CQC Auditor

SINGLE ASSESSMENT FRAMEWORK

The 34 CQC quality statements for GP practices, with examples of evidence

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Read online: https://www.cqcaudit.ai/blog/cqc-quality-statements-gp-practices-evidence-examples

In short: CQC assesses every GP practice in England against 34 quality statements, grouped under its five key questions. Each is scored 1 to 4 on the evidence, and those scores decide the rating for each key question. This is the full list of all 34 in CQC's own words, with the evidence categories CQC says it usually looks at for each one in primary care, and what that evidence tends to look like inside a practice. A printable PDF version is at the end of this post.

If you manage a GP practice, the CQC quality statements are what your assessment is built on. Not the five key questions on their own, and not the old key lines of enquiry. Since CQC's single assessment framework arrived, the quality statements are what an inspector scores, and the scores are what your rating is made from. Most CQC quality statements lists online are either CQC's own pages, spread across dozens of screens, or versions written for care homes. This one is for general practice. Everything in CQC's words is quoted. Everything else is our reading, after seventeen years of preparing practices for inspection.

What a CQC quality statement is

CQC describes quality statements as "the commitments that providers, commissioners and system leaders should live up to." They are written as "we statements", in the voice of the practice, which is why each one below begins with "We". CQC's guidance says the framework "retains our 5 key questions and the 4-point ratings scale", and that quality statements "have replaced our previous key lines of enquiry (KLOEs), prompts and ratings characteristics."

There are 34 for a GP practice: eight under Safe, six under Effective, five under Caring, seven under Responsive and eight under Well-led. We counted them page by page on CQC's site, because the number is quoted differently in a surprising number of places.

How they are scored

Each statement CQC assesses gets a score from 1 to 4. CQC's words: "Evidence shows significant shortfalls", "Evidence shows some shortfalls", "Evidence shows a good standard", "Evidence shows an exceptional standard". Inspectors "use professional judgement to assign the score, based on the

evidence categories they have looked at for each quality statement."

At key question level the scores are added, divided by the maximum possible, and turned into a rating: 25 to 38% inadequate, 39 to 62% requires improvement, 63 to 87% good, 88% and above outstanding. Two limiting rules sit on top. In the good range, any statement scoring 1 limits the rating to requires improvement. In the outstanding range, any 1 or 2 limits it to good. Our How we score page works through the arithmetic, with CQC's wording for each score.

CQC may not look at all 34 each time. It can "be selective in which quality statements we look at – this could be one, several or all." For a practice that has never been rated, it "will need to assess all quality statements in a key question before we publish the rating."

The evidence CQC looks at

CQC groups evidence into six categories: people's experience of health and care services, feedback from staff and leaders, feedback from partners, observation, processes, and outcomes. For primary health services, which includes NHS GP practices, CQC publishes which categories it "will usually look at" for each statement. That mapping sits under every statement below. CQC's caveat: "These lists are a guide, not a checklist." It will collect evidence in all the relevant categories "for our first assessments under the new approach" and "following new registrations", and may look at others "if evidence suggests that we need to."

The category a practice controls most is processes: "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, "findings and learning from safety incidents", "access times for treatment and care" and "case note reviews of people's care or clinical records." That is your policies, logs, audits and minutes. And one line that is easy to miss: "We do not want providers to prepare specific documents – rather we ask for information they already have."

Under each statement, "CQC usually looks at" is CQC's list for primary health services. "In a practice" is ours.

Safe: eight quality statements

CQC: "By safe, we mean that people are protected from abuse and avoidable harm."

1. Learning culture

"We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: a significant event log where each entry records a decision and a change, complaints learned from, duty of candour evidenced.

2. Safe systems, pathways and transitions

"We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services."

CQC usually looks at: people's experience, staff and leaders, partners, processes.

In a practice: referral tracking, two week wait safety netting, how hospital letters and discharge summaries are actioned.

3. Safeguarding

"We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately."

CQC usually looks at: staff and leaders, partners, observation.

In a practice: a policy that names your practice and leads, training at the level each role needs, a reviewed register of vulnerable patients. Processes is not listed here; inspectors expect to hear it from staff and partners.

4. Involving people to manage risks

"We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: how reception and clinicians spot and escalate a deteriorating patient, sepsis awareness, emergency equipment checks.

5. Safe environments

"We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care."

CQC usually looks at: staff and leaders, observation, processes.

In a practice: premises risk assessments, fire and legionella records, calibration, emergency medicines and equipment in date. What the inspector sees on the day counts.

6. Safe and effective staffing

"We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: recruitment files and DBS checks, a training record for everyone including reception,

induction, appraisal and supervision records, a rota that covers sessions safely.

7. Infection prevention and control

"We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly."

CQC usually looks at: people's experience, staff and leaders, observation, processes.

In a practice: a named IPC lead, an annual audit with an action plan that was followed up, cleaning schedules, staff immunisation records.

