Frequently asked questions

Intelligent Monitoring: NHS acute hospitals

Contents

1. What is CQC's Intelligent Monitoring?	The new Intelligent Monitoring tool has been developed to give our inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust or a specialist NHS trust. The system is built on a set of indicators that look at a range of information including patient experience, staff experience and performance. The indicators relate to the five key questions we will ask of all services: are they safe, effective, caring, responsive, and well-led?
2. How will CQC use this analysis?	CQC will use the indicators to raise questions about the quality of care, but we will not use them on their own to make final judgements. These judgements will always be based on a combination of what we find at inspection, intelligent monitoring analysis and local information from the trust and other organisations.
3. How have the indicators been selected?	The indicators are those that we consider to be the most important for monitoring risks to the quality of care in acute hospital services. We selected these indicators because they measure things that have a high impact on people and because they can alert us to changes in those areas. We have engaged and consulted, and we tested the indicator set with a wide range of stakeholders. Our inspection programme will help us to refine the intelligence monitoring tool. For example, it will allow us to see whether trusts that don't flag up with many concerns are judged to be good when we inspect, or whether trusts that appear to be concerning are better than we expect.
4. In the June 2013 consultation document you described 'tier 2' and 'tier 3' indicators. How do these fit with the intelligent monitoring tool?	Tier 2 indicators include a much wider range of intelligence which, on their own, may not trigger us into taking action. We will check them if the first set of indicators signals a concern, to help us understand the issues raised and decide what an inspection should focus on. This set of indicators will be considered in the planning stage for inspection, and analyses of these indicators will feature in the data packs that are prepared for each inspection. We are committed to improving the intelligent monitoring tool as we go, and we know, for example, that there are other aspects of quality that we cannot yet monitor because of limited national datasets. We described the developmental aspects of the model as 'tier 3' and we will continue to test new indicator sources.

5. Which data sources have been used?	We have created indicators using existing datasets that CQC can access or information that is submitted directly to CQC. Some of the main datasets that have been used include: • Hospital Episode Statistics. • Incidents reported to National Reporting and Learning System. • Never Events reported to the Strategic Executive Information System (STEIS). • National Inpatient Surveys. • Experience information reported on NHS Choices, Patient Opinion, and to CQC. • NHS Staff Survey. • Junior Doctor Survey. • Electronic Staff Record. • Staff concerns reported to CQC (whistleblowing information). For a more detailed explanation of the data sources that we have used to generate these indicators, please refer to the document 'Indicators and methodology' on our website.
6. How up to date are the datasets that you are using?	CQC uses the most up-to-date datasets that we can access. The time period varies depending on the dataset. For some indicators there is a time lag between the date the data was originally collected and the point at which the information is available to CQC, whereas for others we can have access to the data source within a week.
7. How often will the indicators be published and where?	The indicators will be published quarterly on CQC's website: www.cqc.org.uk/hospitalmonitoring.
8. Do you wait for the refreshed data to make decisions about inspections? What if there's a serious incident at a hospital?	We'll continue to carry out inspections whenever we have information that people might be at risk of poor care. Intelligent monitoring helps us to determine our programme of inspections. If we had concerns that people were at risk, we would carry out an immediate inspection, outside of our planned programme.

9. How have you created the bands used to categorise trusts and how will you use these?	Trusts have been categorised into one of six summary bands, with Band 1 representing highest risk and Band 6 the lowest risk. The bands have been assigned based on the proportion of indicators that have been identified as 'risk' or 'elevated risk', or if there are known serious concerns with trusts (for example, trusts in special measures) they are categorised as Band 1. The bandings give CQC, and hospitals, a guide to the number of issues we need to look into in more depth. They should prompt hospitals to ask questions about their own performance in relation to others.
10. My local NHS trust is flagged as having a 'risk' or 'elevated risk' for a specific indicator. Is it safe?	The monitoring shows where there are issues we need to look into. It does not mean that people are at risk. You should always consult your GP or other medical professional about your treatment options.
11. Why are you using Dr Foster's hospital standardised mortality ratios (HSMRs)?	We have included the hospital standardised mortality ratios (HSMRs) calculated by Dr Foster Intelligence because this is a publicly available indicator. CQC has a data sharing agreement with Dr Foster Intelligence to govern the exchange of this information.
12. What's happened to the Quality and Risk Profiles (QRP)?	We will no longer be producing QRPs for acute and specialist trusts. We will phase these out for other types of services over the next year.