

Application to add a regulated activity to an existing provider registration

Note: You can also use this form to add a location where it will be used to carry on the new regulated activity

Application by an existing service provider

Applications under section 11 of the Health and Social Care Act 2008

This form must only be used by:

Existing service providers applying to add a regulated activity to their registration.

It can also be used to add a location where it will be used to carry on the new regulated activity.

It must not be used by:

- service providers ('providers') that are not yet registered;
- providers who want **only** to add a location; or
- managers, for any purpose.

Registration entitles you to provide 'regulated activity' as defined by Section 8 of the Health and Social Care Act 2008 and by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can read continuously updated versions of the Act and regulations on our website: www.cqc.org.uk.

It is an offence under section 10 of the Health and Social Care Act 2008 to carry on a regulated activity without being registered by the Care Quality Commission. You could be prosecuted, and it could lead to your application being refused.

Your managers

All:

- partnerships;
- organisations (excluding NHS bodies in relation to healthcare regulated activities), and
- providers who are individuals who will not be in day-to-day charge of carrying on the regulated activity in this application

must have a **registered manager** for the regulated activity, normally a separate one at each location. Managers can sometimes manage more than one regulated activity and/or location (see the relevant guidance on our website).

If any location added in this application already exists, and:

- is being transferred or sold to you by an existing registered provider, and
- has an existing registered manager who you intend to employ to manage the same regulated activity(s) with the same conditions on their registration at the same location(s)

then the manager(s) does not have to submit the normal full application forms. They can use a fast track process that uses a shorter form to both cancel their existing registration and apply for new registration with you as provider.

If you intend any registered managers already working for you to manage the regulated activity in this application, they must submit forms to add (and if necessary remove) regulated activities and/or locations, as needed.

All other managers must submit a full new registered manager application form, even if they are registered as a manager elsewhere or have been in the past.

Managers should download and fill in the appropriate forms. The form finder pages on our website will help them to do so. You must submit all required manager's form(s) with this application.

Fees

Before you complete section 3 of this form, we strongly advise you to read the guidance about service types on page 13 of the *Guidance about compliance: Essential standards of quality and safety*.

You should also read our guidance for providers about fees. Both of these documents are available on our website.

You must check or tick the boxes for the services you will provide at **each** location in this application. **The service type(s) you select are used to calculate your annual fee.** The service types you declare should match the description of your service in your Statement of Purpose. You can read more information about annual fees on our website.

Confidential personal information

Please make sure that your application does not include any confidential personal information about the people who will use your service or your staff. This includes any information that can identify a person. We will reject any application form that includes such information.

Filling in this form

You must provide an answer to every field marked with an asterisk (*). Other fields are optional but if you have the information please provide it. We will have to reject an incomplete application and return it.

You must complete the declaration of compliance section for each regulated activity at each location where it will be provided.

You can fill in and submit this form either on paper or on a computer. If you fill it in on a computer you can submit it by attaching it to an email – this is the best way to make applications to the Care Quality Commission.

This form has been prepared as a 'protected' Word document. This means that if you use a computer you can easily move from answer to answer using your 'tab', down arrow, and 'page down' keys. You can also click from answer to answer using a mouse. You can put an 'X' in checkboxes using your space bar or mouse. If you need to make changes to your answers, you can go backwards using your 'page up' key, up arrow key, or mouse.

You can't use the spell check function or format text with bullet points in protected Word documents. If you want to check spelling or use bullet points, type or paste text into a blank new document, correct any spelling errors, add any bullet points, and then copy and paste it into the appropriate part of your application form.

You can fill in this form on a computer using 'Microsoft Word' or 'Open Office'. Open Office is a free programme you can download from www.openoffice.org. The spaces for answers will expand while you type if needed.

If you are filling in this form on paper and need more space to answer any questions, please submit additional clearly numbered sheets and mark them with the question number from this form.

Additional sections

Where your application includes more than one **existing location** or more than one **new location**, you will have to download, fill in and submit relevant additional sections of the main form. There is information about this at the relevant places in this form.

