

ASF STANDARDS · PRIMARY HEALTH CLINIC · STANDARD 9

Standard 9 — Sustainable Care

7 criteria · 2 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 6, 6th Edition

CRITERIA IN THIS STANDARD

- 9.1 — Environmental Impact Is Genuinely Assessed, Appropriate to a Primary Care Setting
- 9.2 — Clinical Waste Is Genuinely Segregated and Responsibly Disposed
- 9.3 — Procurement Genuinely Considers Environmental Impact
- 9.4 — Energy and Resource Use Are Genuinely Monitored and Reduced Where Possible
- 9.5 — Patients and Staff Are Genuinely Engaged in Sustainability Practice
- 9.6 — The Clinic Genuinely Plans for Climate-Related Operational Risk
- 9.7 — Sustainability Commitments Are Genuinely Reviewed, Not Static

Environmental Impact Is Genuinely Assessed, Appropriate to a Primary Care Setting

STANDARD

The clinic genuinely assesses its environmental impact — energy, water, waste — proportionate to its role as a

community-facing primary care facility, not assumed

unnecessary given its typically modest scale.

In plain terms: The clinic has actually looked at its real environmental footprint — not assumed that being a small, community clinic means it doesn’t need to check.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Primary health clinics operate at the frontline of population health in many of the communities they serve, often with genuinely limited resources — but with a network of such clinics operating across a region, their combined environmental impact genuinely matters, even when any single clinic’s footprint looks small in isolation. A real, proportionate assessment reflects that scale honestly rather than skipping it entirely.

WHAT GOOD LOOKS LIKE

- The clinic has genuinely assessed its impact, appropriate to its size.
- The assessment genuinely covers energy, waste, and water.
- The assessment is genuinely revisited periodically.

COMMON FAILURE MODES

- No assessment has ever been conducted, justified by the clinic’s small size.

WORKED EXAMPLE

IN PRACTICE	
<i>A community clinic with no prior environmental review.</i>	
BEFORE	Nobody had ever looked at the clinic’s energy, waste, or water use as anything other than routine operating costs.
ACTION	A simple baseline was compiled using the past year’s utility and waste collection records.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull the last 12 months of utility and waste data.
2. Compile a simple baseline.

The most common mistake: Treating clinic size as a reason real assessment isn't worth doing.

SELF-ASSESSMENT QUESTIONS

1. Has the clinic genuinely assessed its environmental impact? — *A real, documented assessment.*

Evidence: Baseline assessment document

2. Does this genuinely cover energy, waste, and water? — *Real, multi-dimensional coverage.*

Evidence: Multi-dimensional data

3. Is the assessment genuinely revisited periodically? — *Real, periodic review.*

Evidence: Review schedule

COMMON REASONS FOR A PARTIAL ANSWER

- Energy use is tracked but waste and water are not.

IMPLEMENTATION PLAN

When	What
Week 1-2	Compile a baseline covering all three dimensions.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Baseline review	Reviews the baseline for genuine, multi-dimensional coverage.

SUPERVISOR TIPS

- Ask to see actual figures, not a general statement.

World Health Organization. WHO Guidance for Climate-Resilient and Environmentally Sustainable Health Care Facilities. Geneva: WHO; 2020.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

9.2 Clinical Waste Is Genuinely Segregated and Responsibly Disposed STANDARD

Clinical and hazardous waste is genuinely segregated from general waste at the point of generation and disposed of through a responsible, verified pathway — not a waste stream mixed for convenience given the clinic's typically lower volume.

In plain terms: Medical waste is kept genuinely separate from regular trash, right from when it's generated, and goes somewhere genuinely responsible.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Vaccination programmes and routine procedures mean primary care clinics genuinely generate sharps and clinical waste despite their modest scale, and the hazard this waste carries doesn't scale down with facility size. A real, verified disposal pathway matters regardless of how small the clinic is.

WHAT GOOD LOOKS LIKE

- Clinical waste is genuinely segregated consistently.
- The disposal pathway is genuinely verified.
- Staff are genuinely trained with real, observable compliance.

COMMON FAILURE MODES

- Sharps are occasionally placed in general waste under time pressure.

IN PRACTICE

A clinic with an unverified waste contractor.

BEFORE

A waste contractor was used but its licence and actual disposal pathway had never been checked.

ACTION

The contractor's licence and disposal site were directly verified and documented.

AFTER

The Monitor reviewed the verification record. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Verify your waste contractor's licence and disposal pathway directly.

The most common mistake: Assuming a contracted waste disposal company is compliant without ever independently verifying it.

SELF-ASSESSMENT QUESTIONS

1. Is clinical waste genuinely segregated at every point of generation? — *Real, consistent segregation.*

Evidence: Direct observation

2. Is the disposal pathway genuinely verified? — *A real, verified pathway.*

Evidence: Contractor verification record

3. Are staff genuinely trained with real, observable compliance? — *Real, demonstrated practice.*

Evidence: Training record

COMMON REASONS FOR A PARTIAL ANSWER

- **Segregation is good in theory but lapses during busy vaccination days.**

When	What
Week 1	Verify the waste contractor's licence and pathway.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Direct observation	Observes segregation during an actual busy period.

SUPERVISOR TIPS

- Check a bin during a busy vaccination clinic day.

EVIDENCE BASE

World Health Organization. Safe Management of Wastes from Health-Care Activities. Geneva: WHO; 2014.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

9.3

Procurement Genuinely Considers Environmental Impact

CORE

Procurement decisions genuinely factor in environmental impact alongside cost and patient need — including vaccine and supply packaging common to high-volume primary care delivery — not sustainability treated as an afterthought with purchasing decided purely on price.

In plain terms: When the clinic buys vaccines and routine supplies, it actually thinks about environmental impact as one real factor — not purely the cheapest option.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

Vaccination programmes and routine preventive services generate genuinely high, recurring volumes of packaging and single-use supplies, and across an entire population-health programme this adds up to a real, significant environmental impact. This is marked Core because this is precisely the recurring, high-volume purchasing where genuine environmental consideration, applied consistently, makes the real difference.

WHAT GOOD LOOKS LIKE

- Environmental impact is genuinely weighed for high-volume purchases.
- A real, documented instance shows this influencing a purchase.
- High-volume consumables are genuinely reviewed.

COMMON FAILURE MODES

- Vaccine and supply purchasing is decided purely on unit cost.

WORKED EXAMPLE

IN PRACTICE	
A clinic reviewing its vaccine supply contract.	
BEFORE	The vaccine supplier was chosen purely on cost, with packaging waste never considered.
ACTION	Environmental criteria were added to the next supply contract evaluation.
AFTER	The Monitor reviewed the documented decision. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add environmental criteria to the highest-volume supply contract evaluations.

The most common mistake: High-volume recurring purchases never actually weighing environmental impact.

1. Does procurement genuinely weigh environmental impact? —

Real, documented consideration.

