

# Additional section 2: New location details

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| **The new location(s) and the regulated activities and service types provided at them** |
| Please provide details about the regulated activities and services you will provide at the location shown below.  We need information about services because your registration fees are based on the services you provide.  **If you don’t give us full information about all of your new locations we will have to return your application.** |

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| **\*2.1** Location Readiness |
| You must not begin to provide regulated activity (or activities) at a new location until that location is included in your conditions of registration. Do not Submit this application if your location is not ready to be assessed as this will result in your application being returned. |

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| **\*2.2 Purchase or transfer of existing location(s)** | | | | | |
| Is this application the result of the purchase or transfer of a service for which a different provider is already registered under the Health and Social Care Act 2008 (as amended)? | | | | | |
| Yes | |  | No |  |  |
| If ‘Yes', please fill in the details of the existing registered provider below: | | | | | |
| \*CQC provider name |  | | | | |
| \*CQC Provider ID (if known) |  | | | | |
| \*Business telephone number |  | | | | |
| \*Business Email address |  | | | | |
| CQC may need to contact the existing provider regarding this application.  Please check/tick if you do **not** wish CQC to contact the existing provider regarding this application.  Check/Ticking this box may result in delays to processing your application. | | | |  |  |

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| **\*2.3 Details for Location number:** | | **1** | **of:** | |  | **locations** |
| CQC Location ID (if known) |  | | | | | |
| \*Name of location |  | | | | | |
| \*Address line 1 |  | | | | | |
| \*Address line 2 |  | | | | | |
| \*Town/city |  | | | | | |
| County |  | | | \*Postcode | |  |
| \*Business/mobile telephone number |  | | | | | |
| No of places or beds (\*if applicable) | | | | | |  |
| \*Business Email address |  | | | | | |

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| **\*2.4 Planning consent** | | | | | | | | |
| Does this location have planning consent to provide the regulated activity (or activities) you intend to carry on there? | | | | | | | | |
| Yes | |  | No |  | Not applicable | |  |  |
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| Local authority |  | | Date of consent received (dd/mm/yyyy) | | |  | |  |
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| Where you have indicated **no** or **not applicable** and you do not have planning consent, please explain why it is not needed or why it is not yet received. | | | | | | | | |
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| **\*2.5 Building Regulations** | | | | | | |
| Is there Building Regulations approval for any applicable building works undertaken at this location? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
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| Where you have indicated **no** or **not applicable** and the relevant Building Regulations Certificates have yet to be issued, please tell us when you expect to receive them. | | | | | | |
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| **\*2.6 Food safety** | | | | | | |
| If you will provide food to the people who use your service at or from this location, have you registered with the relevant local council’s Environmental Health Department as a food business? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
| Where you have not registered with the Environmental Health Department or if you have indicated this is not applicable please explain why. | | | | | | |
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| **\*2.7 Safety of equipment, plant and utilities** | | | | | | |
| Do you have maintenance contracts in relation to all the equipment, plant and utilities you own, lease or use – or will own, lease or use – in relation to providing your service in this location? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
| If ‘No’, please describe the equipment, plant and utilities not covered by maintenance contracts and how you will ensure that servicing and repairs are undertaken in a timely and prompt way, as required by their manufacturer’s instructions. | | | | | | |
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| **\*2.8 Landlord/Mortgage lender permission** | | | | | | |
| Where you do not own this location, do you have your landlord’s written permission to use it to carry on the regulated activity (or activities) you intend to provide there?  Where you do not own this location and you have a mortgage, do you have the mortgage lender’s written permission to use it to carry on the regulated activity (or activities) you intend to provide there? | | | | | | |
| Yes |  | No |  | Not applicable |  |  |
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| Where you do not have the landlord’s or mortgage lender’s permission, please explain why it is not needed or not yet received. | | | | | | |
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| **\*2.9 The regulated activities you will carry on at this location** | | |
| Please check/tick the regulated activities you want to carry on at this location. These are defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended), Regulation 3 and Schedule 1.  **Note: You cannot apply to carry on regulated activities that you are not already registered to provide. If you wish to add a regulated activity, a different form is available for this** | | |
| Personal care – (RA1) |  |  |
| Accommodation for persons who require nursing or personal care – (RA2)  (Please also see Section 3.12 in each location section if you have  checked/ticked this activity) |  |  |
| Accommodation for persons who require treatment for substance misuse – (RA3) |  |  |
| Treatment of disease, disorder or injury – (RA5) |  |  |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 – (RA6) |  |  |
| Surgical procedures – (RA7) |  |  |
| Diagnostic and screening procedures – (RA8) |  |  |
| Management of supply of blood and blood derived products – (RA9) |  |  |
| Transport services, triage and medical advice provided remotely - (RA10) |  |  |
| Maternity and midwifery services – (RA11) |  |  |
| Termination of pregnancies – (RA12) |  |  |
| Services in slimming clinics – (RA13) |  |  |
| Nursing care – (RA14) |  |  |
| Family planning service - (RA15) |  |  |

