Royal College of Physicians

National Hip Fracture Database (NHFD)

Room for improvement: hip fracture care in 2024

A report from the National Hip Fracture Database (NHFD)

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BGS British Geriatrics Society Improving healthcare for older people

British Orthopaedic Association

Royal Osteoporosis Society Better bone health for everybody

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Hip fracture in 2024 – the report at a glance

Each year 72,000 people in England, Wales and Northern Ireland have a hip fracture – and with an ageing population this figure could double by 2060. It is therefore important to both improve hip fracture patient care and do all we can to prevent this injury. This report examines how care in 2024 aligns to our three patient goals:

1 Getting to the right place

Will I receive an anaesthetic nerve block to numb my hip pain, and be admitted to a specialist ward where a team of doctors, nurses and therapists can work together with me to plan my surgery and rehabilitation?

✓ Over three-quarters of patients now receive a pain-relieving nerve block to help make them comfortable when they first present with a hip fracture.

✗ But 20 hospitals (12%) recorded that the average delay patients experienced before they were admitted to a bed on an appropriate orthopaedic ward was over 24 hours.

2 Getting up after surgery

Will I have surgery by the day after I'm admitted and return to the ward with a clear plan for my treatment that means I am not confused and can get out of bed to eat a normal meal the next day?

✓ Most patients (93%) are screened for delirium after surgery, but this year over 50,000 patients (69%) were also screened when they first presented with a hip fracture.

✗ But just 58% of patients received surgery by the day after their hip fracture, far fewer than the 68% reported before the COVID-19 pandemic.

3 Getting back home again

Will I get back to my home before my hospital admission, be supported to take bone strengthening treatment to avoid future fractures, and followed-up so my experience in hospital can help improve the care of future patients?

✓ For the first time, we can report that the majority of patients (54%) are known to be receiving bone strengthening medication to prevent future fractures.

✗ But a small number of hospitals still report that practically none of their patients are being offered effective fracture prevention medication, and the NHFD will be contacting them to offer support to these teams.

Introduction

The National Hip Fracture Database (NHFD) is part of the Falls and Fragility Fracture Audit Programme (FFFAP) commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the governments of Wales, Northern Ireland, Guernsey, and the Isle of Man as part of the National Clinical Audit and Patient Outcomes Programme.

Hip fracture is the most common serious injury affecting frail and older people and the most common reason for them to need emergency anaesthesia and surgery. For 16 years the NHFD has examined the care provided to every over 60 year old who breaks their hip. All will need admission to hospital and this single injury leads to the occupation of one in 30 of all hospital beds, at a cost of £2 billion.

Most patients are aged over 80 and ageing of the UK population means that the total number of people with this injury has been predicted to double by the year 2060. However, improvements in population health, including the management of osteoporosis, may explain why the NHFD has not seen evidence of such a trend.

The total number of hip fractures has increased by 6.2% since the COVID-19 pandemic, from 67,673 in 2019 to 71,885 in 2024. However, this rise is much smaller than might be expected on the basis of the growth of the older population, with the number of over 80 year olds having grown by 13.4% over the same period.

The length of time people have to wait for surgery also remains a concern. Poorer population fitness and increased pressure on orthopaedic services following the COVID-19 pandemic have persisted: in 2024 just 58% of people received surgery by the day after they presented with a hip fracture, compared to 68% in 2019.

We work with a wide group of patients, clinicians, healthcare workers and national groups to review our findings and to develop recommendations that will improve patients' care.

Our 16 previous annual reports, website and dozens of published studies based on our data provide clinical staff and managers with a wealth of technical information about hip fracture care.

The background, aims and scope of work of the NHFD can be found online, as well as the methods of data analysis. A glossary of terms is available here and acknowledgements can also be read online. You can also read this table, which connects recommendations from this report and key messages to clinical guidance.

The NHFD provides continuously updated data on our website, which are available to all.

This short video explains how health service managers and others can use the website to compare care in different parts of the UK.

Clinical staff can use the website to guide meetings in which they review the care they provide, alongside its outcome and feedback from patients – and consider how they might improve these. Patients, their families and carers, and members of the public can use the website to understand the performance of their local hospital and access resources co-produced with the FFFAP Patient and Carer Panel.

