Regulators' Pioneer Fund project: Regulatory recognition and sharing of innovative practice by NHS GP providers to reduce health inequalities

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Report for the Department for Business, Energy & Industrial Strategy

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Summary

In September 2021, the Care Quality Commission (CQC), in partnership with Yorkshire and Humber Academic Health Science Network, submitted a successful joint bid to the Department for Business, Energy & Industrial Strategy (BEIS) through the Regulators' Pioneers Fund. Our successful bid was for funding for a project to explore how our regulatory process could capture and consider innovation in GP practices to respond to health inequalities.

The aims of the project were to:

- **identify examples of innovation that reduces health inequalities, and share these so that others may implement similar strategies among their own populations, which would reduce health inequalities nationwide**
- **explore ways in which GP practices can show evidence of their innovation to reduce health inequalities that can be recognised as part of CQC's regulatory process.**

Context

Our initial research highlighted that where we are born, grow up, live, work, and the decisions we make for ourselves collectively have a bigger impact on our health than just the health care we receive. Researchers at the University of York Centre for Health Economics estimated that in 2011/2012, socio-economic inequalities cost the NHS £4.8 billion a year, in inpatient admissions alone. NHS England directed funding through the Long Term Plan Implementation Framework, estimated to be worth up to £1 billion by 2023/2024, towards geographies with high health inequalities, and expects all local health systems to provide specific measurable goals for narrowing inequalities through improvements to service, including those relating to poverty.

Primary care is the gateway to accessing healthcare services for the majority of people, with over 300 million appointments made in general practice each year (NHS Digital, 2021). However, the ability for all people to access high quality primary care is not yet equal. GP practices in areas of deprivation have fewer GPs per patient and, once adjusted for greater health needs, less funding. In the face of these resourcing challenges, it is unsurprising that there are lower patient satisfaction scores and lower Quality and Outcomes Framework (QOF) performance for these practices, as shown in the Health Foundation's 2021 briefing Level or not.

The significant impact of the COVID-19 pandemic has exposed and exacerbated many of the inequalities faced by both people who use services and care providers. It has contributed to significant changes in how care is delivered, particularly how general practice has responded to the challenges.

Currently, our regulatory processes focus on outcomes for patients, and it can be difficult for us to disentangle the quality of care in a GP practice from the impact of wider factors affecting health within the local population, such as poverty. This Regulators' Pioneers Fund project aims to look at how practices in areas of deprivation that are responding to health inequalities can have their innovation duly recognised in CQC's regulatory processes.

As part of our strategy from 2021 and our new regulatory approach, we are developing ways to consider and reflect the innovative approaches taken by health and care providers to respond to and tackle inequalities. This project echoes the aims of our strategy, which sets out ambitions under four themes:

- people and communities
- smarter regulation
- safety through learning
- accelerating improvement.

The strategy also includes two cross-cutting core ambitions:

- assessing local systems – providing independent assurance to the public of the quality of care in their area

- tackling inequalities in health and care – pushing for equality of access, experiences and outcomes from health and social care services.

Importantly, we also have a commitment to encouraging and championing innovation and research that benefits people and where the innovation results in more effective and efficient services.

How we carried out the project

We worked in partnership with Yorkshire and Humber Academic Health Science Network (Yorkshire & Humber AHSN). In the bid for funding, we set out the key project deliverables, which were to:

- review literature to identify key features of innovation to reduce health inequalities in primary care

- carry out fieldwork to understand experiences of GP practices in undertaking innovative projects

- identify and share case studies from practices that had undertaken innovative projects to respond to health inequalities

- develop a resource to support practices to have their innovative practices recognised through regulatory frameworks and shared with others to encourage improvements

- identify ways in which the findings from this project could inform CQC's regulatory processes.

We set up regular working group meetings to coordinate workstreams and discuss the ongoing fieldwork. The initial fieldwork was completed by Yorkshire & Humber AHSN, with further involvement from CQC as the project progressed. The fieldwork was underpinned by an initial literature review that was undertaken by Yorkshire & Humber AHSN. Thereafter, the fieldwork included collecting case studies from innovative GP practices, chairing and attending roundtable events and holding reference groups with inspectors, and with patients and carers.

Key outcomes

The key outcomes of this project are the important and valuable feedback and learning that we gained when developing our resource for NHS GP providers. This will help us to identify the best ways to support practices to show evidence of their innovation, and to inform how we develop our future regulatory assessments.

We are using existing quality improvement methodology to develop this as an online resource that will also share examples of innovative ways in which practices have responded to health inequalities. This will support providers through their innovation journey and enable a shared understanding between NHS GP providers and CQC colleagues when making regulatory assessments about innovation to reduce health inequalities.