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| **\*The services provided at this location** |
| Before you complete this section, you are strongly advised to read the guidance about service types that can be found in the ‘Guidance for providers about meeting the regulations’.  The service type(s) you select are used to calculate your annual fee, so it is important to select only those that apply to each of the locations you are applying to add to your conditions of registration.  You should also read our guidance for providers about fees before completing this section. These guidance documents are available on our website. |

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| **\*2.10 The service types provided at this location** | |
| Please check or tick **ONLY** the service types that will be provided at this location. | |
| **Healthcare services** | |
| **Acute services (ACS)**  If you have checked/ticked this service type, but the only or main activity provided at this location is one of those listed below, please **also check/tick the relevant box**.  If you provide other services at this location as well as Acute services (ACS), or more than one of the activities below at this location, **do not check/tick the boxes below.**   |  |  | | --- | --- | | (a) Haemodialysis or peritoneal dialysis |  | | (b) Dental treatment carried out under general anaesthesia |  | | (c) The termination of pregnancies |  | | (d) Hyperbaric therapy |  | | (e) Refractive eye surgery |  | | (f) Surgical procedures associated with in vitro fertilisation or assisted conception |  | | (g) Obstetric services and, in connection with childbirth, medical services |  | | (h) Cosmetic surgery |  | | (i) Acute services, where the location has no overnight beds for patients |  | |  |
| **Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)** |  |
| **Rehabilitation services (RHS)** |  |
| **Hyperbaric chamber services (HBC)** |  |
| **Hospice services (HPS)**  If you have ticked this service type, please **also** complete **one** of the following questions only:   |  |  | | --- | --- | | (a) Does your hospice service provide overnight beds for patients?  (Please complete even if your service also includes  community or outreach services.) |  | | (b) Does your service provide hospice at home services or end of life or respite care for people in the community? |  | |  |
| **Long-term conditions services (LTC)** |  |
| **Prison health care services (PHS)** |  |
| **Residential substance misuse treatment/rehabilitation services (RSM)** |  |
| **Community or integrated healthcare** | |
| **Community health care services (CHC)**  Please also tick if you are a nursing agency only |  |
| **Doctors’ consultation services (DCS)** |  |
| **Doctors’ treatment services (DTS)** |  |
| **Dental services (DEN)**  If this is a single location only please also complete the following question.   |  |  | | --- | --- | | Please state the number of dental chairs at this location  (State ‘0’ if you are a domiciliary dental provider and have no dental chairs of your own) |  |   **Do not complete this question if you are applying to carry on activities at or from more than one location.** |  |
| **Diagnostic and/or screening services (DSS)**  You should **ONLY** tick this service type if diagnostic and/or screening services are the only or main activity you provide at this location. If you provide other services at this location, you should not select this service type, even if you provide the regulated activity of Diagnostic and screening procedures.  **If you have selected DSS, please also complete the following questions:**   |  |  | | --- | --- | | (a) If you are registering as an organisation or a partnership and provide diagnostic and screening services as your sole or main activity, please check/tick this box |  | | (b) If you are registering as an individual, for the regulated activity of Diagnostic and screening procedures ONLY, AND are registering for one location ONLY, please check/tick this box |  | |  |
| **Community-based services for people with a learning disability (LDC)** |  |
| **Mobile doctor’s services (MBS)** |  |
| **Community-based services for people with mental health needs (MHC)** |  |
| **Community-based services for people who misuse substances (SMC)** |  |
| **Urgent care services (UCS)** |  |
| **Residential social care** | |
| **Specialist college service (SPC)** |  |
| **Care home service with nursing (CHN)** |  |
| **Care home service without nursing (CHS)** |  |
| **Community social care** | |
| **Domiciliary care service (DCC)** |  |
| **Extra Care housing services (EXC)** |  |
| **Shared Lives (SHL)** |  |
| **Supported living service (SLS)** |  |
| **Miscellaneous healthcare** | |
| **Ambulance services (AMB)** |  |
| **Blood and transplant services (BTS)** |  |
| **Remote clinical advice services (RCA)** |  |

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| **For Primary Medical Service providers only**  Please select what type of location this is. | |
| **NHS GP practice** |  |
| **NHS out-of-hours service** |  |
| **Urgent care centre** |  |
| **Minor injury unit** |  |
| **Walk-in centre** |  |
| **Other** |  |
| **Please check/tick the box if you are a dispensing practice** |  |