8. Medicines optimisation

"We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen."

CQC usually looks at: people's experience, staff and leaders, observation, processes, and for GP services, outcomes.

In a practice: prescribing audits, high risk drug monitoring, MHRA alerts actioned, fridge logs, patient group directions, medication reviews. One of two statements where CQC lists outcomes for GP services, so prescribing data is in play.

Effective: six quality statements

CQC: "By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence."

9. Assessing needs

"We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: long term condition reviews, care planning for complex patients, communication needs recorded and met.

10. Delivering evidence-based care and treatment

"We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: clinical audit against NICE guidance, how new guidance reaches clinicians, record reviews. CQC says it may "carry out online reviews of clinical records."

11. How staff, teams and services work together

"We work effectively across teams and services to support people. We make sure they only need to tell

their story once by sharing their assessment of needs when they move between different services."

CQC usually looks at: people's experience, staff and leaders, partners, processes.

In a practice: multidisciplinary meetings with minutes, shared care arrangements, working with the PCN and community teams.

12. Supporting people to live healthier lives

"We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: screening and immunisation uptake and what you do about low uptake, social prescribing, health checks.

13. Monitoring and improving outcomes

"We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves."

CQC usually looks at: people's experience, staff and leaders, processes, and for GP services, outcomes.

In a practice: completed audit cycles, outcome data used for improvement rather than filed, evidence that results changed something. The second statement where outcomes is listed for GP services.

14. Consent to care and treatment

"We tell people about their rights around consent and respect these when we deliver person-centred care and treatment."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: a consent policy, mental capacity assessments recorded properly, consent documented for procedures.

Caring: five quality statements

CQC: "By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect."

15. Kindness, compassion and dignity

"We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect."

CQC usually looks at: people's experience, staff and leaders, partners for GP services, observation.

In a practice: GP patient survey results and what you did with them, privacy at reception, chaperone arrangements, how staff speak to patients on the day.

16. Treating people as individuals

"We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: reasonable adjustments recorded and acted on, interpreter use, carers identified and supported.

17. Independence, choice and control

"We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: shared decision making, online access to records and appointments, support for self management.

18. Responding to people's immediate needs

"We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress."

CQC usually looks at: people's experience, staff and leaders.

In a practice: how reception handles a distressed or unwell patient, and what staff say about it. No processes category is listed here.

19. Workforce wellbeing and enablement

"We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care."

CQC usually looks at: staff and leaders, processes.

In a practice: staff surveys and what changed after them, wellbeing support, how leaders respond when staff raise pressure.

Responsive: seven quality statements

CQC: "By responsive, we mean that services are organised so that they meet people's needs."

20. Person-centred care

"We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs."

CQC usually looks at: people's experience, staff and leaders.

In a practice: care plans patients have agreed, continuity for those who need it, feedback that says people were involved.

21. Care provision, integration, and continuity

"We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity."

CQC usually looks at: staff and leaders, partners, processes.

In a practice: knowing your population, services shaped to it, partners who can describe how you work with them.

22. Providing information

"We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: the Accessible Information Standard in use, an up to date website and leaflet, translated or easy read material where needed.

23. Listening to and involving people

"We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: a complaints process that is analysed, a patient participation group with evidence of influence, friends and family test results, "you said, we did" that is real.

24. Equity in access

"We make sure that everyone can access the care, support and treatment they need when they need it."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: appointment and demand data, how same day and routine capacity is monitored, telephone performance, digital and non digital routes, what you have done for groups who struggle to get in.

25. Equity in experiences and outcomes

"We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: knowing which groups on your list do worse, and something you changed because of it.

26. Planning for the future

"We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life."

CQC usually looks at: people's experience, staff and leaders, processes.

In a practice: a palliative care register with regular review, advance care planning, DNACPR decisions recorded correctly.

Well-led: eight quality statements

CQC: "By well-led, we mean that 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."

27. Shared direction and culture

"We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these."

CQC usually looks at: staff and leaders, processes.

In a practice: a strategy staff recognise, values that show in how the practice runs, leaders who describe the challenges honestly.

28. Capable, compassionate and inclusive leaders

"We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty."

CQC usually looks at: staff and leaders, processes.

In a practice: clear leadership roles, visible and approachable partners and managers, succession planning.

29. Freedom to speak up

"We foster a positive culture where people feel that they can speak up and that their voice will be heard."

CQC usually looks at: staff and leaders, processes.

In a practice: a speak up policy staff know, a named guardian or route, examples of concerns raised and acted on.

30. Workforce equality, diversity and inclusion

"We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality

and equity for people who work for us."

CQC usually looks at: staff and leaders for GP services, processes.

In a practice: equality and diversity policy and training, fair recruitment, reasonable adjustments for staff.

31. Governance, management and sustainability

"We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate."

CQC usually looks at: staff and leaders, processes.

In a practice: meetings that record decisions, a reviewed risk register, current policies that name your practice, business continuity, data security and the DSPT, performance information leaders actually use.