Next steps

The findings of the project will feed into the ongoing development of our new single assessment framework and the evidence that we need to assess the quality and safety of health and care services. We will use the learning to ensure that the assessment framework and our associated methods and processes (for example, training of inspection teams, established ways of working, QA processes) actively respond to and work to support innovation in addressing pre-existing inequalities.

Because the new assessment framework is still in development, we'll implement the learning in stages:

Firstly, we will develop an online resource for both NHS GP practices and CQC inspectors, based on our learning from the project. We will communicate this to GP providers to raise awareness and to highlight that we are interested in hearing about innovative practice and recognising it through our regulatory assessments.

Secondly, under the new regulatory model, we will build a process to enable NHS GP practices to present evidence of their innovations to tackle health inequalities as part of their regulatory assessment.

Background to the project

In September 2021, the Care Quality Commission (CQC) in partnership with Yorkshire and Humber Academic Science Health Network submitted a successful joint bid to the Department for Business, Energy & Industrial Strategy (BEIS) through the Regulators' Pioneers Fund. The Regulators' Pioneer Fund gives funding to projects led by regulators and local authorities to help create a UK regulatory environment that encourages innovation. Our successful bid was for a project to explore how our regulatory process could capture and consider innovation in NHS GP practices to respond to health inequalities.

The aims of the project were to:

- **identify and share examples of innovation that reduces health inequalities, and share these so that others may implement similar strategies among their own populations, which would reduce health inequalities nationwide**

- **explore ways in which GP practices can show evidence of their innovation to reduce health inequalities that can be recognised as part of CQC's regulatory process.**

Reducing inequalities in people's access, experiences and outcomes from health and care services and promoting innovation is a fundamental part of CQC's strategy. We know that many GP practices are developing innovative ways to reduce health inequalities in their local populations, but through our current approach it is difficult to measure these. To help achieve our strategic ambition, we need to improve how we gather evidence about these innovations and use this in our decision-making and regulatory judgements. We hope to continue fostering a supportive regulatory environment for services where they feel able to try new approaches to care that reduce inequalities.

Innovation to tackle health inequalities may not be recognised if a GP practice can't demonstrate measurable outcomes. It is recognised that innovations to reduce health inequalities can take months or years to show demonstrable improvements to population health, which means that innovative efforts may not reflect immediate improvement in health outcomes. This can mean that although a practice serving a population in an area of deprivation may be planning or implementing innovation to reduce health inequalities, the work may not be observed in a CQC inspection and therefore not contribute to a higher quality rating. These practices often struggle to recognise and present their improvement attempts as innovative and CQC may not recognise the efforts if they cannot demonstrate measurable outcomes. This may result in GPs perceiving that CQC does not value innovative solutions and potentially lead to lower job satisfaction and/or issues with the recruitment or retention of staff, which in itself could affect patient satisfaction or CQC ratings.

Our current monitoring and inspection process often relies on data indicators to inform judgements. Although we use the best up-to-date information available to us to review practices' performance, these indicators could be more challenging to meet when a practice is serving a population in an area of deprivation. As part of our research on the experiences and impact of CQC regulation on ethnic minority-led GP providers, we surveyed providers whose practice served socio-economically deprived patient populations. Of the respondents, 33% (118/357) felt negatively affected by the indicators that we use, compared with just 10% (35/336) of practices that were not serving socio-economically deprived patient populations. Through this work, we heard that although practices in areas of deprivation may show innovative and committed efforts to improving health inequalities, the innovation will not be given full recognition in the current regulatory framework if the innovation does not bring about improvements that result in indicators falling within defined targets.

The wider context

Literature and research around health inequalities

The Department of Health and Social Care (DHSC) describes health inequalities as differences in health across the population between different societal groups that are avoidable and unfair. These inequalities arise from wider determinants of health, originally described by Dahlgren and Whitehead in 1991. In Health inequalities: reducing inequalities in local areas, Public Health England (now UK Health Security Agency and Office for Health Improvement and Disparity) observed that health inequalities between population groups arise across at least four overlapping categories:

- socio-economic status and deprivation
- protected equality characteristics
- vulnerable groups of society
- geography.

The Marmot Review report, Fair Society, Healthy Lives, commented on how health inequalities arise from a complex interaction of many factors that are strongly affected by a person's economic and social status and are largely preventable, costing between £36-40 billion through lost taxes, welfare payments and costs to the NHS. The review found that people living in the poorest neighbourhoods tend to die an average of seven years earlier and spend more of their lives with a disability than their counterparts living in the richest neighbourhoods. Reducing health inequalities is a priority for the NHS, particularly as research has shown that there is a difference of 19 years in the healthy life expectancy between the most and least deprived areas. This concerning disparity is continuing to grow.

