

EVIDENCE AND COMPLIANCE

Clinical Supervision in GP practices: What CQC actually asks for

CQC AI Auditor team · Published 13 October 2026 · 11 min read

Read online: <https://www.cqcaudit.ai/blog/clinical-supervision-cqc-requirements-gp-practices>

In short: CQC does not hand GP practices a supervision template or a required number of sessions. What it asks for is set out in Regulation 18, the Safe and effective staffing quality statement and a handful of GP mythbusters: every clinician, employed by you or not, has someone senior to turn to on the day, has regular clinical or professional supervision suited to their role, and you can show how you know they are competent and staying that way. This post puts CQC's wording in one place, adds NHS England's guidance on how often, and ends with a list of what to have ready.

General practice teams have changed. A practice may now have advanced nurse practitioners, clinical pharmacists, paramedics, physiotherapists, physician associates and care coordinators, some employed by the practice and some by the primary care network or a trust. CQC's expectations on supervision are spread across several pages, so it is easy to over prepare in one area and miss another. Everything quoted below is CQC's or NHS England's own wording, from pages read on 13 October 2026. Where we give practical examples of our own, we say so.

What the law says: Regulation 18

The starting point is Regulation 18: Staffing. [Regulation 18](#) requires that staff "receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform".

CQC's guidance on the regulation adds four lines that matter for a GP practice:

- "Where appropriate, staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out their role unsupervised."
- "Staff should receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained."
- "Health, social and other care professionals must have access to clinical or professional supervision as required, in line with the requirements of the relevant professional regulator."
- "Staff should receive regular appraisal of their performance in their role from an appropriately skilled and experienced person"

Two things stand out. Supervision is tied to competence, both reaching it and keeping it. And the word

CQC uses is "appropriate", not a fixed number. None of the CQC pages quoted in this post sets a frequency for supervision in general practice. The frequencies further down come from NHS England.

Where supervision sits in the assessment framework

In the single assessment framework, supervision belongs to the [Safe and effective staffing](#) quality statement under Safe. The statement itself reads: "We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development."

CQC's explanation of what the statement means includes this line: "Staff receive the support they need to deliver safe care. This includes supervision, appraisal and support to develop, improve services and where needed, professional revalidation."

If you want to see how this statement sits alongside the other 33, our [guide to the 34 CQC quality statements](#) lists them all in CQC's wording, and [how CQC scores a GP practice](#) explains why a single statement scored low can limit the rating for a whole key question.

The three kinds of supervision CQC describes

[GP mythbuster 106](#), Staff not directly employed by a GP practice, sets out the clearest definition. It starts with the principle: "A senior member of the clinical primary care team should provide day-to-day supervision of all clinical staff under their direction and control." It then lists three kinds of supervision:

- **Clinic/practice supervision:** "day-to-day support for issues arising in the practice"
- **Clinical/professional supervision:** "regular support to promote high clinical standards and develop professional expertise. This does not always need to be a GP"
- **Educational supervision:** "supports learning and enables learners to achieve proficiency."

These are three different things, and a practice can have one without the others. A duty doctor rota shows who covers clinic supervision on the day. It does not show that your clinical pharmacist has regular clinical supervision, or that a trainee has an educational supervisor. It is worth checking that each clinician has the kinds of supervision their role needs, and that you can show it.

Note the line "This does not always need to be a GP". An experienced clinical pharmacist can supervise a newer one, and an advanced nurse practitioner can supervise another nurse, where that fits the role and the professional regulator's requirements.

Staff you do not employ are still your responsibility

Many clinicians in general practice are employed by the primary care network, a federation or a trust. CQC is clear about where responsibility sits: "Providers are accountable for staff who they may not employ directly, but who deliver regulated activity on their behalf."

Mythbuster 106 explains that the meaning of "employed" in the regulations "means anyone who works for the provider, under their ongoing direction and control." It says practices "must clearly agree the responsibilities and accountabilities of both parties", covering employment, supervision and training. For recruitment checks, the practice does not have to repeat them, but must "reasonably assure themselves

that it has been done", for example through a "letter of confirmation", a "memorandum of understanding" or a "service level agreement from the trust."