Patient demographics in 2024	Sex		Age (years)/Age groups				Socio-economic deprivation (IMD)				
	N	Women	Mean (SD)	60–69	70–79	80–89	90+	Most deprived	2	3	4	Least deprived
England	65,133	69.0%	82.4 (8.6)	8.9%	25.4%	43.9%	21.8%	17.1%	18.2%	21.2%	21.9%	21.6%
Northern Ireland	2,347	69.7%	80.7 (8.8)	13.4%	27.2%	43.5%	15.9%					
Wales	4,401	68.3%	81.9 (8.6)	9.1%	27.9%	43.8%	19.2%	16.1%	21.6%	21.1%	21.2%	20.0%

Key findings for 2024

Emergency departments know that at least one person each day will present who needs urgent admission for hip fracture surgery. But in 2024, patients spent an average of 15 hours waiting before they were made comfortable in a bed, on a ward appropriate to their needs.

It is a concern that two hospitals (1%) still recorded over 10% of patients as not receiving surgery; that 5% of all operations were recorded as having been performed by unsupervised trainees and that nine hospitals (5%) recorded over 10% of patients as not being allowed to fully weight bear after surgery.

Our 2022 facilities survey found over a quarter (30%) of hospitals were only providing physiotherapy to all their patients on Monday to Friday. NHFD data have been used to develop the REDUCE toolkit, which shows how therapy on Saturday and/or Sunday could see patients spending 2.3 fewer days in hospital, with a cost saving of £676 per patient.

A quarter of people who break their hip will have another fragility fracture in the future. The majority (56%) do now receive bone strengthening medication, but 10 hospitals (6%) discharged over three-quarters of patients without them receiving effective bone protection.

The NHFD has not found inequalities in hip fracture care and outcome for people of different ages, sexes or ethnicities. However, inequality is seen for other fractures compared to hip fractures. People with pubic ramus fractures are the next largest group needing admission and these patients' need for care is very similar to that offered after hip fracture surgery.

Recommendations

By April 2026, all Integrated Care Boards (ICBs), health boards in Wales and health and social care trusts in Northern Ireland should:

2. Require emergency and orthopaedic departments to agree fast-track admission policies, so that at least one in five patients reach a specialist orthopaedic ward within 4 hours of admission with a hip fracture.
3. Review each hospital's NHFD data to ensure that at least 95% of patients are able to access surgery, that this is documented as having been supervised by a senior surgeon and that it allows them to get up fully weightbearing.
4. Require each hospital to commission appropriate physiotherapy capacity so that all inpatients recovering from hip fracture can receive at least one session of physiotherapist-directed rehabilitation each weekend.
5. Require all hospital teams to review their use of injectable bone protection, so that at least half of all patients are recorded to be on bone strengthening medication 4 months after a hip fracture.

1. NHS England and Welsh government should use the results of the audit of pelvic ring fracture we will be piloting from January 2026 to challenge the main form of inequity in the management of fragility fracture which, as both the NHFD and GIRFT have shown, relates to the care of people with fractures at different sites.

How soon will I be made comfortable and admitted to the right ward?

1. ICBs and health boards should require emergency and orthopaedic departments to agree fast-track admission policies, so that at least one in five patients reach a specialist orthopaedic ward within 4 hours of admission with a hip fracture.

Patients with hip fractures are an ideal test of hospital admission pathways. Most people who fall and break their hip are brought to hospital by ambulance. They may have spent time on the floor before being found, waited for or in an ambulance before entering the emergency department (ED).

Their arrival should not be a surprise – nearly all EDs expect to see at least one or two of these patients each day. These patients will all need to be admitted, and pathways should be in place to make this as easy for them as possible.

Emergency department care

Once patients are in hospital, ED staff and members of the orthopaedic team need to work together to understand the patient's medical, psychological and social background, the fall and any injuries they may have.