32. Partnerships and communities

"We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement."

CQC usually looks at: people's experience, staff and leaders, partners, processes.

In a practice: the PCN, the ICB, community and voluntary services, and evidence those relationships produce something for patients.

33. Learning, improvement and innovation

"We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research."

CQC usually looks at: staff and leaders for GP services only, processes.

In a practice: completed quality improvement projects, learning shared beyond the practice, staff who can name something the practice changed and why.

34. Environmental sustainability - sustainable development

"We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same."

In a practice: a green plan or equivalent, inhaler prescribing and waste, energy and travel. One point of precision: this statement sits under Well-led on CQC's assessment framework pages, but it is not on CQC's primary health services evidence categories page, which lists seven Well-led statements. We have kept it because it is in the framework, and left the evidence categories blank because CQC has.

A guide, not a checklist

That line is CQC's, and it cuts both ways. A document for every statement does not earn a 3, and a missing document does not automatically earn a 1. The score is the inspector's judgement of the evidence in the categories they looked at, and CQC says the evidence for GP practices "will be different to what we'll have available to us in an assessment of a home care service." So the evidence has to do two things: exist, and show the thing the statement describes. A significant event log that records that an event was discussed does not show a learning culture. One that records what changed does.

What is changing at CQC

CQC has said it will remove scoring from its assessment approach, and that future rating judgements "will be made holistically using the professional judgement of our inspection teams." It published four draft sector specific frameworks in March 2026, including one for primary care and community services, in which quality statements are replaced by key lines of enquiry. Consultation closed on 12 June 2026. Pilots run from June to October with evaluation in November, and CQC says pilot judgements "have no legal standing and will not affect regulatory status or rating."

None of that is live. CQC's May 2026 update tells providers to "continue to refer to the current published guidance on how we assess quality and performance" until the new approach is implemented. Its August update says it is still testing and piloting the draft frameworks across all sectors, with more sector specific engagement planned for the autumn, and it gives no start date. Until CQC brings the new approach in, the single assessment framework and these 34 statements are what your practice is assessed against. We will publish a full guide to the draft primary care framework once we have read it in full and CQC has said more about timing, and we will update this page when CQC confirms a date.

Know what your evidence says before CQC reads it

The list tells you what CQC assesses. It does not tell you what your evidence would score. Our free Self-Check takes you through every quality statement in around one to two hours and gives you a rating and a report based on what you tell us. The Full AI audit goes further: it reads the documents your practice already holds, interviews you on them the way an inspector would, and scores what you can show against each of the 34 statements, with the reasoning written out. Start your free Self-Check at cqcaudit.ai.

Frequently asked questions

How many CQC quality statements are there?

Thirty four across the five key questions: eight under Safe, six under Effective, five under Caring, seven under Responsive and eight under Well-led, counted from CQC's assessment framework pages.

Does CQC look at every quality statement in every assessment?

Not necessarily. CQC says it can look at "one, several or all." For a service never rated, it assesses all statements in a key question before publishing a rating. Under Returning to Good and Outstanding, it reviews non clinical quality statements in lower risk practices.

Are the quality statements being replaced?

CQC's draft sector frameworks replace them with key lines of enquiry, and CQC has said it will remove scoring. The drafts are in pilot and are not live. Until CQC implements the new approach, the 34 quality statements apply.

What evidence does CQC want for the quality statements?

CQC groups evidence into six categories and publishes which it usually looks at for each statement in primary care. It calls the lists "a guide, not a checklist" and asks for "information they already have" rather than documents prepared for the inspection.

Ask us

We do not run comments on Insights. If there is a quality statement you would like us to go deeper on, ask on our LinkedIn page or reply to the newsletter and we will cover the questions that keep coming up.

Sources

- CQC, Assessment framework and the five key question pages with each quality statement (Safe page last updated 22 February 2024; statement pages 22 February and 25 June 2024). Read 28 September 2026.
- CQC, Primary health services: evidence categories (index 22 February 2024; Responsive 5 July 2024; Well-led 13 August 2025). Read 28 September 2026.
- CQC, Assessing quality and performance (2 July 2026); Differences from our previous model (21 May 2024); How we gather evidence (21 May 2024); How we reach a rating (13 May 2025). Read 28 September 2026.
- CQC, Evidence categories (29 April 2024); Evidence categories for sector groups (4 February 2025); Processes (22 February 2024). Read 28 September 2026.
- CQC, Glossary of terms used in the guidance for providers and managers (16 May 2025). Read 28 September 2026.
- CQC, Our initial response to our public consultation: Better regulation, better care; Give your views on draft sector-specific assessment frameworks (15 June 2026); Piloting, testing and evaluation of new assessment method (4 June 2026); Priorities for delivering more assessments and tackling aged ratings (26 May 2026); Rebuilding our regulatory approach and digital services (27 August 2026). Read 28 and 30 September 2026.