Evidence: Procurement criteria

2. Is there a real, documented instance of this genuinely influencing a purchase? — *A concrete, real example.*

Evidence: Purchasing decision record

3. Are high-volume consumables genuinely reviewed for lower-impact alternatives? — *A real, ongoing review.*

Evidence: Consumables review record

COMMON REASONS FOR A PARTIAL ANSWER

- **Environmental impact is discussed informally but never actually documented.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Add environmental criteria to supply contract evaluations.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Procurement review	Reviews a purchasing decision for documented environmental consideration.

SUPERVISOR TIPS

- **Ask about the vaccine or highest-volume supply contract specifically.**

EVIDENCE BASE

NHS England. Delivering a Net Zero National Health Service. London: NHS England; 2022.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

Energy and Resource Use Are

9.4 Genuinely Monitored and Reduced

Where Possible

STANDARD

The clinic genuinely monitors its energy and resource consumption, pursuing real, achievable reductions appropriate to its scale and the communities it serves — not resource use left untracked because the facility is small.

In plain terms: The clinic actually tracks its energy and resource use and takes real steps to reduce it where genuinely possible.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A primary care clinic can genuinely track and improve its energy use without sophisticated infrastructure — even a modest, consistent monitoring practice can identify real, achievable savings over time, especially across a network of similar clinics.

WHAT GOOD LOOKS LIKE

- Consumption is genuinely tracked.
- At least one real efficiency improvement has been pursued.
- Progress is genuinely reviewed periodically.

COMMON FAILURE MODES

- Bills are paid with no one actually reviewing consumption trends.

WORKED EXAMPLE

IN PRACTICE

A clinic that had never reviewed its energy trends.

BEFORE

Monthly bills were paid with no comparison month to month.

ACTION A simple tracking spreadsheet was set up, and a phased LED conversion begun.

AFTER The Monitor reviewed the tracking data and the conversion record. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Set up basic consumption tracking.

The most common mistake: Paying utility bills with no one actually looking at consumption trends.

SELF-ASSESSMENT QUESTIONS

1. Is energy consumption genuinely tracked? — *Real, ongoing tracking.*

Evidence: Consumption tracking record

2. Has the clinic genuinely pursued at least one real efficiency improvement? — *A real, concrete improvement.*

Evidence: Specific improvement record

3. Is progress genuinely reviewed periodically? — *Real, periodic review.*

Evidence: Review schedule

COMMON REASONS FOR A PARTIAL ANSWER

- Tracking exists but has never led to a real improvement.

IMPLEMENTATION PLAN

When	What
Week 1-2	Set up tracking and identify an improvement.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Tracking review	Reviews the tracking record for genuine, ongoing monitoring.

SUPERVISOR TIPS

- Ask to see the actual tracking data.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

9.5

Patients and Staff Are Genuinely Engaged in Sustainability Practice

STANDARD

Staff genuinely understand and participate in the clinic’s sustainability practices, and this understanding genuinely extends to the health-promotion and community-education role primary care clinics often play — not a sustainability policy known only to management.

In plain terms: Staff actually know what the clinic is doing to be more sustainable and genuinely take part — and this can genuinely connect to the clinic’s wider community health-education role.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Primary health clinics genuinely occupy a trusted position within the communities they serve, and sustainability practices that staff genuinely understand and can speak to with patients extend the clinic’s real, broader health-promotion role beyond clinical care alone.

WHAT GOOD LOOKS LIKE

- Staff can genuinely describe a real sustainability practice.
- Patients are genuinely made aware where appropriate.
- Staff input is genuinely sought.

COMMON FAILURE MODES

- Staff are unaware of any specific sustainability practice.

IN PRACTICE

A clinic whose sustainability efforts were known only to the administrator.

BEFORE

A switch to lower-waste supplies had happened with no staff briefing.

ACTION

A brief team briefing explained the change and its rationale.

AFTER

The Monitor asked a staff member who could describe the change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Brief staff on current sustainability practices.

The most common mistake: Sustainability decisions known only at management level.

SELF-ASSESSMENT QUESTIONS

1. Can staff describe a genuine sustainability practice? — *Real, demonstrated awareness.*

Evidence: Staff interview

2. Are patients genuinely made aware where appropriate? — *Real, visible communication.*

Evidence: Patient communication

3. Is staff input genuinely sought? — *Real, two-way engagement.*

Evidence: Staff suggestion record

COMMON REASONS FOR A PARTIAL ANSWER

- Some staff are aware but awareness isn't consistent.

IMPLEMENTATION PLAN

When	What
Week 1	Brief all staff.

Method	What	Detail
ASK	Staff interview	Asks a staff member to describe a specific practice.

SUPERVISOR TIPS

- Ask a non-management staff member.

EVIDENCE BASE

Health Care Without Harm. Global Green and Healthy Hospitals Agenda. Reston: HCWH; 2020.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

9.6 The Clinic Genuinely Plans for Climate-Related Operational Risk CORE

The clinic genuinely considers climate-related risks to its own continuity of operation and, specifically, to the continuity of essential preventive services — vaccination programmes, maternal health visits — that communities genuinely depend on this clinic to deliver reliably.

In plain terms: The clinic has actually thought through what happens to vaccination programmes and other essential services during a climate disruption — because communities genuinely depend on this continuing reliably.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core because primary health clinics often serve as the sole or main access point for essential preventive services in their communities, and a disruption here doesn't just inconvenience this

clinic — it genuinely interrupts population-level programmes like vaccination coverage, with real, measurable public health consequences if continuity planning is absent.

WHAT GOOD LOOKS LIKE • Specific risks are genuinely identified. • A real plan covers continuity of essential preventive services. • This plan is genuinely reviewed and tested.	COMMON FAILURE MODES • No continuity plan exists for vaccination programmes during a disruption.
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WORKED EXAMPLE

IN PRACTICE <i>A clinic with no cold-chain backup plan for vaccine storage during a power outage.</i>	
BEFORE	A previous outage had put the vaccine cold chain at real risk, handled reactively with no formal backup plan.
ACTION	A backup power solution for the vaccine fridge was installed, with a documented activation protocol.
AFTER	The Monitor confirmed the backup system and protocol. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Identify the clinic’s most significant risk to essential preventive service continuity.
2. Build a real response plan.

The most common mistake: No cold-chain backup for vaccine storage during a power disruption.

1. Has the clinic genuinely identified its specific climate-related risks? — *A real, specific risk identification.*

Evidence: Risk identification document

2. Is there a real plan covering continuity of essential preventive services? — *A genuine, usable plan.*

Evidence: Response plan document

3. Is this plan genuinely reviewed and tested? — *Real, periodic review and testing.*

Evidence: Testing record

COMMON REASONS FOR A PARTIAL ANSWER

- A plan exists but hasn't been tested.

IMPLEMENTATION PLAN

When	What
Week 1-3	Build a continuity plan for essential services.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Plan review	Reviews the response plan and testing record.

SUPERVISOR TIPS

- Ask specifically about the vaccine cold-chain backup.