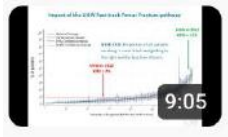
This short video explains how staff in the ED can use the NHFD to improve the care they are providing to people with hip fracture

Hip fractures hurt when the patient moves as the edges of broken bone are very sensitive. A 'nerve block' injection (like the injection given by dentists) in the groin can numb this pain and reduce the need for strong painkillers, which might make people drowsy or confused. It is a triumph that over three-quarters of patients (76%) now receive a nerve block, a significant increase from 57% 5 years ago.

All patients should be checked for delirium (confusion) using the 4A test (4AT) when they present with a hip fracture. Two-thirds of delirium is present on admission and its recognition will guide care to avoid problems as an inpatient.

Prompt admission

Our 2023 report called for hospitals to avoid delay in patients entering and leaving the ED so they are 'fast-tracked' to a proper bed on a specialist ward where a team of nurses, surgeons, therapists and others can work together to plan their care.



The case study in this short video shows how reorganisation of the admission pathway can mean that patients face much shorter times before they are made comfortable on a specialist ward.

Delayed admission is associated with increased risk that the patient may develop a pressure sore, and with poor outcomes (longer hospital stay and higher mortality). The NHFD reports whether patients receive a pain-killing nerve block and get to the right ward within 4 hours (KPI0), to improve their experience in the first hours. In 2024, we found that just 9% of patients met this KPI (compared to 8% in 2023).

It is important to try and avoid patients being placed on other (non-orthopaedic) wards or surgical assessment units, where staff may be unfamiliar with their needs. Hip fracture teams should look at how often this happens in their unit and, where it is an issue, consider using a local audit to monitor how it affects patient care.

In 5 hospitals (3%), less than 1% of patients reached an appropriate ward within 4 hours. Patients in these hospitals spent around 20 hours longer in the ED than in hospitals which admitted 20% of patients to a ward within 4 hours. Such hospitals are essentially using one bed-day in ED for each admission. It would be kinder and more efficient to anticipate the needs of the patients who will present each day by prioritising flow so beds are made available and new cases reach an appropriate ward within 4 hours.

Inpatient falls

Although most hip fracture patients fall outdoors or at home, three in every 100 hip fractures happen after a fall when the patient is already in hospital for another reason. Our other audit, the National Audit of Inpatient Falls (NAIF), looks at how hospitals might improve care to avoid such falls and injuries.

How is my operation explained and supervised, so I can get up afterwards?

2. ICBs and health boards should review each hospital's NHFD data to ensure that at least 95% of patients are able to access surgery, that this is documented as supervised by a senior surgeon and that it allows them to get up fully weightbearing.

The time taken to perform surgery is only a very small part of a patient's hospital stay but can be a cause of anxiety and concern for them and their relatives. Leadership of the surgical team and the oversight of the operation, aftercare and governance all play an important role. There are several opportunities for this difficult time to be made less worrisome.

Consent for surgery and discussing non-surgical management

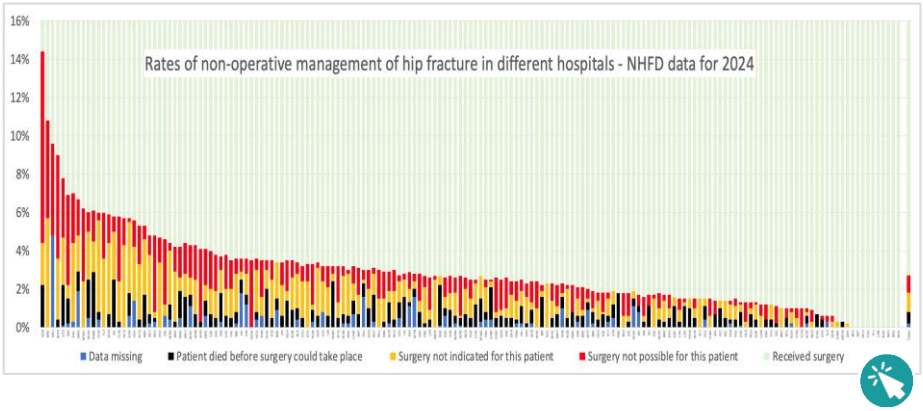
The process of surgical consent is central to alleviating concerns and keeping patients and their relatives informed. The 'consent form' is an important legal document, but its main value in the consenting process lies in how it structures the process of supporting the understanding of those undergoing surgery.

