**Improved transparency of NHS information: hospital mortality data**

Local Health Boards in Wales have today (21 March) published hospital mortality data on their websites.

The Welsh Government’s five-year vision for the NHS in Wales, Together for Health, makes a clear commitment to excellence and to real improvements in the availability of information.

The data, known as the Risk Adjusted Mortality Index (RAMI), is also available via links from the Welsh Government website.

Health Minister Mark Drakeford welcomed the move and said:

“The Welsh Government is committed to transparency on performance and to improving access to NHS information. As from today, anyone in Wales can view a measure of hospital mortality data on Local Health Board and Welsh Government websites.

“The data published today add to a range of information available to help us assess the quality of our care.

“However, while it provides useful information, it should not be viewed in isolation as a measure of the quality of hospital care. We must use this information to drive up the quality of our care.’

Deputy Chief Medical Officer Chris Jones said:

“Only through a mortality case note review can it be determined whether a patient’s death may be associated with poor care. Since 2010, Health Boards have made vast improvements to how they review deaths in hospitals, to ensure there is a real understanding of the quality of care.

“RAMI data is affected by a number of factors including age, place of death, deprivation and the data collection systems from patient records to ensure they accurately reflect the diagnosis and treatment.

“A higher than average number of ‘expected deaths’ should not be interpreted as the number of ‘avoidable deaths’. Mortality data must, however, act as a trigger to review areas where deaths are higher than expected.

“There are some concerns about the quality and consistency of the data provided by Health Boards to the RAMI system, and this is an area in which we want to see improvements. The need to improve the timeliness and accuracy of data collection is well understood by Chief Executives and their boards. Health Boards have plans in place to meet the standards required.”
“Given the complexities of mortality measurements we will be looking at whether we need to develop an official mortality measure tailored specifically to the NHS in Wales.”

Notes

Mortality data are complex, particularly when looking at risk adjusted data, known as the Risk Adjusted Mortality Index (RAMI). Figures are affected by a number of factors including: age; place of death; deprivation and completeness of clinical coding. To aid understanding of mortality measures the Knowledge and Analytical Services department has also published a statistical bulletin today. This is available at [http://wales.gov.uk/topics/statistics/articles/?lang=en](http://wales.gov.uk/topics/statistics/articles/?lang=en).

Raw data from LHBs is used to used to derive risk adjusted mortality indices (RAMI). The RAMI is calculated as the ratio of the actual number of in-hospital deaths to the expected number of deaths. The baseline is set at 100. Therefore a RAMI greater than 100 (for the baseline period) means more deaths occurred than expected and a RAMI of less than 100 means fewer deaths than expected. As hospital mortality rates improve this baseline is reset each year, which explains why the Health Board information is presented separately as RAMI 2011 and RAMI 2012.

The RAMI data in Wales includes community and rehabilitation facilities, while English RAMI data does not. This must be taken into account when attempting comparisons

**National Reporting and Learning System (NRLS)**

All NHS organisations in England and Wales have been able to report to the NRLS since 2005. The primary purpose of the system is to enable learning from patient safety incidents. Imperial College Healthcare NHS Trust is responsible for its operational management.

In addition the reporting of patient safety incidents provides a further safeguard to pick up and investigate any individual case that might give cause for concern. Statistics published yesterday (20 March) by the National Reporting and Learning System (NRLS) show a continued increase in the number of patient safety incidents reported. This is encouraging, as high reporting of incidents shows that NHS organisations are being more open and provides NHS organisations with more opportunities to learn from incidents and improve safety.