SINGLE ASSESSMENT FRAMEWORK

CQC glossary for GP practices: the terms explained

CQC AI Auditor team · Published 1 October 2026 · 10 min read
Read online: https://www.cqcaudit.ai/blog/cqc-glossary-gp-practice-terms-explained

In short: this CQC glossary defines the terms a GP practice manager or partner meets before, during and after an assessment, from key questions and quality statements to scores, ratings, registration and AI. Each definition is drawn from a CQC page and quoted where the wording matters.

CQC has its own vocabulary, and much of it has changed since the single assessment framework arrived. If you have ever stopped at a phrase in a CQC letter and wondered what it means in practice, this page has CQC's terms explained in plain English. We will update it when CQC confirms its new frameworks.

The framework

Single assessment framework. CQC's current assessment framework for every service it regulates. It "retains our 5 key questions and the 4-point ratings scale" and assesses services against quality statements.

Key question. One of the five CQC key questions CQC asks of every service: is it safe, effective, caring, responsive to people's needs, and well-led. Ratings are given at key question level. In CQC's definitions, safe means "people are protected from abuse and avoidable harm"; effective means care "achieves good outcomes, promotes a good quality of life and is based on the best available evidence"; caring means "staff involve and treat people with compassion, kindness, dignity and respect"; responsive means "services are organised so that they meet people's needs"; well-led means "the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture."

> **Quality statement.** What is a quality statement in CQC terms? It is the unit CQC scores: "the commitments that providers, commissioners and system leaders should live up to." There are 34 for a GP practice. They "have replaced our previous key lines of enquiry (KLOEs), prompts and ratings characteristics." Our guide to the 34 quality statements lists all 34 with the evidence for each.

We statement. Another name for a quality statement, because each is written in the provider's voice and begins with "We".

I statement. A line under each quality statement that "reflect what people have said matters to them",

for example "I feel safe and am supported to understand and manage any risks."

Evidence category. One of six evidence categories, the groups CQC sorts evidence into: people's experience of health and care services, feedback from staff and leaders, feedback from partners, observation, processes, and outcomes. CQC publishes which it usually looks at for each statement in primary health services and calls the lists "a guide, not a checklist."

Processes. The evidence category a practice controls most directly: "the series of steps, arrangements or activities that a provider or organisation carries out to deliver safe care that meets people's needs." CQC's examples include audit results, learning from safety incidents, access times and clinical record reviews.

Key line of enquiry (KLOE). CQC key lines of enquiry were the questions CQC used under its previous framework, replaced by quality statements. The term is coming back: CQC's draft sector frameworks use key lines of enquiry again, as "supporting questions, which replace the current quality statements." The drafts are not live, and CQC's August 2026 update gives no start date.

Rating characteristics. Descriptions of "what outstanding, good, requires improvement and inadequate look like in each sector." Removed under the current framework and reintroduced in the drafts, where CQC says they are "an indication" rather than a checklist.

Draft sector specific frameworks. Four drafts published in March 2026 for adult social care, mental health care, primary care and community services, and hospitals. Consultation closed 12 June 2026. Being piloted June to October 2026, with evaluation in November. CQC: "Pilot judgements have no legal standing and will not affect regulatory status or rating."

GP mythbusters. CQC's numbered guidance notes for general practice, which CQC says "clear up some common myths about our inspections of GP services, independent doctors and clinics and out-of-hours services and share agreed guidance to best practice."

The assessment

Planned and responsive assessment. CQC says your next assessment will be either planned or "responsive (where we've received concerning information)."

Focused assessment. A CQC focused assessment looks at some quality statements rather than all. CQC's Returning to Good and Outstanding programme, from March 2026, uses focused assessments of lower risk GP practices rated good or outstanding whose last report was published between 2017 and 2022, "reviewing non-clinical quality statements". CQC's word is focused, not light touch. If concerns are found, inspectors "will consider whether we should carry out a full, rather than focused, assessment." Practices in the programme get at least five working days' notice.

On site and off site. CQC gathers evidence both ways. On site: "observing care and how staff interact with people", the environment, and talking with patients, staff and leaders. Off site: national data such as the GP patient survey and prescribing data, evidence requested by email, online reviews of clinical records, and interviews that may be done online.

Specialist advisor. A professional with current expertise in the sector who supports CQC inspectors "by providing specialist advice and expertise to support our judgements."

Factual accuracy check. Your chance to check the draft report before publication: "We will ask you to check the factual accuracy and completeness of the information we have used to reach our judgements and ratings". You can say where information is incorrect or the evidence is incomplete.

Scores, ratings and the report

> **Score.** The number CQC gives each quality statement it assesses, 1 to 4. In CQC's words: 1, "Evidence shows significant shortfalls"; 2, "Evidence shows some shortfalls"; 3, "Evidence shows a good standard"; 4, "Evidence shows an exceptional standard". CQC changed how it applies scores on 2 December 2024 and no longer scores at evidence category level.

Key question score. The statement scores under a key question added up and divided by the maximum possible, the number of statements multiplied by 4, giving a percentage.

Thresholds. How the percentage becomes a rating: 25 to 38% inadequate, 39 to 62% requires improvement, 63 to 87% good, 88% and above outstanding. The scale starts at 25% because every statement scoring 1 gives 25%.