EVIDENCE BASE

World Health Organization. Operational Framework for Building Climate Resilient Health Systems. Geneva: WHO; 2015.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

9.7

Sustainability Commitments Are Genuinely Reviewed, Not Static

STANDARD

The clinic’s sustainability goals and practices are genuinely reviewed and updated as circumstances change — not a document written once and never genuinely examined for whether it still reflects the clinic’s actual practice.

In plain terms: The clinic’s sustainability goals actually get revisited — not written once and left to go stale.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A document written once and filed away stops genuinely reflecting the clinic’s current practice as circumstances change. Real, periodic review is what keeps sustainability commitments meaningful.

WHAT GOOD LOOKS LIKE

- Goals are genuinely reviewed on a real schedule.
- A real revision instance exists.
- Responsibility is genuinely assigned.

COMMON FAILURE MODES

- A document was written once and never revisited.

WORKED EXAMPLE

IN PRACTICE	
A clinic whose statement predated several supplier changes.	
BEFORE	The statement referenced a supplier no longer used.
ACTION	A named person was assigned annual review responsibility.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Assign named review responsibility.

The most common mistake: A document nobody is specifically responsible for revisiting.

SELF-ASSESSMENT QUESTIONS

1. Are goals genuinely reviewed? — *A real, periodic review.*

Evidence: Review schedule

2. Is there a real revision instance? — *A concrete example.*

Evidence: Revision history

3. Is responsibility genuinely assigned? — *A real, named accountability.*

Evidence: Assigned responsibility documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **A schedule exists but hasn't been followed consistently.**

IMPLEMENTATION PLAN

When	What
Week 1	Assign review responsibility and conduct the first review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Revision history review	Reviews the document's revision history.

SUPERVISOR TIPS

- **Ask who is specifically responsible for review.**

EVIDENCE BASE

United Nations Environment Programme. Sustainable Healthcare Facilities Guidance. Nairobi: UNEP; 2022.

[ASF training courses on GMJ Academy →](#)

← **PHC Standards — all standards**

Self-assess against these criteria →

Standard 10 — Digital Care & AI →

ASF STANDARDS · PRIMARY HEALTH CLINIC · STANDARD 10

Standard 10 — Digital Care and Artificial Intelligence Systems for Care

7 criteria · 2 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 7, 6th Edition

CRITERIA IN THIS STANDARD

10.1 — Digital Systems Are Genuinely Evaluated Before Adoption

10.2 — Digital Care Never Disadvantages a Patient Who Cannot Use It

10.3 — Genuine Technical Support Is Available for Digital Systems

10.4 — AI Systems Are Introduced in Line With Law and Best-Practice Guidance

10.5 — AI Systems Are Genuinely Monitored for Unintended Consequences, Including Equity Impact

10.6 — Staff Are Genuinely Consulted Before an AI System Is Introduced

10.7 — Accountability for AI-Assisted Care Is Explicitly Defined

10.8 — Patients Are Genuinely Informed When Their Care Involves AI

10.1 Digital Systems Are Genuinely Evaluated Before Adoption

STANDARD

Before adopting any new digital system — patient records, vaccination tracking, appointment reminders — the clinic genuinely evaluates its cost, benefit, and compatibility with existing systems, not adopted on vendor assurance with no real internal evaluation.

In plain terms: Before the clinic adopts a new digital tool, someone has actually checked it's worth it and will genuinely work.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Primary care clinics are increasingly offered digital vaccination tracking and reminder systems, often with genuine public-health benefit — but a real evaluation is what distinguishes a tool that actually fits this clinic's workflow from one that creates data-entry burden without a matching real benefit.

WHAT GOOD LOOKS LIKE

- A genuine cost/benefit evaluation happens before adoption.
- Compatibility is genuinely checked.
- Unintended consequences are genuinely considered.

COMMON FAILURE MODES

- A system is adopted on vendor demonstration alone.

WORKED EXAMPLE

IN PRACTICE

A clinic considering a vaccination tracking system.

BEFORE

A vendor demo looked promising but no check was made of whether the system could genuinely

ACTION

A brief evaluation confirmed genuine registry compatibility before full adoption.

AFTER

The Monitor reviewed the evaluation notes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Build a simple evaluation checklist before adoption.

The most common mistake: Skipping evaluation because a system promises genuine public-health benefit.

SELF-ASSESSMENT QUESTIONS

1. Is a genuine cost/benefit evaluation conducted before adoption?

— *A real, documented evaluation.*

Evidence: Evaluation checklist

2. Is compatibility genuinely checked? — *Real, verified compatibility.*

Evidence: Compatibility check record

3. Are unintended consequences genuinely considered? — *Real, proactive consideration.*

Evidence: Pre-launch risk review

COMMON REASONS FOR A PARTIAL ANSWER

- Evaluation happens for major systems but is skipped for smaller add-ons.

IMPLEMENTATION PLAN

When	What
Week 1	Build an evaluation checklist.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Evaluation review	Reviews the evaluation record for a recently adopted system.

- **Ask about the most recently adopted digital tool.**

EVIDENCE BASE

World Health Organization. Global Strategy on Digital Health 2020-2025. Geneva: WHO; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.2 Digital Care Never Disadvantages a Patient Who Cannot Use It

CORE

A genuine process ensures that patients who cannot use digital devices, lack internet access, or face language or literacy barriers are never disadvantaged in booking, reminders, or health communication — a genuinely heightened risk in primary care settings that often serve lower-income, migrant, or less digitally connected populations.

In plain terms: A patient who can't use the clinic's app or doesn't speak the local language still gets exactly the same real access — a genuine alternative, not a quietly worse option.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core because primary health clinics genuinely, frequently serve exactly the populations most vulnerable to digital exclusion — lower-income patients, migrants, those with limited literacy in the local language. A digital-only pathway here doesn't create a minor inconvenience; it can genuinely cut off access to care for precisely the patients the clinic most exists to serve.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- A genuine, equally functional alternative exists.

- New services are genuinely pre-tested with the actual patient population, including language barriers.
- Real evidence shows equivalent service.

- A digital reminder system assumes smartphone access and local-language literacy.

WORKED EXAMPLE

IN PRACTICE

A clinic that introduced SMS appointment reminders.

BEFORE	SMS reminders were sent only in the majority local language, leaving a genuine minority of patients without reliable reminders.
ACTION	Reminders were added in the clinic's second most common patient language, and a phone-call alternative was explicitly offered to any patient who preferred it.
AFTER	The Monitor confirmed both the multilingual reminders and the phone alternative were genuinely functioning. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check your digital communication actually reaches your real patient population's language needs.

The most common mistake: A digital communication system designed around the majority patient profile, quietly excluding a genuine minority.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, equally functional alternative? — *A real, equivalent alternative.*

Evidence: Documented alternative channel

Evidence: Pre-launch testing record

3. Is there real evidence the alternative delivers equivalent service?
— A real, demonstrated instance.
Evidence: Direct test or comparison data

COMMON REASONS FOR A PARTIAL ANSWER

- An alternative exists but isn't genuinely promoted to patients who need it.