If you are submitting this application by email, you must attach all of the required additional sections and manager application forms, as well as this main form, to your application email. If you are submitting your application by post you must enclose all of the forms in your application envelope.

If you do not attach or enclose additional location and manager forms *where they are needed*, we will have to return your application.

We may ask for more information and may carry out a site visit where necessary after you have submitted this form.

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Statement on the Data Protection Act 1998

You must sign the statement below. If you don't, we will have to return your application.

I understand that the Care Quality Commission will use the information provided on this form (including personal data), and other relevant information that we obtain or receive, for the purposes of performing our regulatory functions.

In particular, this information will be used to make regulatory judgements in relation to the registration of individuals and providers and in relation to monitoring compliance with relevant regulations.

This includes publication of:

- A register of providers
- Conditions of registration
- Reports relating to compliance with regulations
- Other information that we may publish to assist the public in understanding the quality of services and the regulatory actions of the Commission

Information (including personal data) may also be shared with other regulators and public bodies where necessary or expedient to assist in the exercise of public functions.

Registration application forms are processed on behalf of CQC. Personal data is processed in accordance with the Data Protection Act 1998.

If you are submitting this form electronically, we will accept a typed-in name as your signature.

*Applicant's signature	Michael Wilson
*Applicant's name	Michael Wilson
*Date (dd/mm/yy)	6 th November 2013

Section 1: Service provider and the additional regulated activity

1.1 Details of the service provider	
*CQC service provider ID [†]	1-114641605
*Name	Surrey and Sussex Healthcare NHS Trust
Name you trade under if this is different to the above	
*Business address line 1	Trust Headquarters East Surrey Hospital Redhill Surrey
*Postcode	RH1 5RH
Email address	michael.wilson@sash.nhs.uk
Telephone	01737 768511

[†] Your provider ID is found at the top right-hand side of your certificate of registration

You have already supplied CQC with an address for service of documents in accordance with Sections 93 and 94 of the Health and Social Care Act 2008 in relation to your existing registered activity(s). CQC will use this address for service in relation to the additional regulated activity being applied for. We will continue to use the full postal address you have already supplied as your contact details on our website and on your certificate of registration.

If your current address for service of documents is not an email address:

The Care Quality Commission has decided that its preferred method of sending statutory notices, including notices of proposal and decision about applications, is by email. Email ensures fast and efficient delivery of important information.

By submitting this application, you are confirming your willingness for us to use the email address shown at 1.1 above for service of documents and for sending all other correspondence to you in relation to this application and all existing regulated activities. If you do not want to receive documents by email please check or tick the box below. We will not share this email address with anyone else.

I do NOT wish to receive notices and other documents from CQC by email	<input type="checkbox"/>
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It is vital that the postal and email addresses you supply are valid, clear and accurate, and that you keep us up to date with any changes.

You can supply alternative contact details at 1.2 below if this would be helpful. We will **only** use these details while processing this application. We will not use this address for service of documents or other correspondence.

1.2 Alternative correspondence address	
Name	
Address line 1	
Address line 2	
Town/city	
County	
Postcode	
Email address	
Telephone	

*1.3 The new regulated activity

Please check / tick the regulated activity you want to add to your registration (**one only per form**).

Regulated activities are defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Schedule 1.

Personal care	<input type="checkbox"/>	
Accommodation for persons who require nursing or personal care (Please also see section 5.7 in each location section if you have checked / ticked this activity)	<input type="checkbox"/>	
Accommodation for persons who require treatment for substance misuse	<input type="checkbox"/>	
Accommodation and nursing or personal care in the further education sector	<input type="checkbox"/>	
Treatment of disease, disorder or injury	<input type="checkbox"/>	
Assessment or medical treatment for persons detained under the 1983 Act (The Mental Health Act 1983)	<input type="checkbox"/>	
Surgical procedures	<input type="checkbox"/>	
Diagnostic and screening procedures	<input type="checkbox"/>	
Management of supply of blood and blood derived products etc	<input checked="" type="checkbox"/>	
Transport services, triage and medical advice provided remotely	<input type="checkbox"/>	
Maternity and midwifery services	<input type="checkbox"/>	
Termination of pregnancies	<input type="checkbox"/>	
Services in slimming clinics	<input type="checkbox"/>	
Nursing care	<input type="checkbox"/>	
Family planning service	<input type="checkbox"/>	