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| **2.11 Condition of registration about the number of persons accommodated to receive nursing or personal care at this location** | | |
| Only check or tick the box in this section if you checked / ticked the regulated activity ‘Accommodation for persons who require nursing or personal care’ at Section 3.9 and either the service type ‘Care home service without nursing’ or ‘Care home service with nursing’ at Section 3.10**. If this does not apply to you go straight to Section 3.13.**  Please check / tick the box below to confirm that you are agreeing in writing to a condition of registration that says:  **“The number of persons accommodated to receive nursing or personal care at this location must not exceed [number].”**  The number in this condition will normally be the one you filled in at Section 3.3 (number of places or beds). We will contact you if we decide we cannot agree to your proposed number for this condition. | | |
| **I/We agree in writing to the condition of registration shown above, using the number of places or beds we proposed in Section 3.3 of this form** |  |  |

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| **2.12 Condition of registration about not providing nursing care at this location** | | |
| Only check / tick the box below if you checked / ticked the regulated activity ‘Accommodation for persons who require nursing or personal care’ at Section 3.9 **AND** the service type‘Care home service without nursing (CHS)’ at Section 3.10. **If this does not apply to you please go to Section 3.13.**  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **“The provider must not provide nursing care under the accommodation for persons who require nursing or personal care regulated activity at this location.”** | | |
| **I/We agree in writing to the condition of registration shown above** |  |  |

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| **2.13 Condition of registration about the regulated activity (or activities) at this and other locations** | | |
| Please check / tick below to confirm that you are agreeing in writing to a condition of registration in respect of each regulated activity that says:  **“This Regulated Activity may only be carried on at or from the following locations:**  **<First location>**  **<Second location> (if there is one)**  **(and so on for any more locations)”**  The locations in this condition will be those specified in each Section 3 submitted with this application. The regulated activities will be the ones you specified in Section 3.9. | | |
| **I/We agree in writing to the condition of registration shown above** |  |  |

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| **\*2.14 Service user bands** | | | | | | | |
| Please look at our [**guidance on service user bands**](https://www.cqc.org.uk/guidance-providers/registration/service-user-bands) before you complete this section.  Please check or tick **all** of the descriptions / service user bands for the people that will use this location. If you will provide a service to everyone you can check or tick “Whole population”.  **Who will use the services at this location?**   General public (all GPs and most primary medical services should select this)  Specific groups (e.g. only people with mental health needs or specific age groups) | | | | | | | |
| **Age groups** | | | | | | | |
| Whole population | Children  0 to 3 | Children  4 to 12 | | Children  13 to 17 | Adults  18 to 65 | Adults  65 + | |
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| **Service user band** | | | | | | | |
| Dementia | | |  | People detained under the Mental Health Act | | |  |
| Mental health | | |  | People who misuse drugs or alcohol | | |  |
| People with an eating disorder | | |  | Sensory impairment | | |  |
| Learning disabilities or autistic spectrum disorder | | |  | Physical disability | | |  |

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| **2.15 Condition of registration about providing a specialist service to people with a learning disability or people with a learning disability and autism.** | | |
| [**(See Guidance on agreeing to routine conditions)**](http://www.cqc.org.uk/applicationhelp62)  **This section only applies if you:**   * have applied for **ANY** of the following regulated activities:   + Accommodation for persons who require nursing or personal care   + Personal care   + Assessment or medical treatment for persons detained under the Mental Health Act 1983   **AND**   * have **NOT** selected the service user band of Learning disability or autistic spectrum disorder in section 3.14 above.   **If this does not apply to you, go straight to section 4 below.**  If this location will provide community or residential adult social care services  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for care or support is as a direct result of the person’s learning disability and or autism at or from [this location].’**  If this location will provide in-patient mental health services.  Please check / tick below to confirm that you are agreeing in writing to a condition of registration that says:  **‘The registered provider must not provide [regulated activity] in a specialist service to people whose presenting need for assessment or treatment is as a direct result of the person’s learning disability and or autism at or from [this location].’**  Note: We are adding this condition because you will not be providing a specialist service to people with a learning disability or autistic people. Because of this we will not assess your ability to deliver a service in line with [**Right support, right care, right culture**](https://www.cqc.org.uk/guidance-providers/autistic-people-learning-disability/right-support-right-care-right-culture).  If want to provide a specialist service to people with a learning disability or autistic people in the future, you can apply to remove the condition. We must approve your application before you start providing the service. | | |
| **I/We agree in writing to the condition of registration shown above** |  |  |

**Important**: Please note if you have not agreed to the condition above because you are intending to provide a specialist service to people with a learning disability and autistic people you will also need to submit an [additional form](https://www.cqc.org.uk/sites/default/files/2022-06/20220504_additional_form_for_providers_of_services_for_autistic_people_and_people_with_%20learning_disabilities.docx) to support your application process.

**Section 3: How you will provide your service**

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| **\*3.1 Please describe how you will ensure this location will be safe and that the service provided will be caring, responsive, effective and well-led** |
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