IMPLEMENTATION PLAN

When	What
Week 1	Audit digital communication for genuine language and access coverage.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Direct test	Tests the non-digital alternative directly.

SUPERVISOR TIPS

- Ask about the clinic's actual patient population language mix.

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health. Geneva: WHO; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.3

Genuine Technical Support Is Available for Digital Systems

STANDARD

The clinic has genuine access to technical support — in-house, vendor-provided, or contracted — for its digital systems, with testing before full implementation, not systems left running with no real support behind them.

In plain terms: When a digital system breaks, there's a real person to call.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Primary care clinics typically lack dedicated IT staff, making a genuine, accessible vendor support relationship particularly important — without it, a system failure can disrupt vaccination tracking or patient records with no real path to resolution.

WHAT GOOD LOOKS LIKE

- Genuine, accessible support exists.
- Testing genuinely occurs before implementation.
- A real, known escalation path exists.

COMMON FAILURE MODES

- Support knowledge rests with one staff member with no documented record.

WORKED EXAMPLE

IN PRACTICE

A clinic with no documented support contact.

BEFORE	Support knowledge lived only with the staff member who originally set up the system.
ACTION	A support contact card was posted and documented for all staff.
AFTER	The Monitor asked a staff member who correctly identified the support contact. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Document and post support contacts for every digital system.

The most common mistake: Support knowledge living only with whoever originally set up the system.

1. Does the clinic have genuine, accessible technical support? —

Real, available support.

Evidence: Support contract

2. Were genuine testing and quality checks performed before implementation? — *A real pre-launch check.*

Evidence: Testing record

3. Is there a real, known route to support? — *A genuine, known path.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- Support contact knowledge depends on one staff member.

IMPLEMENTATION PLAN

When	What
Week 1	Document support contacts for all systems.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a staff member who they'd contact for an issue.

SUPERVISOR TIPS

- Ask a front-desk staff member, not the clinic director.

EVIDENCE BASE

NHS Digital. Technology Assessment Criteria for Digital Health Products.

London: NHS Digital; 2022.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.4 AI Systems Are Introduced in Line With Law and Best-Practice Guidance

STANDARD

Any artificial intelligence tool used to support screening, triage, or risk stratification is introduced in accordance with

applicable law, or where none exists, with available best practice guidance such as WHO's AI ethics and governance guidance — not adopted with no reference to any external standard of responsible use.

In plain terms: Before using an AI screening tool, the clinic has actually checked what the law requires — not made it up as it went along.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

AI screening tools are increasingly deployed in community and primary care settings for population-level risk stratification, and a real, grounded governance basis is what separates responsible adoption from an ungoverned experiment affecting real community health decisions.

WHAT GOOD LOOKS LIKE

- AI systems are genuinely introduced in line with applicable law.
- Where no law exists, introduction is genuinely informed by recognized guidance.
- The clinic can identify the specific basis.

COMMON FAILURE MODES

- No reference to law or guidance was made before adoption.

WORKED EXAMPLE

IN PRACTICE

A clinic using an AI-assisted diabetes risk screening tool.

BEFORE	The tool had been adopted with no check of applicable regulation or any formal reference to external guidance.
ACTION	A governance review confirmed applicable regulation and formally adopted WHO's AI

AFTER

The Monitor reviewed the governance note.
Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check for applicable AI regulation and document a governance basis.

The most common mistake:

Adopting an AI tool on clinical recommendation alone with no separate governance check.

SELF-ASSESSMENT QUESTIONS

1. Is any AI system genuinely introduced in line with applicable law?
— *Real, verified compliance.*
Evidence: Regulatory check record
2. Where no law exists, is introduction genuinely informed by recognized guidance? — *A real, referenced source.*
Evidence: Documented guidance reference
3. Can the clinic identify the specific basis for AI governance? — *A real, specific answer.*
Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- A guidance source is named but hasn't actually been reviewed for its application.

IMPLEMENTATION PLAN

When	What
Week 1-2	Document a governance basis for each AI tool.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Governance note review	Reviews the documented governance basis.

SUPERVISOR TIPS

- Ask for the name of the specific guidance document.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

AI Systems Are Genuinely Monitored for

10.5 Unintended Consequences, Including CORE

Equity Impact

The clinic genuinely monitors any AI-assisted screening or risk tool for over-diagnosis, missed diagnosis, and specifically for differential accuracy across the clinic’s actual patient population — a genuine, documented risk where AI tools trained on unrepresentative data can perform less reliably for exactly the populations primary care most often serves.

In plain terms: The clinic actually keeps checking whether its AI screening tool works equally well for everyone it actually serves — not just assuming it’s accurate across the board.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core because of a genuine, well-documented risk specific to this setting: AI diagnostic and screening tools are frequently trained on data that underrepresents the exact populations — lower-income, certain ethnic groups, older adults — that primary health clinics most often serve, and this can produce genuinely lower accuracy for exactly the patients the clinic exists to protect, without that gap ever being visible unless someone specifically checks for it.

WHAT GOOD LOOKS LIKE

- AI output is genuinely audited.

COMMON FAILURE MODES

- Accuracy is assumed uniform with no equity-

- Accuracy is genuinely checked for consistency across the real patient population.
- A documented instance exists of monitoring catching a real issue.

WORKED EXAMPLE

IN PRACTICE	
A clinic using an AI-assisted skin condition screening tool.	
BEFORE	The tool's accuracy had never been checked specifically across the clinic's genuinely diverse patient population, despite known industry concerns about such tools' accuracy on darker skin tones.
ACTION	A quarterly audit was introduced specifically comparing tool accuracy against independent clinical review across the clinic's actual patient demographic range.
AFTER	The Monitor reviewed the audit methodology confirming genuine, demographic-specific comparison. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Establish an audit that genuinely checks accuracy across your actual patient population's diversity.

The most common mistake: Auditing overall accuracy without ever checking whether it's genuinely consistent across the clinic's actual patient population.

SELF-ASSESSMENT QUESTIONS

1. Is AI-assisted output genuinely audited? — *Real, ongoing audit.*
Evidence: Audit record

2. Is accuracy genuinely checked for consistency across the entire population? — *A real, specific equity check.*

Evidence: Demographic-specific audit data

3. Is there a documented instance of monitoring identifying a genuine issue? — *A real, concrete example.*

Evidence: Issue response record

COMMON REASONS FOR A PARTIAL ANSWER

- **Overall accuracy is checked but not broken down by patient demographic.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Establish a demographic-aware audit process.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Audit review	Reviews the audit for genuine, demographic-specific comparison.

SUPERVISOR TIPS

- **Ask specifically whether accuracy has ever been checked across patient demographics.**

EVIDENCE BASE

Obermeyer Z, Powers B, Vogeli C, Mullainathan S. Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations. *Science*. 2019;366(6464):447-453.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.6 Staff Are Genuinely Consulted Before an AI System Is Introduced

STANDARD

Clinical staff who will actually use a new AI tool are genuinely consulted before its introduction, with real training

needs identified and addressed — not a tool rolled out with no engagement beyond a brief notification.