Section 2: Nominated individuals (organisations only)

Section 2 is **ONLY** to be completed by providers that are **organisations** (for example, companies, NHS trusts, local authorities and charities)

Partnerships and individuals, please go straight to Section 3

*2.1 Nominated individual details	
Please provide details of the nominated individual for the new regulated activity (this may be an existing nominated individual).	
*Title	Mr
*First name	Michael
Middle name (if applicable)	
*Last name	Wilson
Previous name (if applicable)	
*Business address line 1	Surrey & Sussex Healthcare NHS Trust Trust Headquarters, East Surrey Hospital, Canada Avenue, Redhill, Surrey RH1 5RH
*Business address line 2	Trust Headquarters, East Surrey Hospital, Canada Avenue
*Town/city	Redhill
*County:	Surrey
*Postcode	RH1 5RH
*Email	Michael.Wilson@sash.nhs.uk
*Main business telephone	01737 768511
Fax	

If this is a **new** nominated individual, please also complete sections 2.2 and 2.3

If this is an existing nominated individual, please go straight to section 3

*2.2 Criminal Records Bureau disclosure

Have you applied for and received an **enhanced** Criminal Records Bureau disclosure for the **Nominated Individual** above? (Note that this does not need to be countersigned by CQC.)

Yes



No



If you have not done so, we will have to return your application

Please fill in the CRB number and date of disclosure below

*2.3 Checklist for information about a nominated individual that must be available to the provider

Please confirm that the following information is available if required by the provider.
(Check / tick to show that the information is available, leave blank for no)

The complete list of information that must be available if required by providers can be found in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

If any information is not available, we will have to return your application.

Proof of identity including a recent photograph



A full employment history, together with a satisfactory written explanation of any gaps in employment



Satisfactory evidence of conduct in relevant previous employment where such employment was concerned with the provision of services relating to:



- health and social care
- children or vulnerable adults

If they have previously worked in a position whose duties involved work with vulnerable adults or children, verification (so far as is reasonably practical) of the reason why they left the position and a name and address of someone we can contact to discuss this, if required



Documentary evidence of all relevant qualifications



Section 3: Application details

This section must be filled in by ALL applicants

*3.1 Statement on complying with relevant regulations

Please provide a detailed statement on how you will comply with the regulations relevant to the regulated activity you are applying to add to your registration.

(See our guidance on adding a new regulated activity.)

We may ask for further documents and evidence to support this application.

The Trust provides blood products to other healthcare providers in the local area (2 sites are where the Trust already provides clinical services) underpinned with Service levels Agreements.

The Blood Transfusion department is accredited (as part of Integrated Blood Sciences) with CPA (UK) Ltd and the Trust is compliant with the Blood Safety and Quality Regulations 2005 (as amended) as regulated by the Medicines and Healthcare Products Regulatory Agency.

*3.2 Start date

It takes CQC up to eight weeks to process most applications, and sometimes more. You must not begin to provide the new regulated activity until you are registered to do so.

*When would you like to begin carrying on the additional regulated activity in this application (dd/mm/yy)?

01/01/13

***3.3 Statement of purpose**

The law says that your statement of purpose must be up to date. You are changing the details of your registration, so you must send us an amended copy of the statement of purpose that covers the locations in this application.

If you don't, we will have to return your application.

Every service provider is required by law to have a statement of purpose for each of the regulated activities they carry on. If you carry on more than one regulated activity you can either have separate statements or combine them into one.

By law, the statement of purpose must include:

1. The aims and objectives of the service provider in carrying on the regulated activity.
2. The kinds of services provided for the purposes of carrying on the regulated activity and the range of service users' needs which those services are intended to meet.
3. The full name of the service provider and of any registered manager, together with their business address, telephone number and, where available, electronic mail addresses.
4. The legal status of the service provider.
5. Details of the locations at which the services provided for the purposes of the regulated activity are carried on.