People in areas of deprivation face a range of factors that make them more likely to be in poor health, and more likely to have difficulty accessing health services. Dr Julian Tudor Hart described The Inverse Care Law (The Lancet 1971), suggesting that those who needed health care the most were least likely to receive it. Evidence suggests that these people suffer on three counts:

- they use poor quality services

- have relative difficulty securing access to these services, and
- suffer multiple external disadvantages.

Similar themes were touched on in the NHS Long Term Plan, which notes that where we are born, grow up, live, work, and the decisions we make for ourselves collectively have a bigger impact on our health than just health care. Researchers at the University of York Centre for Health Economics estimated that in 2011/2012, socio-economic inequalities cost the NHS £4.8 billion a year, in inpatient admissions alone. Through the Long Term Plan Implementation Framework, NHS England directed funding, estimated to be worth up to £1 billion by 2023/2024, towards geographies with high health inequalities, and expects all local health systems to provide specific measurable goals for narrowing inequalities through improvements to service including those relating to poverty. A recently established Health Inequalities Improvement Team and Programme aims to embed a culture of 'health inequality improvement' across all NHS systems and levels in the COVID-19 recovery phase and beyond (Tackling Inequalities in NHS Care, 2021).

Health inequalities in primary care

Primary care is the gateway to accessing healthcare services for the majority of people, with over 300 million appointments made in general practice each year (NHS Digital, 2021). Despite the well-publicised challenges of staff shortages and increasing workload being faced by GPs, the majority of respondents in the 2021 NHS England GP patient survey had a good overall experience of their GP practice. However, the ability for all people to access high quality primary care is not yet equal, and in the latest British Social Attitudes survey, public satisfaction with the NHS has fallen to a 25-year low. GP practices in areas of deprivation have fewer GPs per patient and, once adjusted for greater health needs, less funding. In the face of these resourcing challenges, it is unsurprising that there are lower patient satisfaction scores and lower Quality Outcomes Framework (QOF) performance for these practices, as shown in the Health Foundation's 2021 briefing Level or not.

Many primary care providers find themselves in a unique position of having both the medical expertise and deep community links to understand how best to address health inequalities. However, current systems do not always identify the innovation happening in areas of deprivation, so it cannot be reflected in ratings from CQC.

The Marmot review suggested that there should be priorities to develop interventions that address the social determinants of ill-health, and as GPs are often the first port of call for patients across the country, it is imperative that they have the tools that they need to respond to these inequalities. Hailed as the 'bedrock of NHS care', GPs prevent ill health and promote good health, and keep patients out of hospital.

Added to all these factors, the significant impact of the COVID-19 pandemic has exposed and exacerbated many of the inequalities faced by both people who use services and care providers. It has contributed to significant changes in how care is delivered, particularly how general practice has responded to the challenges.

The role of regulation in encouraging innovation to reduce health inequalities

As the basis of our bid for funding from the Regulators' Pioneers Fund, we acknowledged that regulation can and should be a lever to encourage innovation in reducing health inequalities while helping to share good practice between providers, as well as creating large savings in public expenditure.

There are currently limited approaches available to GP practices that help them to show evidence of their innovative work to reduce health inequalities. Although the Royal College of General Practitioners (RCGP) produces a guide to Quality Improvement, this does not address the specific issues around being able to show tangible evidence of innovation in reducing health inequalities. Similarly, NHS England/Improvement produced a menu of evidence-based approaches to reducing health inequalities, but this does not include standardised ways of measuring impact and outcome from projects that are easily adaptable, and the Equity Collection of resources from Public Health England is aimed at local authorities and commissioners, rather than smaller businesses such as GP practices.

Our current regulatory processes focus on outcomes for patients, and it can be difficult for us to disentangle the quality of care in a GP practice from the impact of wider factors affecting health within the local population, such as poverty. The aim of this Regulators' Pioneers Fund project was to explore ways in which practices in areas of deprivation who are responding to health inequalities have their innovation duly recognised in CQC's regulatory processes.

Failure to recognise this innovation in our regulatory processes may be a disincentive for GP practices to carry out innovative work. When this happens, struggling and already under-resourced GP practices may remain in a cycle of inequality where they are unable to recruit and retain staff and encounter difficulties with funding. Failure to recognise innovation may also mean that people in a local area do not have the full picture when choosing between services.

Furthermore, the discussion paper from the King's Fund recommended that CQC should support new ways of working, progress the tackling of health inequalities through proportionate regulatory and performance management and consider the pressures on practices in regulatory assessments.