The consent process must be a shared decision between the clinical teams, the patient and those close to them. Consent often focuses on the choice of operation and information specific to this – but the consent process is broader than this. Consent must include discussion of the risks and balances of the alternative; what might happen if surgery is not performed (non-surgical management).

A small number (0.6%) of patients are so unwell when they present that they die before surgery can go ahead. Another 1% of patients have a fracture that will heal successfully without surgery. In 2024 we found that just 0.9% of patients were felt to be medically unfit for surgery, which is significantly lower than the 1.2% we identified for 2023 in our last annual report.

However, this picture remains very variable and some hospitals continue to report around one in 10 of their patients as not being fit for surgery. This is a cause for concern and where it is a consistent problem the NHFD will be working with and supporting the local clinical teams to review decision making in the pre-operative period.

The clinical leads in every hospital should review their own performance in their governance meetings, using the non-operative management rates figure which presents data for 2023 and 2024; and teams should consider whether this is a topic for improvement work.



Hospitals must use regular audit and interviews with patients to oversee the information transfer and consenting processes, so that all parties are well informed throughout. In order for this to be successful, leadership is required throughout the process – not just from the clinical teams. ICBs and health boards need to ensure that hospitals are in control of this important facet of care. To help with transfer and consenting processes, we have developed a number of videos intended to guide and assist with this.

This video explains how staff can talk to patients about the metalwork needed for their type of fracture.

This video explains how staff can talk to patients and their families about consent and plans for surgery.

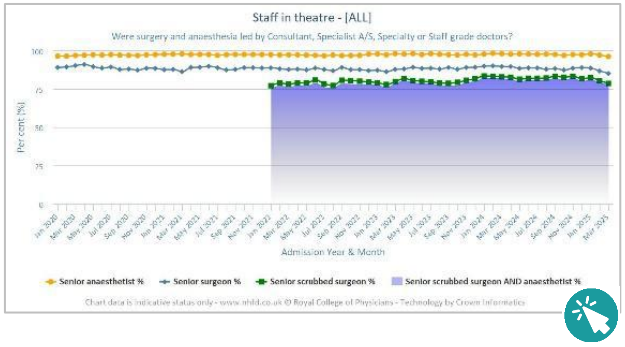
Surgeon and anaesthetist seniority

The seniority of theatre staff is crucial to the quality and outcome of surgery and anaesthesia. It is therefore vital that theatre and NHFD records provide an accurate picture of the seniority of those leading operative care.

Senior surgeons may not always perform the operation themselves. All doctors, including surgeons and anaesthetists, have to be trained. The nature and assessment of training is more stringently monitored than in the past, and new options permit part of training to be 'virtual' or outside the operating theatre. However, there is still a need for doctors to train by looking after real patients.

A senior surgeon may be in the operating theatre 'unscrubbed'; not performing the operation but overseeing it, anticipating difficult parts of surgery and giving constant guidance where needed. With very senior trainees, the consultant may not be in the room but nearby within the theatre suite, immediately available should the need arise. This is normal for an appropriate trainee. However, surgeons and anaesthetists in training should all be supervised to some extent and it is unusual for unsupervised trainee doctors to provide hip fracture care.

In 2025 we launched a run chart of 'theatre staff seniority' that shows how many operations are performed or supervised by 'senior' (i.e. consultant, specialist or specialty) surgeons and anaesthetists.