Statements of purpose should provide:

- An overview of the regulated activity and the locations you carry it on from.
- Information that is detailed enough to enable us to understand what happens at each location, so that we can assess the risks involved. For example, instead of saying "we carry out surgery at hospital x" the statement should say what type of surgery is provided and who it is for: "The surgery we carry out at xx includes specialist surgery such as cardiac and neurosurgery. Cardiac surgery is provided for children as well as adults".
- The lines of accountability for the regulated activity and contact details for the registered person(s) carrying on and managing it.

Section 4: Locations

*4.1 Purchase or transfer of an existing service

Is this application the result of the sale or transfer of a service for which a different person is already registered as provider under the Health and Social Care Act 2008?

Yes

No

*4.2 Location readiness

Is / are the location(s) you will use to carry on the additional regulated activity ready to meet the needs of the people who will use it / them?

Yes

No

If 'No', please describe any building work, conversions, or planning applications that are currently under way, and the date this is expected to be finished.

If you want to carry on the new regulated activity at location(s) that are **already on your certificate of registration**, please now complete Section 5.

If you **ONLY** want to carry on the new regulated activity at **new** locations that are **not** shown on your existing certificate of registration, please go straight to Section 6.

Section 5: Existing locations where you want to carry on the new regulated activity

Please provide details about the services you would provide at relevant locations on your **existing** certificate of registration **if your application to carry on the new regulated activity is approved.**

We need this information because your registration fees are based on the services you provide.

If you are applying to provide the new regulated activity at more than one existing location, you can download additional copies of Section 5 from the website page where you found this form.

If you are filling in this form on paper and need extra space, please add extra numbered sheets as needed and mark them with the question number from this form.

Please give each existing location where you will carry on the new regulated activity 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 these locations we will have to return your application.

The information below is for existing location number:	1	of a total of:		existing locations where I / we will carry on the new regulated activity
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*5.1 Location details

Please fill in the CQC location ID number and address details for **the first existing location on your certificate of registration** where you want to provide the additional regulated activity

* CQC Location 1 ID	RTP
* Location name	East Surrey Hospital
* First line of the address	Trust Headquarters, East Surrey Hospital, Canada Avenue
* Postcode	RH1 5RH

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**.

*The services provided at this location

Please check or tick in the sections below to show the service types that will be provided at this location.

Before you continue, we strongly advise you to read the guidance about service types on page 13 of the *Guidance about compliance: Essential standards of quality and safety*, and our guidance for providers about the fees scheme.

The service types you select may decide your annual fee once you are registered. It is therefore important that you select the correct service types for this location.

Please work through the questions in order, starting with question 5.2

*5.2 Prison Healthcare Services

Do you ONLY provide Prison Healthcare Services (PHS)?

Yes

No

If YES now go to question 5.6

If NO now go to question 5.3

*5.3 Acute Services

Do you ONLY provide Acute Services (ACS)?

Yes

No

If YES now go to question 5.4

If NO now go to question 5.6

*5.4 Further information about Acute Services (only)

Only answer this question if you checked or ticked that you will provide ONLY Acute Services (ACS) in question 5.3.

Where you provide ONLY ONE of the activities below at this location and it is the sole or main activity carried on there, please check or tick it.

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 complete this section**. Instead, go to question 5.5.

(a) dental treatment carried out under general anaesthesia	<input checked="" type="checkbox"/>	
(b) obstetric services and, in connection with childbirth, medical services	<input checked="" type="checkbox"/>	
(c) the termination of pregnancies	<input checked="" type="checkbox"/>	
(d) cosmetic surgery	<input type="checkbox"/>	
(e) haemodialysis or peritoneal dialysis	<input type="checkbox"/>	
(f) refractive eye surgery involving use of a laser or intense pulsed light	<input checked="" type="checkbox"/>	
(g) activities to which the service type DSS (diagnostics and or screening services) applies	<input checked="" type="checkbox"/>	
(h) procedures carried out under anaesthesia or intravenous sedation where those procedures are associated with in vitro fertilisation or assisted conception	<input type="checkbox"/>	