Benefits of regulatory recognition of innovation

Encouraging innovation and recognising this in regulatory processes could lead to cost savings for GP practices as they develop more efficient ways of working, as well as improving the nation's health and the Government's levelling up agenda. Our motivation to address health inequalities is based on the need to ensure that everyone in England receives access to good health care that contributes to better outcomes, in line with NHS priorities. Improvements in regulatory outcomes may result in:

- new funding possibilities
- better recruitment and retention of staff
- better learning and development opportunities

leading to better outcomes for people who use services.

Furthermore, systematically sharing good practice and demonstrating the positive impacts may allow projects to be scaled up and encourage system-wide innovation.

How we carried out the project

We worked in partnership with Yorkshire and Humber Academic Health Science Network (Yorkshire & Humber AHSN). In the bid for funding, we explained the challenges that GP practices currently experience when they want CQC to recognise their innovations as part of their regulatory assessment, and the reasons why improvements are needed. Our bid then detailed how the findings of the project would be used to improve existing frameworks, to encourage improvements and innovation throughout the sector.

The bid set out key project deliverables, which were to:

- review literature to identify key features of innovation to reduce health inequalities in primary care
- carry out fieldwork to understand experiences of GP practices in undertaking innovative projects
- identify case studies from practices that had undertaken innovative projects to respond to health inequalities
- develop a resource to support practices to have their innovative practices recognised through regulatory frameworks and shared with others to encourage improvements
- identify and explore ways in which the findings from this project could inform CQC's regulatory processes.

Defining innovation

To support us to define innovation, we drew on a previous project undertaken through the Regulators' Pioneers Fund when national bodies joined forces to develop a shared understanding of what good innovation looked like. In 2021, Enabling innovation and adoption in health and social care: developing a shared view identified six principles for providers to be more effective at innovating.

1. Develop and deploy innovations with the people that will use them

2. Develop a culture where innovation can happen

3. Support your people

4. Adopt the best ideas and share your learning

5. Focus on outcomes and impact

6. Be flexible when managing change

Through the fieldwork, we discussed with participants what they would consider to be innovative and how CQC could support them with their innovative approaches to respond to health inequalities. Participants emphasised the importance of recognising innovation in its early stages. They said that even when innovation has not succeeded, this should be recognised, as not all innovation will work first time.

Providers wanted to see a more flexible view of innovation that is location-specific and which recognises that innovation in one area might be 'business as usual' in another, rather than adopting a one-size-fits-all approach.

Alignment with our strategy

This project echoes the aims of our strategy, which includes an ambition to tackle inequalities in health and care – pushing for equality of access, experiences and outcomes from health and social care services. We also have a strategic commitment to encourage and champion innovation and research that benefits people, where the innovation results in more effective and efficient services.

While maintaining CQC's role as a regulator, the strategy aims to enable health and care services and local systems to access support to help improve the quality of care where it is needed most. This includes creating a culture where innovation and research can thrive. We recognise that the use of new technology to deliver care may not suit some people, and we will consider what services need to do to ensure that nobody is disadvantaged.

Literature review

Before developing the resource for providers, Yorkshire & Humber AHSN, our partners in the project, carried out a detailed review of literature to understand the context of the issues and inform its development.

The first part of the literature review provided an overview of the wider policy landscape around health inequalities. It identified the role of innovation in tackling inequalities so that we could better understand the drivers and opportunities behind this work within general practice.

The second part reviewed and considered examples of innovative projects from general practice to tackle inequalities. This part of the literature review also identified the common key factors behind successful innovation, which informed the subsequent stages of the project, most notably the development of the online innovation resource for providers.

Fieldwork to gather the evidence

Fieldwork began shortly after starting the literature review. The initial fieldwork was completed by Yorkshire & Humber AHSN, with further involvement from CQC as the project progressed. This included:

- A national callout for NHS GP practices that were undertaking innovative projects to reduce health inequalities. Initially, we collected 79 case studies across all nine regions. We then shortlisted 57 case studies using a prioritisation and scoring matrix, which were peer reviewed by both organisations.

- Identifying examples of innovation from case studies from across the integrated care system (ICS). These are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area.

- Structured interviews with the GP practices to gather more information about their innovation.

- Two roundtable events with 22 external stakeholders, including representatives from NHS England and Improvement, Healthwatch, NICE, the King's Fund, GPs and CCG representatives.

- Reference groups of CQC inspectors to gather their views and experiences of assessing evidence of innovation and how processes could be improved.

- A focus group with patients and carers to gather their views on innovation to respond to health inequalities in general practice.

Throughout this report will we refer to what we learned though this fieldwork and how we will use this learning as we focus on our next steps.

Key learning from the project

The literature review, fieldwork and testing stages provided valuable learning opportunities, which we are using to develop our resources for NHS GP providers. This section summarises the key points raised from each aspect of our project.