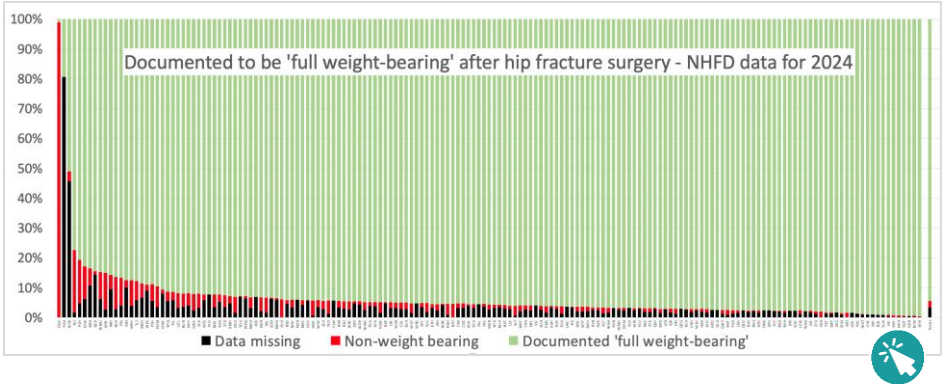
Teams in all hospitals need to review their chart to check that they are reporting data that correctly identifies the seniority of the staff leading theatre care.
In 2024, there were 34 hospitals (20%) that recorded both a senior surgeon and senior anaesthetist for over 90% of all operations. However, 47 hospitals (28%) reported this for fewer than half of cases. In 3,600 (5%) of all operations, both the surgeon and anaesthetist were identified as unsupervised trainee doctors.

Early full weight bearing

The goal of surgery is to allow a patient to get out of bed, to stand and sit in a chair by the next day. Senior input is key to ensure that surgery results in a hip that the patient can confidently put weight on as they try to get up.

However, there is considerable inconsistency in the quality and wording of postoperative weight-bearing instructions both between and within units. A few surgeons place constraints on whether a patient can put their full weight onto the operated leg, limiting both their confidence and that of the staff who will be helping them to rehabilitate. Clear guidance is provided by recent BOAST guidelines, which asks surgeons to record the success of surgery by documenting that patients may weight bear fully and get up without restriction.

Restoration of a patient's ability to walk is often seen as the responsibility of physiotherapists. Clear documentation that a patient can freely weight bear helps nurses to work alongside the therapists, so patients get up sooner, more frequently and return to normal activities at the earliest opportunity.



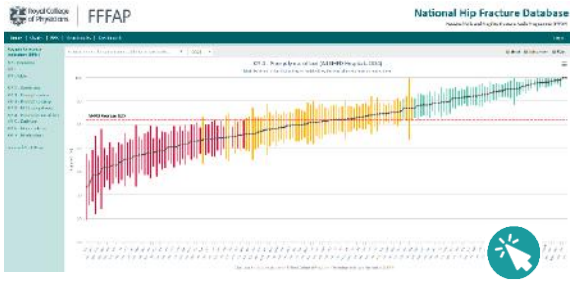
Data for 2024 shows an improvement, with 94.5% of patients (compared to 93.8% in 2023) now documented as 'fully weight bearing'. The weightbearing chart also presents the picture for other types of femur fracture surgery. The local orthopaedic lead in each hospital should use this to decide whether weight-bearing decision-making and communication need to be improved.

How will I be supported to get back on my feet after surgery?

3. ICBs and health boards should require each hospital to commission appropriate physiotherapy capacity so that all inpatients recovering from hip fracture can receive at least one session of physiotherapist-directed rehabilitation each weekend.

Getting up after surgery

The aim of hip fracture surgery is to relieve pain and allow patients to get back on their feet as early as possible.



Patients who get out of bed on the day of, or the day after operation (KPI4) are less likely to die within 30 days and more likely to return home sooner.

Pain, low blood pressure and confusion may limit people getting out of bed after surgery. Anaesthetic teams can help prevent these barriers by providing guidance on pain control and fluid management as part of a Ready to leave recovery tool from our 2023 annual report.

This 4-minute case study describes work led by the physiotherapist team in Cardiff, showing how multidisciplinary working can get most patients out of bed on the same day as their operation.

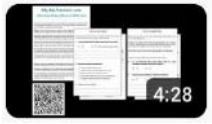
The NHFD measures how many people successfully get up by the day after surgery. But in a well-organised unit at least some patients can get up on the afternoon or evening of surgery, just as they do in elective orthopaedic wards.

This short video describes how physiotherapists and others in the team can use NHFD data to identify common barriers to patients getting up promptly after surgery.

Continuing inpatient rehabilitation

Chartered Society of Physiotherapy (CSP) hip fracture standards state that 'all patients should receive daily physiotherapy'. This is only possible if therapy continues at weekends, so patients do not lose momentum in rehabilitation. Teams can use CSP hip sprint resources to audit their weekend provision.