*5.5 Acute Services together with other services

Do you provide Acute Services with overnight beds

Yes



No



Now go to question 5.6

*5.6 Service types

Please check or tick ALL of the service types that will be provided at this location

Acute services (ACS)	<input checked="" type="checkbox"/>
Prison healthcare services (PHS)	<input type="checkbox"/>
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	<input type="checkbox"/>
Hospice services (HPS)	<input type="checkbox"/>
Rehabilitation services (RHS)	<input type="checkbox"/>
Long-term conditions services (LTC)	<input type="checkbox"/>
Residential substance misuse treatment and/or rehabilitation service (RSM)	<input type="checkbox"/>
Hyperbaric chamber (HBC)	<input type="checkbox"/>
Community healthcare service (CHC)	<input type="checkbox"/>
CHC: Please also tick if you are a nursing agency only	<input type="checkbox"/>
Community-based services for people with mental health needs (MHC)	<input type="checkbox"/>
Community-based services for people with a learning disability (LDC)	<input type="checkbox"/>
Community-based services for people who misuse substances (SMC)	<input type="checkbox"/>
Urgent care services (UCS)	<input type="checkbox"/>
Doctors consultation service (DCS)	<input type="checkbox"/>
Doctors treatment service (DTS)	<input type="checkbox"/>
Mobile doctor service (MBS)	<input type="checkbox"/>
Dental service (DEN)	<input checked="" type="checkbox"/>
Diagnostic and or screening service (DSS)	<input checked="" type="checkbox"/>
Care home service without nursing (CHS)	<input type="checkbox"/>
(Please also see section 5.7 below if you have checked / ticked this service type)	
Care home service with nursing (CHN)	<input type="checkbox"/>
Specialist college service (SPC)	<input type="checkbox"/>
Domiciliary care service (DCC)	<input type="checkbox"/>
Supported living service (SLS)	<input type="checkbox"/>
Shared Lives (SHL)	<input type="checkbox"/>
Extra Care housing services (EXC)	<input type="checkbox"/>
Ambulance service (AMB)	<input type="checkbox"/>
Remote clinical advice service (RCA)	<input type="checkbox"/>
Blood and Transplant service (BTS)	<input checked="" type="checkbox"/>

*5.7 Accommodation for persons who require nursing or personal care

Only answer this question if you checked / ticked:

‘Accommodation for persons who require nursing or personal care’ as a regulated activity you intend to provide at this location at section 3.2 above, **AND**

‘Care home service without nursing (CHS)’ at section 3.8 above

(If this does not apply to you please go straight to section 3.10 below)

The regulated activity(s) you selected at 3.2 above and the service types you selected at 3.8 above show that you are not applying to provide nursing care at this location. Please 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 agree to the condition shown above

*5.8 Service user bands

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 ‘The whole population’.

Adults aged 18-65	<input type="checkbox"/>	Adults aged 65+	<input type="checkbox"/>
Mental health	<input type="checkbox"/>	Sensory impairment	<input type="checkbox"/>
Physical disability	<input type="checkbox"/>	People detained under the Mental Health Act	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	People who misuse drugs or alcohol	<input type="checkbox"/>
People with an eating disorder	<input type="checkbox"/>	Learning difficulties or autistic spectrum disorder	<input type="checkbox"/>
Children aged 0 – 3 years	<input type="checkbox"/>	Children aged 4-12	<input type="checkbox"/>
		Children aged 13-18	<input type="checkbox"/>
The whole population	<input type="checkbox"/>	Other (please specify below)	<input type="checkbox"/>

5.9 Declaration of compliance at this existing location

Before you make this declaration you must refer to the Health and Social Care Act 2008 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which set out the legal obligations on a person or organisation registered to provide regulated activities. You must be sure you have understood their requirements.

The Guidance about Compliance for providers shows how the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 regulation can be met.

You may decide to comply with relevant regulations in another way. If you do you should be ready to explain how and why you comply with the relevant regulation(s), and provide evidence where necessary about how your alternative approach will be just as or more effective in making sure that the regulations are met.