External stakeholder roundtable events

The first roundtable event for GPs and experts in this area was chaired by Yorkshire & Humber AHSN. The purpose of this roundtable was to gather further views on the proposed innovation resource and review CQC's current methods for capturing innovation through inspection and monitoring. CQC representatives only joined in towards the final stages of the meeting to ensure an open and honest dialogue. The second roundtable was chaired by CQC and used as an opportunity to present the draft resource and capture views and feedback.

When we started developing the resource for providers, we had proposed using forms for GP providers to submit to update CQC on the innovation journey. However, GP practices told us in the roundtable events that this only added to the immense burden that they were already under. They also told us that they would not be inclined to use the resource if it made no impact on their CQC regulatory outcome, and so we changed our initial approach.

Inspectors' reference group

In the group discussions for CQC inspectors, some inspectors strongly indicated that there was limited recognition in CQC's current methodology, including at quality assurance panels, of the contexts in which some practices operate and the unique challenges of their environment. They said that CQC's current assessment methodology does not capture the challenges for some practices in meeting even basic standards of care in areas of high deprivation.

Inspectors told us that reducing health inequalities is not a specific focus of CQC's assessment and reporting, and there is a lack of prompts to capture innovation with the specific goal of addressing health inequalities. They said that CQC's current assessment focuses on data and clinical outcomes for whole or specific groups in the population. This encourages practices to focus wholly on what they are doing to meet performance targets.

Inspectors shared their experiences of looking for evidence of the impact and outcomes of a provider's innovation. They found that providers do not always recognise that what they are doing is innovative, and they experience difficulties providing evidence of the impact as they are not able to provide data to show this. As a result, inspectors struggle to write up and reflect the innovative work in a way that will have a positive impact on ratings.

Participants shared reflections on what could be improved in our processes to allow CQC to better recognise innovative practice to reduce health inequalities. This included:

- clarity on the evidence that CQC needs to demonstrate innovation, and how this should be reported
- recognition of the challenging circumstances in which providers work, and reflecting this in our judgements
- clarity on the requirements for a practice to remain rated as outstanding and/or be recognised as innovative.

Inspectors also gave insights on the support and guidance that could benefit GP practices in providing evidence of innovation to reduce health inequalities. This included:

- links to other sources of support for providers

- case studies, outlining impact or other features that will help the innovation to be recognised
- guidance on collating appropriate evidence to highlight innovation
- a blog about innovation.

Experts by Experience focus groups

Experts by Experience are people who have recent personal experience (within the last five years) of using or caring for someone who uses health, mental health and/or social care services that we regulate. Participants in a focus group with Experts by Experience recounted the challenges they had experienced in accessing GP practices. They told us they were aware of the challenges that GP practices are currently facing. They felt that our proposed resource should provide support for practices as well as giving examples of how similar practices had responded to the health inequalities of their practice population.

In addition to the roundtable discussions and focus groups, there were also interviews with GP practices to discuss their experiences of innovation to respond to health inequalities.

Literature review

We identified that common key factors to success included the need for collaboration with all key system players and others to realise innovative ambitions. This part of the literature review found that successful practices understand local communities, their needs and their drivers, and work with these communities to design and implement innovation. Further, for innovation to be successful, practices recognise that this joint working with communities extends to the wider workforce, with ongoing involvement and collaboration. Practice cultures must be aligned and receptive to innovative approaches.

Other key factors to success were identified, including:

- identifying new ways of working
- engaging with staff

- aligning care with identified needs
- building community partnerships and public confidence
- connecting communities
- creating new service opportunities
- demonstrating resilience
- actively seeking and acting on patient feedback
- addressing variability in performance.

Summary of themes from the learning

From our review of the fieldwork, we were able to see consistent and valuable themes emerging, which has informed the development of our work. We summarise the feedback, points raised and learning under the following themes.

CQC's regulatory methods

Participants reflected on our current regulatory methods and discussed suggestions for how they felt we could improve these to support and share innovation to respond to health inequalities. We are already considering and reflecting much of this feedback in our new single assessment framework and approach to assessments.

- **Consider the context around how GP practices are responding to their local challenges.** This includes how practices respond to their specific context in terms of providing good quality care rather than take a 'one-size-fits-all' approach and recognise their starting point (for example, levels of patient engagement in key services such as immunisation and screenings) as well as their external environment, the systems they are working in and their ability to influence this.

- **Consider qualitative as well as quantitative outcomes.** Innovation doesn't always result in quantitative outcomes; it can be qualitative too. As not all innovation can be quantified, consider the 'social impact' of measures (how they affect individuals) rather than just delivering national targets. Providers felt CQC needs to recognise this in its assessments.