In plain terms: Before a new AI tool goes live, the staff who will actually use it have had a real say.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Frontline clinicians, nurses, and community health workers in a primary care setting often have the clearest, most grounded sense of how a new AI screening tool will actually function in practice with their real patient population — genuine consultation surfaces this knowledge before it becomes a real problem.

WHAT GOOD LOOKS LIKE

- Staff are genuinely consulted before introduction.
- Consultation genuinely identifies training needs.
- Staff can describe genuine consultation.

COMMON FAILURE MODES

- Staff learn about a new tool only once the decision is final.

WORKED EXAMPLE

IN PRACTICE	
<i>A clinic introducing an AI-assisted screening tool.</i>	
BEFORE	Nurses received an email announcing the tool with no prior input sought.
ACTION	The launch was delayed to hold a genuine consultation session, surfacing a real workflow concern addressed before go-live.
AFTER	The Monitor interviewed a nurse who described the consultation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: Treating a notification email as equivalent to genuine consultation.

SELF-ASSESSMENT QUESTIONS

1. Are staff genuinely consulted before introduction? — *Real, prior consultation.*

Evidence: Consultation record

2. Does consultation genuinely identify training needs, actually addressed? — *Real needs matched by real training.*

Evidence: Training delivery record

3. Can staff describe having been genuinely consulted? — *Tests whether consultation actually registered.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Consultation happened with one lead clinician but not the wider team.**

IMPLEMENTATION PLAN

When	What
Before any launch	Hold genuine consultation with actual users.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks staff whether they felt genuinely consulted.

SUPERVISOR TIPS

- **Ask for a specific example of a change made because of staff input.**

EVIDENCE BASE

Topol EJ. High-Performance Medicine: The Convergence of Human and Artificial Intelligence. *Nature Medicine*. 2019;25(1):44-56.

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10.7 Accountability for AI-Assisted Care Is Explicitly Defined STANDARD

The clinic has genuinely considered and documented accountability for care decisions made with AI support — who is responsible when an AI-assisted decision is wrong — not leaving this as an unexamined question until it actually matters.

In plain terms: Everyone knows, in advance, who is actually responsible if an AI-supported decision turns out to be wrong.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Without clear, documented accountability, a safety incident involving AI-assisted screening risks becoming a confused dispute over responsibility exactly when clarity matters most — for the patient, the clinician, and the clinic's own ability to learn from what happened.

WHAT GOOD LOOKS LIKE

- Clinical accountability is explicitly documented.
- Clinicians genuinely understand their own accountability.
- A defined process exists for reviewing accountability.

COMMON FAILURE MODES

- Accountability has never been explicitly addressed.

WORKED EXAMPLE

IN PRACTICE

A clinic using an AI-assisted risk stratification tool.

GILS Labour Studies were unclear whether responsibility for a missed high-risk flag sat with the nurse or the AI system.

ACTION

A clear policy was documented: the tool is decision support only, and the reviewing clinician retains full accountability.

AFTER

The Monitor interviewed a nurse who could clearly state her own accountability. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

- 1. Explicitly document where clinical accountability sits for each AI tool.

The most common mistake: Leaving accountability ambiguous until an actual incident forces clarity.

SELF-ASSESSMENT QUESTIONS

- 1. Is clinical accountability explicitly documented? — *A real, clear answer.*
Evidence: Documented accountability policy
- 2. Do clinicians genuinely understand their own accountability? — *Real, demonstrated understanding.*
Evidence: Staff interview
- 3. Is there a defined process for reviewing accountability in a safety incident? — *A real, usable process.*
Evidence: Incident review protocol

COMMON REASONS FOR A PARTIAL ANSWER

- A policy exists but hasn’t been communicated to frontline staff.

IMPLEMENTATION PLAN

When	What
Week 1	Document accountability for each AI tool in use.

Method	What	Detail
ASK	Staff interview	Asks a clinician to describe their accountability.

SUPERVISOR TIPS

- Ask a clinician directly: if the AI flagged something wrong, who is responsible?

EVIDENCE BASE

European Commission. Ethics Guidelines for Trustworthy Artificial Intelligence. Brussels: European Commission; 2019.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.8

Patients Are Genuinely Informed When Their Care Involves AI

STANDARD

A patient whose care involves an aspect delivered with AI system support is genuinely informed of this — not left to assume every decision was made by a human clinician alone, with disclosure treated as optional rather than a genuine, standard part of informed care.

In plain terms: If AI is actually involved in part of a patient’s care, they’re genuinely told — not left to assume a human made every decision alone.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A patient’s genuine right to understand their own care includes knowing, in plain terms, when a decision affecting them was shaped by an AI system rather than a clinician’s judgement alone. This is especially relevant in a primary health clinic setting, where AI-assisted

screening tools may genuinely flag risk factors a patient would want to know were AI-generated. Disclosure buried in a general consent form a patient never actually reads does not meet this bar.

WHAT GOOD LOOKS LIKE • Patients are genuinely informed when AI is involved in their care. • Disclosure is genuinely understandable, in plain language. • A patient can genuinely confirm they were told.	COMMON FAILURE MODES • AI disclosure is buried in a general consent form, technically present but never genuinely read or understood.
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WORKED EXAMPLE

IN PRACTICE <i>A clinic using an AI-assisted screening tool for a chronic disease risk check.</i>	
BEFORE	AI’s role was mentioned only in a lengthy general consent document, which patients signed without genuine awareness that an AI tool had actually been involved in their specific screening.
ACTION	A brief, plain-language note was added to the results conversation: “An AI-assisted tool helped flag your risk level; your clinician reviewed it directly.”
AFTER	The Monitor interviewed a patient who could genuinely confirm they understood AI had been involved. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a brief, plain-language disclosure point at the moment results or care decisions involving AI are actually discussed with the patient.

The most common mistake: Treating a line buried in a general consent form as genuine disclosure, when the patient never

SELF-ASSESSMENT QUESTIONS

1. Is a patient genuinely informed when AI is involved in their care?

— *Real, standard disclosure.*

Evidence: Disclosure protocol

2. Is this disclosure genuinely understandable, not buried in technical language? — *A real, plain-language explanation.*

Evidence: Disclosure wording sample

3. Can a patient asked directly confirm they were genuinely told? —

A real, concrete confirmation.

Evidence: Patient interview

COMMON REASONS FOR A PARTIAL ANSWER

- Disclosure exists in a consent form but patients genuinely cannot recall or explain it when asked directly.

IMPLEMENTATION PLAN

When	What
Week 1-2	Draft plain-language disclosure wording for each AI-assisted care point and train staff to deliver it.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Patient interview	Asks a patient whether they were genuinely told AI was involved in their care.

SUPERVISOR TIPS

- Ask a patient directly rather than relying on the consent form’s existence alone.

