

# Additional Section 6: New locations where you want to carry on the new regulated activity

For use ONLY by existing providers when applying to add a new regulated activity

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| **\*6.1 Locations, regulated activities and service types** |
| Please use this form to provide details about an additional location where you are applying to add a new regulated activity to your registration and want to carry the new activity on at a new location.  You must use a separate form for each additional location where you will carry on the new activity.  Please give each new location a number so that we know you have sent us information about all of the new locations. If you don’t give us information about all of your locations we will have to return your application. |

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| The information below is for new location number: |  | of a total of: |  | new locations |

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| **\*6.1 Purchase or transfer of existing location(s)** | | | | | | | |
| Does this application involve the purchase or transfer of location(s) being used by an existing provider that is already registered under the Act? | | Yes |  | No |  | |  |
| If ‘Yes', please fill in the details of the existing registered provider below: | | | | | | | |
| \*CQC provider name |  | | | | | | |
| \*CQC Provider ID |  | | | | | | |
| CQC Location ID |  | | | | | | |
| \*Business/mobile telephone number |  | | | | | | |
| \*Email address |  | | | | | | |
| CQC may need to contact the existing provider about this application. Please tick if you do **not** wish CQC to contact the existing provider about this application. | | | | |  |  | |

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| **6.2 Details for Location number:** | | **1** | **of:** |  | **locations** |
| \*Name of location |  | | | | |
| \*Address line 1 |  | | | | |
| \*Postcode |  | | | | |
| No of places or beds (\*if applicable) | |  | | | |
| **Day-to-day management of regulated activity at this location** | | | | | |
| Where required, applications for registration from managers in respect of this location, including from *existing* managers to continue their registration to manage it under your registration, must be submitted **with this application**. | | | | | |

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| **\*6.3 All regulated activities you propose to carry on at this location** | | | |
| **You cannot apply to carry on a regulated activity at this location that is not also checked / ticked in Section 1.2** | | | |
| Personal care – (RA1) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Accommodation for persons who require nursing or personal care – (RA2) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Accommodation for persons who require treatment for substance misuse – (RA3) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Treatment of disease, disorder or injury – (RA5) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 – (RA6) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Surgical procedures – (RA7) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Diagnostic and screening procedures – (RA8) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Management of supply of blood and blood derived products – (RA9) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Transport services, triage and medical advice provided remotely - (RA10) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Maternity and midwifery services – (RA11) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Termination of pregnancies – (RA12) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Services in slimming clinics – (RA13) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Nursing care – (RA14) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| Family planning services - (RA15) |  | |  |
| Please provide below an explanation for choosing this regulated activity and describe what service you will be providing at this location. | | | |
| **\*6.4 The service types 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 about the Regulations for Providers**  **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 registering**.  **You should also read our guidance for providers about fees before completing this section.** These guidance documents are available on our website. 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 doctors 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 indicate if this is a dispensing practice** |  |

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| **6.5 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 6.3 and either the service type ‘Care home service without nursing’ or ‘Care home service with nursing’ at Section 6.4 above**. If this does not apply to you go straight to Section 6.7.**  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 6.2 above (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 6.2 of this form |  |  |

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| **6.6 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 6.3 **AND** the service type‘Care home service without nursing (CHS)’ at Section 6.4. **If this does not apply to you please go to Section 6.7.**  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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| **6.7 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 6.2 submitted with this application. The regulated activities will be the ones you specified in Section 6.3. | | |
| I/We agree in writing to the condition of registration shown above |  |  |

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| **\*6.8 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 disability or autistic spectrum disorder | | |  | | Physical disability | | |  |

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| **\*6.9 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 | |  |  |
| T | | | | | | | | |
| Local authority |  | | Date of consent  (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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| **\*6.10 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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| **\*6.11 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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| **\*6.12 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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| **\*6.13 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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