Work using NHFD data has shown that patients spend 2.3 fewer days in hospital if that hospital provides physiotherapy on a Saturday and/or Sunday. The results of this work were used in building the REDUCE hip fracture implementation toolkit, which shows that reduced length of stay with providing weekend physiotherapy should deliver a notional cost saving of £676 per patient.



This 4-minute video describes how you can use the results of the REDUCE project in developing business cases, including one to establish weekend physiotherapy.

Continuing rehabilitation after discharge

The CSP hip fracture standards also highlight the importance of starting community rehabilitation within 72 hours of leaving the acute hospital. Our Physiotherapy Sprint Audit (PHFSA) found 79% of patients waited over a week for such input. The REDUCE study showed hospitals who understood these delays had far fewer readmissions.

NICE guidance [CG124] recognises the importance of regular meetings between hospital ward and community staff to optimise rehabilitation pathways. Regular multidisciplinary clinical governance meetings provide a forum to review quality outcomes and plan service improvement.

The REDUCE study demonstrated physiotherapy attendance at such meetings was associated with a 6% lower mortality and an increased likelihood of patients returning home. A recent NHFD survey revealed that physiotherapists attend 88% of such meetings.

Fairness: will I receive the same quality of care as other people?

The UK has legal safeguards so that the healthcare people receive should not be affected by 'protected characteristics' such as their age, sex and ethnicity.

Age and sex

In the past, older people were less likely to receive surgery after a hip fracture. The work of the NHFD means that nearly everyone now has surgery. No one is 'too old for an operation', but older people tend to have more health problems than younger people.

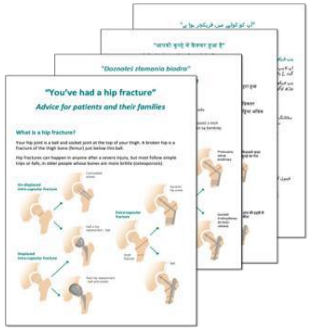
Women can develop osteoporosis after menopause, increasing their risk of fractures. However, fractures in men often reflect other health problems. Men with hip fractures tend to be less healthy and make a poorer recovery after a hip fracture.

Our 2024 report showed that most patients are cared for by multidisciplinary teams led by doctors specialising in the care of older people, and that a patient's age or sex had no effect on which surgeons and anaesthetists did their operation.

Our first webinar of 2025 discussed the pioneering work that has been done using NHFD data to challenges inequalities in the care of people with hip fracture.

Ethnicity

Patients need to understand what is happening if they are to make informed decisions about their care. This understanding will depend on the quality of the information they are offered.



Last year's NHFD report launched a ward poster with QR codes linked to a multilingual resource making such information available to people for whom English is not a first language.

A collaboration with University of Leeds led by an NHFD fellow has examined how people from different ethnic groups recover after a hip fracture.

Recovery was affected by differences in the age, sex and mental and physical comorbidities of different ethnic groups. But after correcting for these, there was no difference in the number of White and non-White patients dying in the month after hip fracture.

Non-White patients' risk of dying in the following year was lower; just three-quarters that of White patients.

These results suggest that the type of care that people receive is not affected by who they are but depends on their previous health. This equity is reassuring but does not mean other barriers and inequalities do not exist.

Comparison of White and non-White patients admitted with hip fracture
Sohail Nisar *et al. Bone and Joint Journal* 2024