You must have regard to Regulation 26(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which requires registered persons to have regard to the Guidance about Compliance.

You must declare compliance with all of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the regulated activities you will carry on at this location.

We declare that we will comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 for each regulated activity that we will carry on at this location:

Yes

No

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

*6.1 Locations, regulated activities and service types

Please provide details about the **new** locations where you will carry on the new regulated activity. This means locations that are not on your current certificate of registration. These include new build locations, locations currently carried on by other providers, or locations you are converting from other uses.

If you are applying to provide the new regulated activity at more than one new location, you can download additional copies of Section 6 from the website page where you found this form.

If you are filling in this form on paper and need extra space, please add extra numbered sheets as needed, mark them with the question number from this form.

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.

The information below is for new location number:	1	of a total of:		new locations
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CQC Location ID			
(If another provider is already registered to carry on or manage regulated activity here)			
*Name of location			
*Location address line 1			
*Location address line 2			
*Town/ city		*County	
*Postcode		*Telephone	
*No of places or beds (not NHS)		Fax	
Email			
Website			

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**.

*The services provided at this location

Please check or tick the service types that will be provided at this location.

Before you continue, we strongly advise you to read the guidance about service types on page 13 of the Guidance about Compliance: Essential standards of quality and safety, and our guidance for providers about the fees scheme.

The service types you select may decide your annual fee once you are registered. It is therefore important that you only select the service types that apply to this location.

Please work through the questions in order, starting with question 6.2.

*6.2 Prison Healthcare Services

Do you **ONLY** provide Prison Healthcare Services (PHS)?

Yes

No

If YES now go to question 6.6

If NO now go to question 6.3

*6.3 Acute Services

Do you **ONLY** provide Acute Services (ACS)?

Yes

No

If YES now go to question 6.4

If NO now go to question 6.6

*6.4 Further information about Acute Services (only)

Only answer this question if you checked or ticked that you will provide ONLY Acute Services (ACS) in question 6.3.

Where you provide ONLY ONE of the activities below at this location and it is the sole or main activity carried on there, please check or tick it.

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 complete this section**. Instead, go to question 6.5.

(a) dental treatment carried out under general anaesthesia	<input type="checkbox"/>	
(b) obstetric services and, in connection with childbirth, medical services	<input type="checkbox"/>	
(c) the termination of pregnancies	<input type="checkbox"/>	
(d) cosmetic surgery	<input type="checkbox"/>	
(e) haemodialysis or peritoneal dialysis	<input type="checkbox"/>	
(f) refractive eye surgery involving use of a laser or intense pulsed light	<input type="checkbox"/>	
(g) activities to which the service type DSS (diagnostics and or screening services) applies	<input type="checkbox"/>	
(h) procedures carried out under anaesthesia or intravenous sedation where those procedures are associated with in vitro fertilisation or assisted conception	<input type="checkbox"/>	

*6.5 Acute Services together with other services

Do you provide Acute Services with overnight beds?

Yes

No

Now go to question 6.6

*6.6 Service types

Please check or tick ALL of the service types that will be provided at this location

Acute services (ACS)	<input type="checkbox"/>
Prison healthcare services (PHS)	<input type="checkbox"/>
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	<input type="checkbox"/>
Hospice services (HPS)	<input type="checkbox"/>
Rehabilitation services (RHS)	<input type="checkbox"/>
Long-term conditions services (LTC)	<input type="checkbox"/>
Residential substance misuse treatment and/or rehabilitation service (RSM)	<input type="checkbox"/>
Hyperbaric chamber (HBC)	<input type="checkbox"/>
Community healthcare service (CHC)	<input type="checkbox"/>
CHC: Please also tick if you are a nursing agency only	<input type="checkbox"/>
Community-based services for people with mental health needs (MHC)	<input type="checkbox"/>
Community-based services for people with a learning disability (LDC)	<input type="checkbox"/>
Community-based services for people who misuse substances (SMC)	<input type="checkbox"/>
Urgent care services (UCS)	<input type="checkbox"/>
Doctors consultation service (DCS)	<input type="checkbox"/>
Doctors treatment service (DTS)	<input type="checkbox"/>
Mobile doctor service (MBS)	<input type="checkbox"/>
Dental service (DEN)	<input type="checkbox"/>
Diagnostic and or screening service (DSS)	<input type="checkbox"/>
Care home service without nursing (CHS)	<input type="checkbox"/>
(Please also see section 5.7 below if you have checked / ticked this service type)	
Care home service with nursing (CHN)	<input type="checkbox"/>
Specialist college service (SPC)	<input type="checkbox"/>
Domiciliary care service (DCC)	<input type="checkbox"/>
Supported living service (SLS)	<input type="checkbox"/>
Shared Lives (SHL)	<input type="checkbox"/>
Extra Care housing services (EXC)	<input type="checkbox"/>
Ambulance service (AMB)	<input type="checkbox"/>
Remote clinical advice service (RCA)	<input type="checkbox"/>
Blood and Transplant service (BTS)	<input type="checkbox"/>