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health: Guidance on Large Multi-Modal Models. Geneva: WHO; 2024.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **PHC Standards — all standards**

Self-assess against these criteria →

← **Standard 9 — Sustainable Care**

Standard 11 — Supporting the Care Workforce →

ASF STANDARDS · PRIMARY HEALTH CLINIC · STANDARD 11

Standard 11 — Supporting the Care Workforce

8 criteria · 3 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 8, 6th Edition

CRITERIA IN THIS STANDARD

- 11.1 — Every Member of the Workforce Is Genuinely Credentialed for Their Actual Role**
- 11.2 — Ongoing Competency Is Genuinely, Regularly Evaluated**
- 11.3 — Staff Have Genuine Access to Ongoing Education and Skill Development**
- 11.4 — Workforce Health and Safety Is Genuinely Protected**
- 11.5 — Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved**
- 11.6 — Staff Are Genuinely Protected From Violence and Aggression**
- 11.7 — Workforce Feedback Is Genuinely Gathered and Acted On**
- 11.8 — Sick Leave and Attrition Data Genuinely Inform Organisational Learning**
- 11.9 — Equality, Diversity and Inclusion Across the Workforce Are Genuinely Monitored**

Every Member of the Workforce Is

11.1 Genuinely Credentialed for Their Actual Role

CORE

Every member of the clinic’s workforce — employed clinicians, community health workers, visiting specialists, and volunteers alike — has genuine assurance of the qualifications and scope of practice their role requires, including community health workers whose training and scope are often genuinely distinct from licensed clinical staff.

In plain terms: Everyone involved in care here — including community health workers, who have a genuinely distinct kind of training — has had their real qualifications and scope genuinely checked and respected.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Community health workers play a genuinely vital, distinct role in primary care, often bridging clinical services and community outreach without holding a formal clinical licence — their training is real and valuable but genuinely different from a nurse’s or physician’s, and a credentialing process that fails to distinguish this creates a real risk: either their legitimate role is undervalued, or their actual scope of practice is exceeded without anyone noticing.

WHAT GOOD LOOKS LIKE

- Genuine assurance extends to community health workers appropriately.
- Scope of practice is genuinely verified and respected.
- A real corrective process exists for a scope

COMMON FAILURE MODES

- Community health workers’ training basis is never documented or verified.

WORKED EXAMPLE

IN PRACTICE

A clinic employing community health workers with no documented scope.

BEFORE

Community health workers' training had never been formally documented, and their actual scope of practice in the field was undefined, leading to inconsistent practice.

ACTION

A clear scope-of-practice document was created specific to the community health worker role, matched to their genuine training background.

AFTER

The Monitor reviewed the scope document and confirmed it was genuinely specific to this role, not a generic clinical scope. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Document the genuine training basis and scope for community health worker roles specifically.

The most common mistake: Applying a generic clinical credentialing framework that doesn't genuinely fit the distinct training basis of community health workers.

SELF-ASSESSMENT QUESTIONS

1. Does genuine assurance extend to community health workers? —

Real, consistent coverage appropriate to their genuinely distinct training.

Evidence: Role-specific credential records

2. Is scope of practice genuinely verified and respected in daily practice? — *A specific, documented match.*

Evidence: Scope verification record

3. Is there a real process if someone practises outside their verified scope? — *A genuine corrective process.*

Evidence: Correction procedure

- **Licensed clinicians are credentialed but community health workers' basis is undocumented.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Document role-specific scope for community health workers.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Credential review	Reviews role-specific credential records across all workforce categories.

SUPERVISOR TIPS

- **Ask specifically about community health workers' documented scope.**

EVIDENCE BASE

World Health Organization. Community Health Worker Programmes: Guidelines. Geneva: WHO; 2018.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

11.2 Ongoing Competency Is Genuinely, Regularly Evaluated

CORE

The continued competency of every workforce member is genuinely, regularly evaluated against their actual job description and scope, including the genuinely distinct competencies required of community-facing and preventive care roles.

In plain terms: Staff competency keeps getting genuinely checked — including the specific skills community health workers and preventive care staff actually need.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Preventive care and population health practice evolve genuinely over time — vaccination schedules, screening guidelines, health education approaches — and competency evaluation needs to reflect this evolving, distinct knowledge base, not a generic clinical competency check that doesn't actually match this role's real focus.

WHAT GOOD LOOKS LIKE

- Competency is genuinely evaluated on a real schedule.
- Evaluation genuinely covers actual current duties.
- A genuine gap triggers a real response.

COMMON FAILURE MODES

- A generic evaluation form doesn't actually reflect preventive care-specific competencies.

WORKED EXAMPLE

IN PRACTICE

A clinic using a generic evaluation form for all staff.

BEFORE

A single generic evaluation form was applied to all staff roles, with no distinct criteria for community health workers or preventive care specialists.

ACTION

Role-specific evaluation criteria were developed, reflecting the genuine current competencies preventive care and community outreach roles actually require.

AFTER

The Monitor reviewed a recent evaluation and confirmed it genuinely reflected role-specific competencies. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: A generic evaluation form applied uniformly, not reflecting each role's genuinely distinct focus.

SELF-ASSESSMENT QUESTIONS

1. Is ongoing competency genuinely evaluated on a real schedule?

— *A real, periodic evaluation.*

Evidence: Evaluation records

2. Does evaluation genuinely cover actual current duties? — *A*

specific, role-relevant check.

Evidence: Role-specific criteria

3. Does a genuine gap trigger a real response? — *A genuine*

corrective process.

Evidence: Correction record

COMMON REASONS FOR A PARTIAL ANSWER

- **Evaluation happens but uses a generic form.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Build role-specific evaluation criteria.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Evaluation review	Reviews evaluation for genuine, role-specific substance.

SUPERVISOR TIPS

- **Compare a community health worker's evaluation to a nurse's**
— **they should look genuinely different.**

EVIDENCE BASE

Institute of Medicine. Health Professions Education: A Bridge to Quality.
Washington DC: National Academies Press; 2003.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

11.3

Staff Have Genuine Access to Ongoing Education and Skill Development

STANDARD

Every workforce member has genuine access to ongoing education — including public health and preventive care updates genuinely relevant to a primary care setting’s population-health role — not education treated as a one-time induction event.

In plain terms: Staff can actually keep learning — specifically in public health and preventive care, genuinely central to this setting’s work.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Public health guidance — vaccination schedules, screening recommendations, outbreak response — evolves genuinely and sometimes rapidly, and staff without ongoing access to this evolving knowledge risk delivering outdated preventive care advice to the communities relying on them.

WHAT GOOD LOOKS LIKE

- Genuine, ongoing access to education beyond induction.
- Real development opportunities in public health specifically.
- Staff can describe a real opportunity taken.

COMMON FAILURE MODES

- Education stops after induction, missing evolving public health guidance.

WORKED EXAMPLE

IN PRACTICE

A clinic with no ongoing public health education.

BEFORE	Staff had received no update training on the latest vaccination schedule changes.
ACTION	A biannual public health update session was introduced.
AFTER	The Monitor interviewed staff who could describe the recent update. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a biannual public health guidance update.

The most common mistake: Assuming public health guidance changes slowly enough not to need genuine, ongoing staff education.