	White	non-White
Proportion of hip fracture admissions 2011-2020 (%)	97.7	2.3
Demographics:		
Female (%)	71.5	65.1
Mean age (years)	83.0	81.2
Most deprived quintile (%)	17.2	29.4
Most affluent quintile (%)	20.3	13.1
Prior to hip fracture:		
Lived in own home (%)	78.2	87.1
Lived in institutional care (%)	21.8	12.9
Freely mobile without aids (%)	34.6	33.8
Normal Abbreviated Mental Test score (%)	62.0	53.3
American Society of Anesthesiology grade ASA 4-5 (%)	16.2	16.9
Fracture:		
Intracapsular (%)	60.1	53.9
Intertrochanteric (%)	34.4	39.3
A3/Subtrochanteric (%)	5.5	6.7
Operation:		
Cannulated crews (%)	3.4	3.0
Uncemented hemiarthroplasty (%)	6.7	7.2
Cemented hemiarthroplasty (%)	38.0	32.0
Total hip replacement (%)	6.7	5.4
Nail or sliding hip screw (%)	45.1	52.5
Performance:		
Mean time to operation (hours)	32.1	33.6
Out of bed by the day after surgery (%)	79.0	74.3
Re-operation (%)	2.6	3.7
Discharge destination:		
Returned to own home (%)	50.2	61.4
Rehabilitation unit (%)	18.3	14.9
Care home (%)	22.2	13.0
Acute hospital (%)	0.9	1.5
Died as an inpatient (%)	8.4	9.2

Socio-economic deprivation

Finally, it is known that a patient's risk of having a hip fracture is affected by their social and financial factors. A measure called the index of multiple deprivation (IMD) can be used to examine the health of people from more affluent (IMD1) and more deprived (IMD5) areas.

A project by the REDUCE study team, funded by the Royal Osteoporosis Society (ROS), is using NHFD data to see how patients' age, sex, ethnicity, health and IMD all affect their recovery after a hip fracture. We plan to use the results of this project in next year's NHFD report.

Fairness: does every fracture lead to the same quality of care?

4. ICBs and health boards should require all hospital teams to review their use of injectable bone protection, so that at least half of all patients are recorded to be on bone strengthening medication 4 months after a hip fracture.

Despite huge progress in the last 16 years, there is still great variation in the quality of care people receive in different parts of the country. One example is how well different hospitals protect their patients against future fractures.

A quarter of people who break their hip have another fracture within 5 years. The NHFD measures how many are known to be on effective bone strengthening treatment 4 months after a hip fracture (KPI7). This figure rose from 43% to 56% in the time since a Call to action in September 2023. This meant that over 10,000 (14%) more people received bone protection in 2024.

Most hospitals (58%) give over a third of their patients the osteoporosis treatment as a drip (zoledronate) before they leave hospital, as was advocated by the 2023 Call to action. However, 16 hospitals (9%) did this for fewer than 5% of their patients.

Zoledronate costs just a few pounds, so the total cost of giving bone protection to a third of the patients in these 16 hospitals would have been less than the cost of the care for just one person with a hip fracture that might have been prevented.

This short video outlines how drip treatment with zoledronate can help to ensure that the majority of people receive effective bone strengthening treatment before they leave hospital.

No patient should expect to leave hospital after a stroke or heart attack without appropriate treatment to prevent another, but in some hospitals this still seems to be usual practice after a fragility fracture. For this reason the NHFD are following the Healthcare Quality Improvement Partnership's cause for concern policy; challenging the ICBs, health boards and executives responsible for these hospitals in order to ensure that effective bone protection is provided to their patients.

5. NHS England and Welsh government should use the results of the audit of pelvic ring fracture we will be piloting from January 2026 to challenge the main form of inequity in the management of fragility fracture which, as both the NHFD and GIRFT have shown, relates to the care of people with fractures at different sites.

People with fragility fractures in other bones

The NHFD has extended its work so that people with other fractures can benefit from what has been achieved for those with a hip fracture.

Most people with a hip fracture now receive bone treatment, but only one-third of people with a fracture at the other end of their thigh bone (distal femur) are treated in this way. 20 hospitals (13%) did not offer bone protection to any of these patients. The NHFD has published these figures and aims to start reporting data from 2026.

Even greater variation is seen for admissions with other fracture sites. We believe inequality in the care of other fracture types would be best addressed by extending the remit of the NHFD to people with pubic ramus and pelvic ring fractures. This is the third most common fracture admission – an injury for which NHFD-led improvements modelled on hip fracture would lead to dramatic patient benefits.

Our other audit, the Fracture Liaison Service Database (FLS-DB) aims to ensure that all patients over 50 years old with a fragility fracture of any bone are assessed for bone strengthening treatment. Analysis by the NHFD and FLS-DB has shown that in 2022 the FLS-DB identified that 57,000 people with a fragility fracture had missed out on the opportunity for effective fracture prevention.