*6.7 Accommodation for persons who require nursing or personal care

Only answer this question if you checked / ticked:

‘Accommodation for persons who require nursing or personal care’ as a regulated activity you intend to provide at this location at section 3.2 above, **AND**

‘Care home service without nursing (CHS)’ at section 3.8 above

(If this does not apply to you please go straight to section 3.10 below)

The regulated activity(s) you selected at 3.2 above and the service types you selected at 3.8 above show that you are not applying to provide nursing care at this location. Please tick below to confirm that you agree 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 agree to the condition shown above

*6.8 Service user bands

Please check or 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 ‘The whole population’.

Adults aged 18-65	<input type="checkbox"/>	Adults aged 65+	<input type="checkbox"/>		
Mental health	<input type="checkbox"/>	Sensory impairment	<input type="checkbox"/>		
Physical disability	<input type="checkbox"/>	People detained under the Mental Health Act	<input type="checkbox"/>		
Dementia	<input type="checkbox"/>	People who misuse drugs or alcohol	<input type="checkbox"/>		
People with an eating disorder	<input type="checkbox"/>	Learning difficulties or autistic spectrum disorder	<input type="checkbox"/>		
Children aged 0 – 3 years	<input type="checkbox"/>	Children aged 4-12	<input type="checkbox"/>	Children aged 13-18	<input type="checkbox"/>
The whole population	<input type="checkbox"/>	Other (please specify below)	<input type="checkbox"/>		

*6.9 Location readiness

Is the location ready to meet the needs of the people who will use it?

Yes

No

If 'No', please describe any building work, conversions, or planning applications that are currently underway, and the date this is expected to be finished.

*6.10 Accessibility

Is the location accessible to all people, including people with disabilities?

Yes

No

If 'No', please describe in what way it does not do so, why it is impossible to make the premises fully accessible, and the reasonable adjustments that you have been able to make.

***6.11 Other businesses at the location**

Are any other businesses carried on or going to be carried on at the location?

Yes

No

If 'Yes', please describe the other business carried on and the impact this has or will have on people.

***6.12 Security of records**

Will records be kept in a way that meets the requirements of the Data Protection Act 1998?

Yes

No

If 'No', please describe how records are processed and stored.

*6.13 Security of the premises

Are the premises secure and do they prevent access to people with no reason to be there?

Yes



No



If 'No', please describe how people are kept safe and their privacy and property protected.

6.14 Declaration of compliance at this new location

Before you make this declaration you must refer to the Health and Social Care Act 2008, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009, which set out the legal obligations on a person or organisation registered to provide regulated activities. You must be sure you have understood their requirements.

The Guidance about Compliance for providers illustrates how the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 regulation can be met.

You may decide to comply with relevant regulations in another way. If you do you should be ready to explain how and why you comply with the relevant regulation(s), and provide evidence where necessary about how your alternative approach will be just as or more effective in making sure that the regulations are met.

You must have regard to Regulation 26(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which requires registered persons to have regard to the Guidance about Compliance.

You must now declare compliance with all of the requirements of the above Act and regulations that are relevant to the regulated activities you will carry on at this location.

