD requirements

- An authorisation by a clinician to administer a medicinal product
- **Examples**
 - List of patients for a flu clinic
 - Direction for a B12 created and digitally authorised by a clinician within a patient record
- **Must contain:**
 - name(s) of patient(s) and/or other individual patient identifiers including age if a child
 - name, form and strength of medicine
 - route of administration
 - dose
 - frequency
 - date of treatment/number of doses/frequency/ date treatment ends as applicable
 - signature of prescriber.

Provision of Flu and B12s by HCA under a PSD

Issue with Consent

New guidance from UKHSA states:

“it is outside the scope of practice of a HCSW (Healthcare Support Worker – inc HCAs) to undertake a clinical assessment for vaccination, **take informed consent** or work to Patient Group Directions (PGDs). For this reason, they may be better employed in roles other than vaccine administration ”

Therefore, the expectation is that **a clinician will not only review the patient's record to decide if treatment is clinically appropriate, a clinician must also obtain valid consent from the patient to have treatment.**

Impact for HCAs working in general practice?

Overview of other sessions

- **Safe part 1:** Significant events and safeguarding and recruitment
- **Safe part 2:** Premises and infection control
- **Safe part 3:** Medicines management, medical emergencies and clinical administration
- **Effective:** Audit, training, supervision, appraisal and consent
- **Caring:** Patient and staff feedback, carers and reasonable adjustments
- **Responsive:** Access and complaints
- **Well-led:** Governance, leadership and innovation

The End

Question Time!

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