- **Dedicate part of the assessment to tackling health inequalities.** Providers wanted to see a dedicated space for this in CQC's regulatory processes with guidance on what is required for an innovative project to be recognised and assessed, as it is currently unclear where innovation would sit in assessments.

- **Provide clarity and transparency about evidence of innovation.** Providers didn't always view their work as 'innovative', so they wanted CQC to publish clear guidelines on what is being measured, so they can think about how their work can demonstrate this.

- **Enable ongoing recording of innovation.** As innovation is continual and integrated, innovations have sometimes become 'business as usual' by the time we inspect, and so practices don't think of it as innovative, and it is not considered in assessments. Providers wanted a way of recording this on an ongoing basis, so they could better see their progress over time and ensure it is not missed during an inspection, and that practices whose efforts have been recognised do not regress.

- **Improve relationships with providers.** Echoing our research on the experiences and impact of CQC regulation for minority ethnic-led GP providers, practices reported a perceived lack of compassion in CQC's processes, leading to distrust and unwillingness to share innovative practices. They felt CQC needs to develop a better rapport with practices and build an ongoing relationship with them to ensure they are comfortable sharing all their innovations rather than only the ones they feel will have an impact on their overall rating.

- **Take a quality improvement/improvement focus.** Building a quality improvement focus in our assessments would help to explore what practices do well, amplify this, and improve challenges faced, by taking into account a provider's context, resources, workforce shortages and system support. Providers felt CQC assessments should be a channel for sharing and pointing to good practice and shifting towards creating learning systems.

- **Provide training for inspectors.** Providing support and training to inspectors would help them to understand the various dimensions of inequalities and innovation, so they can factor this into assessments.

- **Recognise the impact of innovation and efforts to tackle health inequalities in ratings.** Providers wanted a way of recognising the effort and energy they put into implementing innovation to encourage those practices that don't meet national targets.

- **Maintain the highest quality of care standards.** Regardless of these points, we still need to ensure we don't compromise on quality of care.

CQC's definition of innovation

The fieldwork also highlighted some areas of learning that can improve how we define and recognise innovation.

- **Considering the trajectory of innovation as well as outcomes.** Outcomes of innovation shouldn't be only acknowledged when they are measurable or tangible, as it can take time to see an impact. CQC should consider the trajectory or process that takes place, recognising innovation at all stages.

- **Early-stage and mature innovation.** More mature projects are likely to have a greater impact, but we also need to recognise early-stage projects to encourage projects to be prioritised in the first place. CQC's framework for recognising innovation could strike a balance between recognising innovation at all stages without losing the accolade of high-impact mature projects. Recognition could form a sliding scale with early-stage projects receiving a lower ranking than more mature projects.

- **Not all innovation will work.** Innovation is risky and some projects won't work but should still be recognised as they can bring about learning for future projects. Providers felt CQC needs to encourage, acknowledge and reward all types of innovative activity, regardless of its impact.

- **Innovation doesn't always align with how work is currently measured.** Sometimes ways of working will be determined by the individual practice and may not align with the way that things have previously been done or are measured.

- **Innovation is not always led by a GP.** Innovative work may be led by other healthcare professionals due to the capacity and resources within the team. Providers felt innovation should be acknowledged irrespective of who is leading this.

- **What is business as usual in one area, may be innovative in another.** Work should not be dismissed as not innovative just because some practices have been using it for a long time, whereas for another practice it is new. Providers felt a need for CQC to recognise that every practice will be working at a different pace and it should still be recognised as innovation.

- **Innovation may challenge the way things are currently done.** Innovation must challenge the status quo and take a different approach to managing health, focusing on more than just treating disease or illness but improving life chances and focusing on overall wellbeing (physical, mental and social).

- **Acknowledging a 'one size fits all' model cannot apply to adopting digital technology.** Although the rapid adoption of technology in response to the COVID-19 pandemic is a step forward, it can also create more barriers for certain groups accessing healthcare. Therefore, one approach should not be mandated or measured.

- **Innovative activity by GPs to tackle inequalities can take place outside the walls of a GP surgery.** Some GPs are leading projects that have an impact on inequality of their own accord or outside their practice. These are currently not acknowledged, so there is a need to consider how to recognise them.

- **Partnership working should be encouraged.** Collaboration with other sectors is key and so there needs to be a mechanism to recognise and reward practices that engage in partnership working.

- **Focus on principles to enable autonomy.** While we should look for projects that other practices can adopt, we need to be cautious about looking only for innovation that can be easily replicated. Something that works in one area might not work in another due to the unique practice population. We should instead work on developing basic principles, allowing for autonomy and personalisation.

Wider support for providers

As well as learning in the areas discussed, feedback from participants in the fieldwork showed a desire to have more support to encourage innovation.