SELF-ASSESSMENT QUESTIONS

1. Does every workforce member have genuine, ongoing access to education? — *Real, continuing access.*

Evidence: Education policy

2. Are genuine development opportunities offered in public health specifically? — *Real opportunities.*

Evidence: Training calendar

3. Can staff describe a real opportunity taken in the past year? — *A real, specific example.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- Education exists but isn't specifically focused on evolving public health guidance.

IMPLEMENTATION PLAN

When	What
Week 1-2	Schedule biannual public health update sessions.

Method	What	Detail
ASK	Staff interview	Asks staff about recent public health education.

SUPERVISOR TIPS

- **Ask specifically about recent vaccination schedule or guidance updates.**

EVIDENCE BASE

World Health Organization. Global Strategy on Human Resources for Health: Workforce 2030. Geneva: WHO; 2016.

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11.4 Workforce Health and Safety Is Genuinely Protected CORE

The clinic genuinely protects the health and safety of its workforce — required vaccinations, personal protective equipment, prevention of needlestick injuries — including community health workers conducting outreach visits outside the clinic itself, who face genuinely distinct safety considerations.

In plain terms: The people working here are genuinely kept safe — including community health workers out doing home or outreach visits, who face a genuinely different kind of risk.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Community health workers conducting field visits work without the physical safety infrastructure of a clinic — no colleagues nearby, no panic alarm, no controlled environment — and a safety policy designed

WHAT GOOD LOOKS LIKE

- PPE is genuinely available and used.
- Field-based safety is genuinely, specifically addressed.
- Vaccinations are genuinely tracked.

COMMON FAILURE MODES

- Safety protocols cover the clinic building but say nothing about field visits.

WORKED EXAMPLE

IN PRACTICE

A clinic whose safety protocol never mentioned field work.

BEFORE	Community health workers conducted home visits alone with no check-in protocol or safety plan specific to field conditions.
ACTION	A field-visit check-in protocol was introduced, including a scheduled call-back and a defined escalation step if contact was missed.
AFTER	The Monitor interviewed a community health worker who could describe the check-in protocol in genuine, real use. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a field-visit safety check-in protocol for community health workers.

The most common mistake: A safety policy that only genuinely addresses risks inside the clinic building, overlooking field-based staff entirely.

SELF-ASSESSMENT QUESTIONS

- 1. Is PPE genuinely available and used? — *Real, observed use.***
Evidence: Direct observation

2. Are genuine, specific measures in place for field-based staff safety? — *Real, specific measures appropriate to this distinct risk.*
Evidence: Field protocol documentation

3. Are required vaccinations genuinely tracked and current? — *Real, verified tracking.*
Evidence: Vaccination records

COMMON REASONS FOR A PARTIAL ANSWER

- **Clinic safety is strong but field safety has never been formally addressed.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a field-visit safety protocol.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a community health worker about field safety practice.

SUPERVISOR TIPS

- **Specifically ask about field or outreach work, not just in-clinic safety.**

EVIDENCE BASE

World Health Organization. Health Worker Safety Charter. Geneva: WHO; 2020.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

11.5 Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved

STANDARD

A genuine process exists for investigating and resolving workplace issues raised by staff — including whistleblowing concerns — with real protection from adverse treatment,

not a grievance process that exists on paper with no real follow-through.

In plain terms: When staff raise a concern, it actually gets looked into, and they’re genuinely protected.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A genuine, trusted reporting channel is what allows real problems — understaffing, unsafe field conditions, care quality concerns — to surface before they compound. Staff who don’t trust the process will often stay silent precisely when their observations matter most.

WHAT GOOD LOOKS LIKE

- A genuine, accessible process exists.
- Real evidence of genuine resolution.
- Genuine protection from adverse treatment.

COMMON FAILURE MODES

- Concerns are discussed informally but never formally raised.

WORKED EXAMPLE

IN PRACTICE <i>A clinic where community health worker concerns rarely reached management.</i>	
BEFORE	Field-based concerns were mentioned informally during check-ins but never formally logged or tracked to resolution.
ACTION	A simple logging step was added to the field check-in process, with a defined review cycle.
AFTER	The Monitor reviewed the log and a documented resolution. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: Field staff concerns discussed informally but never formally tracked through to resolution.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, accessible process for raising issues? — *A real, known process.*

Evidence: Process documentation

2. Is there real evidence of genuine resolution? — *Genuine follow-through.*

Evidence: Resolution log

3. Are staff genuinely protected from adverse treatment? — *Real, demonstrated protection.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A process exists for clinic-based staff but field-based concerns aren't genuinely captured.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Add formal logging to field check-in processes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Resolution log review	Reviews the log for genuine, documented resolution.

SUPERVISOR TIPS

- **Ask specifically whether field-based staff have a genuine reporting route.**

EVIDENCE BASE

International Labour Organization. Violence and Harassment Convention, 2019 (No. 190). Geneva: ILO; 2019.

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11.6 Staff Are Genuinely Protected From Violence and Aggression

STANDARD

The clinic takes genuine, concrete steps to protect staff from aggression — including the genuinely distinct risks faced by community health workers conducting home or outreach visits, who often work without the physical safety infrastructure of a clinic setting.

In plain terms: Real, specific steps protect staff from aggression — including community health workers, who face genuinely higher risk in uncontrolled field settings.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A community health worker conducting a solo home visit genuinely lacks the safety infrastructure of a clinic — no security presence, no colleagues nearby, no controlled environment — making this a genuinely distinct and elevated risk requiring its own specific protective measures, not an afterthought to clinic-based security planning.

WHAT GOOD LOOKS LIKE

- Genuine, specific measures exist for field-based risk.
- Incidents are genuinely tracked.
- Staff can describe a real instance where a measure worked.

COMMON FAILURE MODES

- Field staff have no check-in protocol or escalation plan.

WORKED EXAMPLE

IN PRACTICE

A clinic whose field staff had no safety protocol.

BEFORE	Community health workers conducted home visits with no defined safety plan or check-in system.
ACTION	A scheduled check-in system with a defined escalation path was introduced, alongside basic situational awareness training.
AFTER	The Monitor confirmed the check-in protocol was genuinely in daily use. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a check-in system for field-based staff.

The most common mistake: Treating field-based aggression risk as outside the scope of workplace safety planning entirely.

SELF-ASSESSMENT QUESTIONS

1. Are genuine, specific measures in place for field-based risk? —

Real, specific measures appropriate to this setting.

Evidence: Field safety documentation

2. Are incidents genuinely tracked and reviewed? — *Real, systematic tracking.*

Evidence: Incident log

3. Can staff describe a real instance where a measure worked? — *A real, concrete example.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- A check-in protocol exists but isn't genuinely followed consistently.

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a check-in and escalation system for field staff.

Method	What	Detail
ASK	Staff interview	Asks field staff about the real check-in protocol.

SUPERVISOR TIPS

- Ask a community health worker directly about field safety.