Limiting rule. Two rules on CQC's How we reach a rating page that stop a low score being hidden. "If the key question score is within the good range, but one or more of the quality statement scores is 1, the rating is limited to requires improvement." And: "If the key question score is within the outstanding range, but one or more of the quality statement scores is 1 or 2, the rating is limited to good."

Rating. One of four: outstanding, good, requires improvement, inadequate. GP practices are rated at two levels: each key question, and an aggregated overall rating for the service.

Overall rating. The five key question ratings combined under CQC's rating principles. The overall rating "will normally be good if there are no key question ratings of inadequate and no more than one key question rating of requires improvement", and normally requires improvement "if 2 or more of the key questions are rated as requires improvement."

Aged rating. CQC's own phrase for ratings that may no longer reflect current performance. Services with ratings older than seven years are among its assessment priorities for primary care.

Rating process review. The route to challenge a published rating, only on the ground "that we have failed to follow our process for making rating decisions", not because you disagree with the judgement. Requested within 15 working days of publication by the registered manager or nominated individual, in no more than 500 words. "All scores and ratings can go down as well as up as a result of a review." It is "the final CQC process for challenging a rating."

Registration and regulation

Provider. "An individual person, partnership or organisation registered with CQC to carry on one or more regulated activities." For most GP practices, the partnership.

Regulated activity. An activity that must be registered with CQC, listed in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The fourteen include treatment of disease, disorder or injury, diagnostic and screening procedures, surgical procedures, maternity and midwifery services and family planning services. "Each regulated activity requires a separate

registration."

Location. The places where you provide services. CQC: "We call these locations."

Registered manager. The CQC registered manager is the person registered with CQC to manage the regulated activity at a location, under Regulation 7 of the Regulated Activities Regulations. In a GP practice, often a partner or the practice manager.

Nominated individual. "The person who is employed as a director, manager or secretary of a body and whose name has been notified to CQC as being the person who is responsible for supervising the management of the carrying on of the regulated activity by that body."

Registered person. "A person who is the registered provider or registered manager in respect of one or more regulated activities."

Statement of purpose. The CQC statement of purpose is a document every registered provider must hold and keep up to date, "where you can tell us in your own words" what you do, where you do it and the people your service is for. A legal requirement under Regulation 12 of the Registration Regulations.

Fundamental standards. The standards in the Regulated Activities Regulations, "the standards below which care must never fall." CQC's frameworks "are based on and link to the fundamental standards", and to be rated good, providers "need to demonstrate that they are doing more than the minimum requirements set out in regulations."

The regulations, by number. The ones a GP practice meets most often: 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; 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.

> **Duty of candour.** Regulation 20. It "requires providers to be open with the people who use their service" when "a specified safety incident has occurred in respect of care provided", and sets out "how and when to notify people using their service (or their relevant representatives)".

Statutory notification. Something a practice must tell CQC about by law. GP mythbuster 21: "GP practices are legally obliged to notify CQC about certain changes, events and incidents that affect their service or the people who use it": changes to the registered person or statement of purpose, certain deaths, and incidents such as serious injury, abuse or allegations of abuse, and police involvement.

Enforcement action. "When CQC imposes, varies or removes conditions of registration; when we suspend or cancel a registration whether using urgent procedures or not and issuing Warning Notices, penalty notices, simple cautions; or when we prosecute a provider."

Safeguarding. "Ensuring that people live free from harm, abuse and neglect and, in doing so, protecting their health, wellbeing and human rights."

Supervision. "A process to guide, support and assist employees to enable them to carry out the duties they are employed to perform."

Risk assessment. "The process of identifying all the risks to and from an activity, and assessing the potential impact of each risk."

AI and digital tools

Clinical safety officer (CSO). A senior registered clinician, trained in digital clinical safety, whom adopters of new digital technology must nominate under DCB0160. GP mythbuster 109 says inspectors will look for "a responsible CSO and digital lead".

DCB0129 and DCB0160. The NHS clinical risk management standards. DCB0129 applies to developers of digital technology; DCB0160 to the organisations that adopt it, including GP practices.

DTAC. The Digital Technology Assessment Criteria, used to assess digital health technologies and their suppliers before they are bought.

DPIA. A data protection impact assessment. One of CQC's eleven AI principles.

Hazard log. The record of clinical risks identified for a digital tool. "Your practice should have a hazard log and risk assessments completed in relation to AI tools." Our guide to AI in general practice, on Insights, covers the rest.

A term we use

Domain. Inside the CQC AI Auditor, the five key questions are called domains. They are the same five things. When we write about the framework itself, we use CQC's word: key question.

Missing something?

If a term from a CQC letter or report is not here, ask on our LinkedIn page or reply to the newsletter and we will add it.

Sources

- CQC, Assessing quality and performance (2 July 2026) and its sub pages: Differences from our previous model, How often we assess, How we gather evidence, Levels of ratings, How we reach a rating, Factual accuracy check, Rating process review. Read 1 October 2026.
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- CQC, Update from CQC: Returning to Good and Outstanding (25 March 2026). Read 1 October 2026.
- CQC, Regulations for service providers and managers (7 July 2025) and its Glossary of terms (16 May 2025); Regulated activities (29 January 2025); Statement of purpose (25 March 2026); GP mythbuster 21: Statutory notifications; GP mythbuster 109 (14 July 2025); GP mythbusters (12 February 2026). Read 1 October 2026.