- **Backfill funding.** Providers wanted funding to backfill GP posts that are involved in innovative activity to address health inequalities. This would ensure that being innovative doesn't prevent them from also seeing patients. Although not something CQC can provide, this can be shared with system partners.

- **Forming support networks and sharing best practice.** Providers wanted opportunities for practices to learn from others in similar situations who have managed to improve. This will help spread and encourage innovation and help practices who don't know where to start. Not all innovation is scalable, so this should focus on the process a practice goes through.

- **Specialist support.** There were calls for practices to receive more specialist support to undertake innovative work over and above what a resource or guidance from CQC could achieve.

- **The Health and Social Care Bill.** Feedback referred to the 'triple aim' being more explicit in addressing inequalities and, if the Bill stands as it is, CQC using its influencing role to provide leverage on the bill and ensure the role of tackling health inequalities is prioritised.

Key outcomes of the project

The key outcomes of this project are the important and valuable feedback and learning that we gained from the development of the innovation resource.

The project shows real progress and commitment to our strategy and our new assessment framework and will prove invaluable as we shape our future regulatory approach. We have a much clearer understanding of how CQC as a regulator can encourage and support innovation through the availability of resources for GP providers and for our colleagues.

How we used the research and fieldwork

We initially referred to the planned outputs from this work as a toolkit for practices that would help them to show evidence of their innovation to respond to health inequalities through our regulatory process. However, practices preferred an alternative word to 'toolkit' as this terminology had become overused and unpopular, therefore we refer to the output we will provide as an online innovation resource for providers.

Practices told us in the discussions that it was important for a resource to share innovation and capture learning opportunities. They wanted an online resource so that it was up to date and relevant and contain simple guidance to advise them how their innovation can be recognised, without adding to the pressures that GP practices are currently under. Practices were clear that they wanted their innovation to be recognised as part of their regulatory assessments, rather than through a separate process. It was considered that an additional process would add to work pressures, without having any effect on regulatory outcomes.

Developing an innovation resource for providers

We intend our online resource to provide guidance for GP providers that can help them to use existing quality improvement methodology, which looks at innovation projects as a continuous and ongoing cycle. This would reflect the recommendations from the fieldwork undertaken by Yorkshire & Humber AHSN – that there is a need to recognise and encourage innovation from inception and to acknowledge that not all improvements are easily measured or will work first time.

Through the fieldwork, we ascertained that it's important for CQC to acknowledge a practice's baseline and context, as well as share best practice to spread innovation to ensure improvements across the sector. We therefore want the online resource to share some examples of the case studies from practices that have implemented innovation projects.

The online innovation resource will reflect the key feedback from internal and external stakeholders and from the fieldwork research:

- senior leaders in CQC felt that innovation needs to be an ongoing process
- GP practices wanted CQC to support them to present their innovation through the whole innovation journey and to ensure that it does not add to the pressures that all GP practices are experiencing, particularly those in areas of deprivation.

Using the resource will not be a mandatory process for GP practices, but participants in the roundtable, which included GPs and interested organisations, said they would like their efforts reflected in regulatory assessments. Therefore, the resource is intended to support practices to receive proper regulatory recognition for their innovation.

Practices told us that they would like a guide that spans the entire timeline of an innovation project, meaning they can refer to it at an early stage when scoping and when delivering a project.

Structuring the innovation resource

Feedback obtained throughout the fieldwork helped us to identify what we needed to include in our resource for providers and what the approach should look like.

We tested the concept of an innovation cycle with members of our reference group for inspectors and inspection managers by asking them to apply data from the case studies to it.

Most of the group struggled to allocate the case study they reviewed to a specific stage in the innovation cycle. However, they all identified additional information that would support them to make decisions about which stage the innovation was at, such as:

- evidence to show progress and/or impact
- evidence to support the rationale for the innovation
- patient feedback in relation to the innovation
- details of resources required to implement and sustain the innovation.

It was felt that the concept of looking at innovation as a cycle would be useful to inspection teams as well as providers as it would have the potential to introduce greater consistency in assessments. It would support providers to 'structure' and showcase their innovation or quality improvement journey, and to better understand what CQC is looking for as we make judgements about innovation to reduce health inequalities. Inspectors highlighted the particular importance of testing a resource with providers as it was being developed so that it meets their needs. They also said that the resource needs to reflect the struggles providers have historically faced in having innovation recognised.

The group noted that there's a need for clear guidance to help determine the stages of the innovation, which would help inspectors to recognise this in reporting and contributing to ratings.

Although there were calls for more support from CQC, concerns were raised from both colleagues internally and through our fieldwork discussions about CQC providing any coaching role, as this might be a conflict of interests between coach and regulator. It was also felt that this would need to be a responsibility for the whole system – not just CQC.