EVIDENCE BASE

World Health Organization. Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva: WHO/ILO/ICN/PSI; 2002.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

11.7

Workforce Feedback Is Genuinely Gathered and Acted On

STANDARD

The clinic has a genuine, systematic approach to gathering staff feedback — including community health workers whose field-based role can easily leave them disconnected from clinic-based feedback processes — with real analysis and a genuine, implemented response.

In plain terms: Staff, including those out in the field, get genuinely asked how working here actually is, and real changes happen as a result.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Feedback processes scheduled around clinic-based meetings genuinely risk excluding field-based staff, who are physically absent from the clinic for much of their working time and whose distinct experience — isolation, transport challenges, community relationship dynamics — may never be captured by a clinic-centered process.

WHAT GOOD LOOKS LIKE

- Feedback genuinely reaches field-based staff.
- Feedback is genuinely analysed.
- A documented instance shows a genuine, implemented change.

COMMON FAILURE MODES

- Feedback sessions happen only during clinic-based meetings field staff rarely attend.

WORKED EXAMPLE

IN PRACTICE

A clinic whose feedback sessions rarely reached field staff.

BEFORE	Feedback discussions happened during in-clinic staff meetings that community health workers, often out in the field, rarely attended.
ACTION	A separate feedback channel was introduced for field staff, with a brief phone survey during a scheduled check-in call.
AFTER	The Monitor reviewed response data showing genuine participation from field staff. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether field staff genuinely participate in current feedback processes.

The most common mistake: Feedback processes structured around in-clinic meetings, systematically excluding field-based staff.

SELF-ASSESSMENT QUESTIONS

1. Does feedback genuinely reach field-based staff? — *Real, ongoing collection.*

Evidence: Response data

2. Is feedback genuinely analysed? — *A real, documented analysis.*

3. Is there a documented instance of feedback genuinely leading to a change? — *A real, concrete example.*

Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- Feedback is gathered but field-staff response rate remains genuinely low.

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a field-specific feedback channel.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Response rate review	Reviews feedback response data by role.

SUPERVISOR TIPS

- Specifically check field-staff response rates.

EVIDENCE BASE

NHS England. NHS Staff Survey National Results. Leeds: NHS England; 2023.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

Sick Leave and Attrition Data

11.8 Genuinely Inform Organisational Learning

STANDARD

The clinic genuinely monitors staff sick leave and the real reasons people leave, using this to inform genuine changes supporting workforce wellbeing and retention, not attrition treated as an unexamined, unavoidable cost of doing business.

In plain terms: The clinic actually looks at why staff get sick or leave, and genuinely uses what it learns to make things better.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Primary care, and community health worker roles specifically, often carry genuine attrition risk from the demands of field work, community exposure, and sometimes lower relative compensation — a facility that never genuinely investigates these patterns misses real, actionable insight into what would actually improve retention.

WHAT GOOD LOOKS LIKE

- Sick leave data is genuinely monitored.
- Real reasons for leaving are actually captured.
- A documented instance shows a genuine, implemented change.

COMMON FAILURE MODES

- Community health worker attrition is never separately examined from clinical staff attrition.

WORKED EXAMPLE

IN PRACTICE

A clinic with high community health worker turnover never separately investigated.

BEFORE	Community health worker attrition was combined with overall staff turnover, masking a genuinely higher rate specific to this role.
ACTION	Attrition was tracked separately by role, revealing a genuine pattern linked to transport burden for field visits, leading to a transport stipend.
AFTER	The Monitor reviewed the role-specific data and the resulting change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: Combining attrition data across all roles, masking genuinely distinct patterns specific to community health worker positions.

SELF-ASSESSMENT QUESTIONS

1. Is sick leave data genuinely monitored? — *Real, ongoing analysis.*

Evidence: Sick leave records

2. Are real reasons for leaving actually captured? — *Real, specific exit data.*

Evidence: Exit interview records

3. Is there a documented instance of this data genuinely informing a change? — *A real, concrete example.*

Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- **Attrition data exists but isn't broken down by role.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Break down attrition data by role and investigate patterns.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Exit data review	Reviews role-specific exit data and any resulting change.

SUPERVISOR TIPS

- **Ask whether community health worker attrition is tracked separately.**

EVIDENCE BASE

International Council of Nurses. The Global Nursing Workforce and the COVID-19 Pandemic. Geneva: ICN; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

Equality, Diversity and Inclusion

11.9 Across the Workforce Are Genuinely Monitored

STANDARD

The organisation genuinely monitors and responds to real patterns of equity across recruitment, work allocation, scheduling, and promotion — including across the clinic’s clinical and community health worker staff — not an assumption that fair treatment exists simply because no formal complaint has been raised.

In plain terms: The clinic actually looks at real patterns — who gets hired, which shifts or routes people get, who gets promoted — not just assuming things are fair because nobody has formally complained.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Inequity in recruitment, scheduling, or promotion can genuinely persist for years without a single formal complaint — people often don’t report a pattern they can’t fully see themselves, or don’t trust reporting to change anything. This genuinely matters across both clinical staff and the clinic’s community health worker workforce, who may have less visibility into organisational patterns than office-based staff. Genuine, proactive monitoring of real workforce data is what actually surfaces a pattern that individual complaints alone would likely never reveal.

WHAT GOOD LOOKS LIKE

- Workforce data is genuinely monitored for patterns.
- A genuine pattern triggers a real response.
- A real instance shows monitoring informing a change.

COMMON FAILURE MODES

- No formal complaint has been raised, so the organisation genuinely assumes no issue exists, with no actual data ever reviewed.

IN PRACTICE

A clinic that had never reviewed its own route-assignment data for community health workers.

BEFORE

Field route assignments were managed informally with no genuine review of whether certain workers consistently received less favourable or more difficult routes.

ACTION

A quarterly equity review was introduced, which identified and corrected a genuine, unintentional pattern.

AFTER

The Monitor reviewed the review documentation and the resulting correction. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a regular review of recruitment, scheduling, and promotion data across clinical and community health worker staff.

The most common mistake: Assuming fairness exists because no one has formally complained, with no actual data ever reviewed.

SELF-ASSESSMENT QUESTIONS

1. Is workforce data genuinely monitored for patterns of inequity? —

A real, documented monitoring process.

Evidence: Monitoring protocol

2. Where a genuine pattern is identified, is there a real, defined response? — *A genuine corrective process.*

Evidence: Response record

3. Is there a real, documented instance of this genuinely informing a change? — *A concrete, real example.*

Evidence: Change record

- **Data exists but has genuinely never been reviewed specifically for equity patterns among community health workers.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a quarterly equity review covering recruitment, scheduling, routes, and promotion.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Equity review record	Reviews the monitoring data and any resulting corrective action.

SUPERVISOR TIPS

- **Ask to see the actual data behind the last equity review, including community health worker routes specifically.**

EVIDENCE BASE

World Health Organization. Gender Equity and Human Rights in the Health Workforce. Geneva: WHO; 2019.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **PHC Standards — all standards**

Self-assess against these criteria →

← **Standard 10 — Digital Care & AI**