If this application is approved we will be fully compliant with each regulation for each regulated activity that we will carry on at this location.

Yes



No



Section 7: Application declaration

This declaration must be signed by the applicant.

If the applicant is an organisation, the person who signs must be duly authorised to do so.

If the applicant is a partnership, it must be signed by each member of the partnership.

I/we hereby declare that the information detailed in this application is true and accurate.

I/we understand that Section 37 of the Health and Social Care Act 2008 makes it an offence to knowingly make a statement which is false or misleading in a material respect in this application, or in any of the documents submitted with this application. I/we understand that to knowingly make a false declaration could render me/us liable to prosecution and could lead to the refusal of this application.

I/we understand that it is my/our responsibility to inform the Care Quality Commission of any information that is relevant to my /our application and which may not have been requested, and to update this information accordingly. I/we have kept a copy of all the information submitted in my/our application for my records.

I/we understand that if I/we change my/our postal or email address for service of notices and delivery of other documents I/we must notify CQC using the specific form for this purpose.

In making this application for registration with the Care Quality Commission, I/we agree to comply with the Health and Social Care Act 2008 and associated regulations.

Once registered, I/we agree to inform the Care Quality Commission if there are any changes to compliance with the regulations

I/we understand that non-compliance with the relevant legislation could lead to the refusal of this application or cancellation of registration if I/we do not comply once registered.

I/we agree that the information contained in this form may be used as conditions of registration.

Please check or tick this box to confirm that the appropriate number of registered managers have also submitted applications for registration (where applicable)	<input type="checkbox"/>
--	--------------------------

IF YOU ARE AN NHS TRUST (only), please check or tick this box to confirm that the trust's board members have seen and agreed the contents of this application	<input checked="" type="checkbox"/>
--	-------------------------------------

*Applicant's signature	Michael Wilson
*Applicant's name	Michael Wilson
*Date (dd/mm/yy)	01/11/13

If you are submitting this form electronically we will accept a typed-in name as your signature.

There is space for more partners to sign on the next page.

Partnerships ONLY – additional partners:

Each member of a partnership must sign this declaration. **If they do not do so, we will have to return your application.**

*Partner's signature	
*Applicant's name	
*Date (dd/mm/yy)	
*Partner's signature	
*Applicant's name	
*Date (dd/mm/yy)	
*Partner's signature	
*Applicant's name	
*Date (dd/mm/yy)	
*Partner's signature	
*Applicant's name	
*Date (dd/mm/yy)	
*Partner's signature	
*Applicant's name	
*Date (dd/mm/yy)	
*Partner's signature	
*Applicant's name	
*Date (dd/mm/yy)	

If you are submitting this form electronically we will accept typed-in names as signatures.

How to submit this application and accompanying documents

Please submit this application to the Care Quality Commission, making sure that all required additional forms and documents are included.

The checklist below shows the documents that you may need to include with your application:

Form or document		Done
Statement of purpose	A template is available on our website for you to use if you prefer	<input type="checkbox"/>
Additional EXISTING location sections as needed	Number of EXISTING locations where I/we will carry on the new regulated activity: <input type="text"/>	<input type="checkbox"/>
	Number of additional existing location sections submitted with this application <input type="text"/>	
Additional NEW location sections as needed	Number of NEW locations where I/we will carry on the new regulated activity: <input type="text"/>	<input type="checkbox"/>
	Number of additional new location sections submitted with this application <input type="text"/>	
Registered manager application forms (where relevant)	Number of locations that will have a manager <input type="text"/>	<input type="checkbox"/>
	Number of manager application forms (of all types) submitted with this application <input type="text"/>	

Where to send your application:

You should, wherever possible, **email** your completed form(s) and accompanying documents to: HSCA_Applications@cqc.org.uk

You must attach all the forms and documents to the same email. If you are unable to send us your application by email, you should print and sign your completed form(s) and post them with any accompanying documents in the same envelope to:

CQC HSCA Registrations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do not submit all required forms and information your application will be returned to you.

You can read more information on our website www.cqc.org.uk or call our National Customer Service Centre on **03000 616161**.

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