NHS England's [supervision guidance for primary care network multidisciplinary teams](#) makes the same point for supervision: "Practices/employers do not have to individually provide all elements of clinical/professional supervision", and agreements "should clarify the recruitment checks undertaken and responsibilities for day-to-day clinical supervision."

In practice, the question to be able to answer for every clinician in the building is simple: who supervises them, for which kind of supervision, and where is that written down.

What the mythbusters say, role by role

Several GP mythbusters add role specific detail. The common thread is that you can show how you know each clinician is working within their competence.

Advanced nurse practitioners

[GP mythbuster 66](#) says advanced level nurses "should have arrangements for supervision with someone suitably qualified. For example, a medical colleague or ANP." It adds: "Ongoing clinical supervision will include reviewing patient consultation records. It will also include audit of the ANP's practice." Providers should be able to show how they assure themselves of the nurse's capability "on an ongoing basis", including "a system of structured supervision and review of consultation records."

Non-medical prescribers

[GP mythbuster 95](#) covers pharmacists, nurses, paramedics and physiotherapists who prescribe. Practices "should have systems to make sure they are working within the limits of their competency", and CQC expects supervision and indemnity for all staff, "irrespective of who holds the employment contract." Among the systems CQC lists are "clinical supervision" and "consultation audits and random case reviews".

Physician associates

[GP mythbuster 82](#) is the most specific. Physician associates "must always work under the supervision of doctors and under the direction of a named senior doctor." CQC says organisations should identify an individual at GP partnership or integrated care board level "who is responsible for the supervision and oversight of physician associates", and practices should make sure that:

- "the supervisor is easily accessible"
- "staff know who the supervising member of staff is"
- "staff have enough capacity and capability to supervise."

The General Medical Council has regulated physician associates since 13 December 2024. Following the Leng review, the government said on 16 July 2025 that physician associates "will in future be identified as physician assistants". CQC's mythbuster, last updated in December 2024, still uses the earlier name.

General practice nurses

[GP mythbuster 26](#) says clinical supervision "is effective in making sure a nurse remains clinically competent" and can support revalidation. It should "be undertaken with a suitably-trained peer", "follow a framework" and "be documented." Staff who are learning new skills but are not yet competent "should be appropriately supervised", and CQC expects an appraisal "in the last 12-month period."

How often, and for how long

CQC's own pages do not set a frequency. NHS England's supervision guidance does. It describes itself as a supporting resource rather than contractual guidance, and points to the Network Contract DES for the minimum requirements for staff funded through the Additional Roles Reimbursement Scheme (ARRS). Its supervision table recommends monthly clinical or professional supervision for most roles, including clinical pharmacists, pharmacy technicians, first contact physiotherapists, paramedics, mental health practitioners, nursing associates, physician associates, social prescribing link workers, health and wellbeing coaches and care coordinators. Trainee paramedics have a daily debrief while in training, and physician associate preceptees have daily supervision.

On length, NHS England says: "It is recommended that each clinical supervision session lasts a minimum of an hour." It also lists recording supervision sessions as part of effective supervision, and notes that supervision notes can be used as evidence for CPD and professional revalidation.

CQC mythbuster 106 links to this guidance as the place that "sets out the minimum supervision requirements for staff recruited through ARRS."

What CQC checks

Mythbuster 106 lists what CQC assesses when it looks at staff skills, knowledge and experience. The list "will include but is not limited to" clinical supervision, communication of alerts and guidance, complaints and significant event arrangements, induction, job plans, policies and procedures, quality improvement processes, safe recruitment, and training and development programmes.

It then says CQC will check:

- "how the provider has assured themselves that staff are capable for the role"
- "that the provider maintains this over time through ongoing supervision. This supervision may be carried out by any senior member of the team."

That second point is the one to plan around. A supervision record from the first month of employment shows a clinician was supported when they started. CQC is also asking whether that support continues.

What to have ready

This is our practical list, built from the CQC and NHS England wording above. It is not a CQC checklist, and the evidence that fits will vary with your team.