A total of 69 hospitals (41%) still appear not to have established a FLS to assess and treat such patients. Instead these hospitals will need to look after these patients when they return with another fracture – that could have been avoided.

The ROS provides a range of resources to support the development of FLS business cases and implementation of FLSs. Please email the ROS for further support FLS@theros.org.uk

Improving survival after hip fracture

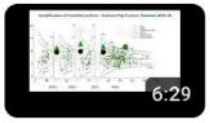
When the NHFD was set up in 2007, the diagnosis of hip fracture was often viewed with a sense of despair by patients and their families. Many had seen friends or relatives die after this injury and even the staff caring for these patients could feel helpless in dealing with the complex physical, mental and social problems. Thankfully, this is no longer the case.

Modern anaesthesia means that 99 out of 100 of even the sickest people with hip fracture survive surgery – and that the vast majority can benefit from the pain relief and the chance to regain independence that surgery offers.

Pre-existing medical illnesses mean that some patients face problems in the following weeks, but 94% of all patients survive beyond the first month after injury. The number who now die in the month after a hip fracture has halved from 11% in 2007, when the NHFD was established.

Helping to improve survival after hip fracture

Our website now shows rates of survival for each hospital over the whole of 2024.



This short video explains how teams can use the NHFD to monitor survival figures in their hospital use this as a stimulus to improve the services they are providing.

We would like to again congratulate Wythenshawe Hospital in Manchester and additionally Southampton General Hospital, which both recorded very high survival figures. Other hospitals should aim to learn from such examples and our 2024 spring conference allowed teams to share their experiences; alongside case studies in our improvement repository.

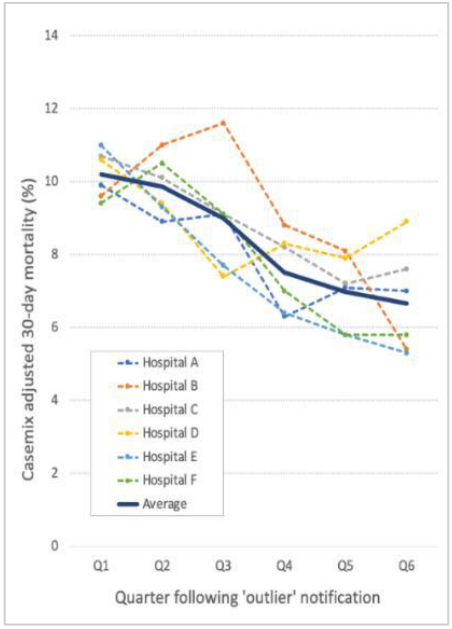
Our reporting on survival helps hospitals to monitor their own success. Every 3 months the NHFD checks its data against the death register to see how many people have died in the month after a hip fracture.

The NHFD then sends this information to our analyst team at the University of Bristol who perform statistical analysis.

One hospital may look after patients who are less fit than those in another. Our reporting takes account of this by looking at the age, sex, health, mobility, type of hip fracture and previous residence of patients in each hospital. You can read more information on how we produce these charts on our website.

Each quarter the NHFD team review the 30-day mortality charts, which allow staff in each hospital to monitor the success of the care they provide.

Some of the 175 hospitals will show unusually low or high numbers of deaths on their chart and these units will be notified of this straight away. Details of when and how this happens can be found in our outlier policy.



In 2024, we contacted six hospitals (4%), which were identified as outliers. The clinical teams and hospital managers were notified that they were recording more deaths than we would have expected, given the patients they had admitted.

Senior managers and clinical leads in all these hospitals were provided with advice on how they might respond to this finding. Ongoing support was provided by the NHFD clinical leads to ensure that they were able to respond and improve as quickly as possible.

This graph shows how those identified as outliers for by 30-day mortality in 2023 responded to the support we provided.

The strategy was different in each hospital, our support being tailored to specific local failings identified in review of their KPI overview table and recommendation of proven improvement strategies described in previous annual reports. The success of this is demonstrated by the fact that these hospitals recorded 30-day mortality to have fallen by a third in the year after their identification as outliers.

Get in touch

For further information, please contact us – we want to hear from you.

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