Yorkshire & Humber AHSN provided suggestions for CQC to make an innovation resource successful:

- Focus guidance on the entire lifespan of the project, for example from the inception through to implementation, audit and beyond. This would enable practices to apply guidance at all stages.

- Promote the definition of innovation and what constitutes 'innovative projects to tackle health inequalities'.

- Encourage practices to develop skills so that they can identify innovative practice to tackle health inequalities.

- Collaborate with other stakeholders from across the system to increase the impact and uptake of the resource.

Data mapping

As part of the testing work, we investigated whether we could measure evidence of improvement from data available to CQC. We looked at a range of quantitative and qualitative data sources covering GP activity and patient experience.

Details about innovation relating to the test scenarios varied and were very limited. This meant we were only able to provide rudimentary mapping of some data sources that could potentially provide some measure of improvement for five of six test scenarios. We could conduct a more comprehensive mapping exercise if we had more information relating to the areas of focus of the innovations. For example, detail around dates of when the innovation started and what stage the test scenario is at in the innovation journey.

Establishing the baseline date before implementing the innovation is important to ascertain which data sources we could use for measuring improvement. For example, changes to Quality and Outcomes Framework (QOF) requirements in response to the COVID-19 pandemic would make it difficult to measure improvements if the innovation's baseline or improvement relied on data from 2020/21 QOF.

The data mapping exercise enabled us to identify the following data sources that could be useful to consider and would provide metrics at primary care network or GP practice level:

- GP Patient Survey (NHSEI), which would be useful to look at whether the patient experience improved after implementing the innovation.

- Metrics from the Primary Care Network dashboard (NHSEI), which would provide data at primary care network and GP practice level such as patient access to online appointments or prescriptions, or measures relating to personalised care plans.

- Quality and Outcomes Framework covering GP achievement against a range of clinical, public health and quality improvement measures.

- UK Health Security Agency metrics covering target-based indicators such as childhood immunisations and cervical screening.

- Qualitative comments from CQC's 'Give feedback on care'.

The test scenarios showed a variety of innovations focusing on specific cohorts of the practice's patient population, for example patients in more vulnerable circumstances and asylum seekers, to improve inclusivity and accessibility for the LGBTQ+ community and patients with complex needs. Patient-level data would present the best opportunity to measure improvement in the implementation of an innovation.

The next steps

We are committed to taking forward the valuable learning from this project. The innovation roadmap reflects the core ambitions of our strategy by identifying innovation to respond to heath inequalities and encouraging improvement by sharing these innovations. Looking to the future, we hope to continue to foster a supportive regulatory environment for services where they feel able to try new approaches to care that reduce health inequalities and where their efforts are recognised within our regulatory approach.

Many of the findings from this project complement already-planned work from CQC's strategy from 2021 and Equality objectives. This includes:

- Greater transparency of evidence requirements through the single assessment framework, so providers will know what they are being assessed against, and greater sharing of scoring so providers can benchmark themselves and learn from others.

- A greater focus on people's experiences.
- Amplifying the voices of people most likely to have poor access, experience or outcomes.
- New dedicated quality statements on health inequalities and innovation in the single assessment framework.
- The development of our future regulatory model, which includes a move towards ongoing assessment of providers. This could create opportunities for GP practices to share innovation more regularly rather than waiting for an inspection.
- Aligning with the improvement focus of the strategy, which should in turn improve relationships with CQC. The project will help us support local systems to drive improvements by having better oversight of activity in their areas, foster an improvement culture in services by asking services to demonstrate their improvement activity around the health inequalities, and form a starting point for improvement conversations.
- Using our independent voice to highlight concerns and share innovation and good practice that can help reduce inequalities.

The timing of this project, and the work on regulatory outcomes for ethnic minority-led GP practices, means that we are in a good position to reflect the learning, as it will feed into the ongoing development of the new single assessment framework and the evidence that we need to assess the quality and safety of health and care services. We will use the learning to ensure that the framework and our associated methods and processes (for example, training of inspection teams, established ways of working, QA processes) actively respond to and work to support innovation in addressing pre-existing inequalities.

We will therefore implement the learning in stages:

Firstly, we will develop an online resource for both NHS GP practices and CQC inspectors, based on our learning from the project. We will communicate this to GP providers to raise awareness and to highlight that we are interested in hearing about innovative practice and recognising it through our regulatory assessments.

Secondly, under the new regulatory model, we will build a process to enable NHS GP practices to present evidence of their innovations to tackle health inequalities as part of their regulatory assessment.

This project has shown a clear need for innovation that responds to health inequalities to be captured and considered as part of CQC's regulatory assessments. We continue to explore exactly what information providers will need to present to show as evidence of their innovation, and how this may contribute to their regulatory assessments.

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