- **A supervision map.** Every clinician, who their clinic supervisor is on the day, who provides their

clinical or professional supervision, and who their educational supervisor is if they are training. Include staff employed by the PCN or a trust.

- **Written agreements for staff you do not employ.** A letter of confirmation, memorandum of understanding or service level agreement that covers recruitment checks and who provides day to day supervision.
- **Dated supervision records.** Notes of each session, kept in a way the clinician and the practice can both find. A supervision agreement setting out how sessions work is good practice in NHS England's guidance.
- **Consultation and prescribing reviews.** For advanced practitioners, non-medical prescribers and physician associates, evidence of consultation record reviews or audits, and what was learned from them.
- **A named lead for physician associates.** The person responsible for their supervision and oversight, and how staff know who to go to.
- **Appraisals and registration checks.** An appraisal in the last 12 months for each member of staff, current professional registration, and prescribing annotations where relevant.
- **Scope of practice.** Job plans or scope documents that show each role works within agreed limits, and that the supervisor knows what those limits are.
- **A supervision policy that matches reality.** If the policy says monthly, the records should show monthly. Check the two side by side, because a policy the records do not support raises questions rather than answering them.

How CQC AI Auditor helps

Supervision records, assurance letters, appraisal logs and audit results are the kind of evidence CQC looks for under Safe and effective staffing. The AI assisted audit in CQC AI Auditor reads the policies, records and minutes you choose to give it, cross references them and scores each quality statement on what your evidence shows, so you can see where your supervision evidence is strong and where it is thin. [How it works](#) explains the two levels. It is our assessment of your evidence, not a prediction of your CQC rating. You can [run your first self check free](#).

Frequently asked questions

Does CQC require monthly clinical supervision in GP practices?

CQC's pages ask for "appropriate" supervision and do not set a frequency. NHS England's supervision guidance for primary care network teams recommends monthly clinical or professional supervision for most ARRS roles, with sessions of at least an hour. CQC's mythbuster 106 points to that guidance for staff recruited through ARRS.

Does clinical supervision have to be done by a GP?

Not always. CQC's mythbuster 106 says clinical or professional supervision "does not always need to be a GP" and that ongoing supervision "may be carried out by any senior member of the team." Physician associates are the exception: CQC says they must always work under the supervision of doctors.

Is a practice responsible for supervising PCN employed staff?

Yes, for staff working under the practice's direction and control. CQC says providers "are accountable for staff who they may not employ directly". The practice does not have to provide every element itself, but it should agree in writing who provides what and be assured it is happening.

What evidence of supervision does CQC look for?

CQC says it will check how the provider has assured itself that staff are capable for the role, and that it maintains this over time through ongoing supervision. In practice that means records of who supervises whom, dated supervision notes, consultation reviews or audits for advanced roles, appraisals and written agreements for staff you do not employ.

Ask us

We do not run comments on Insights. If you have a question about clinical supervision and CQC, ask on [our LinkedIn page](#) or reply to the newsletter.

Sources

- CQC, [Regulation 18: Staffing](#) (page last updated 16 May 2025). Read 13 October 2026.
- CQC, [Safe and effective staffing](#) quality statement (page last updated 22 February 2024). Read 13 October 2026.
- CQC, [GP mythbuster 106: Staff not directly employed by a GP practice](#) (page last updated 2 September 2024). Read 13 October 2026.
- CQC, [GP mythbuster 66: Advanced Nurse Practitioners \(ANPs\) in primary care](#) (page last updated 7 July 2026). Read 13 October 2026.
- CQC, [GP mythbuster 95: Non-medical prescribing](#) (page last updated 15 May 2024). Read 13 October 2026.
- CQC, [GP mythbuster 82: Physician associates in general practice](#) (page last updated 17 December 2024). Read 13 October 2026.
- CQC, [GP mythbuster 26: General practice nurses](#) (page last updated 14 October 2024). Read 13 October 2026.
- NHS England, [Supervision guidance for primary care network multidisciplinary teams](#) (publication reference PR00057_iii). Read 13 October 2026.
- Department of Health and Social Care, [Patient safety boost as PA review recommendations accepted](#) (16 July 2025). Read 13 October 2026.