Royal College of Physicians

National Hip Fracture Database (NHFD)

A broken hip – three steps to recovery

Using the National Hip Fracture Database to understand and improve hip fracture care in 2024

1 January – 31 December 2023

In association with:

British Geriatrics Society
Improving healthcare for older people

British Orthopaedic Association

Royal Osteoporosis Society
Better bone health for everybody

Commissioned by:

HQIP
Healthcare Quality Improvement Partnership

Hip fracture in 2023 – the report at a glance

Every year, over 70,000 people in England, Wales and Northern Ireland will fall and sustain a hip fracture.

Most people (19 out of 20) now survive, so it is not enough to measure quality of care by examining mortality figures alone.

This report shows how the National Hip Fracture Database captures patients' experience and helps to answer questions about three key steps in recovery from this injury.

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?

0. Admission to specialist ward
8%
NHFD overall: 8%

1. Prompt orthogeriatric review
87%
NHFD overall: 87%

More people than last year get to an appropriate ward and receive the care of a team with an orthogeriatrician, though these figures are still poorer than pre-COVID.

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?

3. NICE compliant surgery
66%
NHFD overall: 66%

2. Prompt surgery
58%
NHFD overall: 58%

More people (two thirds) now receive the operation recommended by NICE, and surgery by the day after admission has improved slightly after the delays of the post-COVID period.

5. Not delirious post-op
65%
NHFD overall: 65%

4. Prompt mobillisation
81%
NHFD overall: 81%

As in past years, four out of five patients get out of bed by the day after surgery, though the number shown to be free of delirium has improved to nearly two thirds.

3. Getting back home again

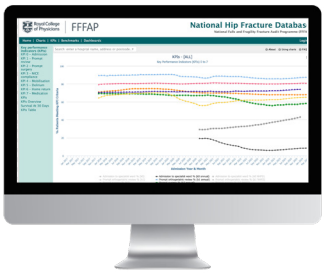
Will I get back to my home before my hospital admission, be supported to take bone strengthening treatment to avoid future fractures, and followed-up so my experience in hospital can help improve the care of future patients?

6. Return to original residence
74%
NHFD overall: 74%

7. Bone medication
43%
NHFD overall: 43%

More people than ever are returning home and successfully being supported to continue with osteoporosis treatment to prevent future fractures.

Visit the NHFD website to see the progress 174 different hospitals and each country are making.



Introduction

Every year, over 70,000 people in England, Wales and Northern Ireland will break their hip. This leads to the occupation of one in thirty hospital beds and a cost of £2 billion to care for this injury.

The National Hip Fracture Database (NHFD), part of the Falls and Fragility Fracture Audit Programme (FFFAP) run by the Royal College of Physicians, uses information from every eligible hospital in these countries to show how the right care and support can help to get people back onto their feet and leading a good quality life.

15 previous annual reports, our 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. A glossary of terms is available here.

In contrast, this report aims to provide readers with a simple guide to all these data and resources by describing the care that hip fracture patients should receive on their journey to recovery:

- as they first present with a new hip fracture
- as surgery allows them to get out of bed again
- through rehabilitation until they are back in their home.

Anyone who wishes can access continuously updated data on the NHFD website.

State of the nation: how to use the NHFD website to review care in each country

This report does not just present a picture of hip fracture care last year but shows what is happening **now** in each of the 174 hospitals in England, Wales and Northern Ireland.

In this way, the interactive report will remain up to date, not only as it is published in 2024 but also as a guide for future readers in future years.

The NHFD has overseen tremendous improvements in hip fracture care over recent years, but admission to hospital with a broken hip remains a traumatic event for patients, their families and carers. The advice and information they all need is very different from the often very technical data displayed on our website.

Experts in the NHFD team include clinicians who have looked after many thousands of patients, as well as people who have sustained this injury themselves, or who have cared for someone who has.

This combination of expertise helps to ensure the patient focus of our work so that it measures, and seeks to improve, what the patient actually experiences.

Our Patient and Carer Panel members have used their real-life experience to create online resources to inform and support patients and carers.

'About your hip fracture' is freely available on the NHFD website; a guide that includes a set of questions based on essential elements of high-quality hip fracture care that patients should consider asking the team looking after them.


About your hip fracture

'A guide for family and carers' gives practical advice about the kind of support and care that someone with a hip fracture might need, and how to help someone you care about to be understood as a unique individual, to eat well, stay connected, and make the best possible recovery.


A guide for family carers

Recommendations

We work with a wide group of patients, clinicians, healthcare workers and national groups to develop recommendations to improve care.

NHS England and Welsh Government should use NHFD data to monitor hospitals' delivery of three key stages of care:

1. **To ensure that hospitals are ready for the people they know will present each day, so patients receive each step of their care at the right place at the right time.**

   Nearly all hospitals can expect to admit at least one patient with a hip fracture each day.

   NHS England and Welsh Government should use hospitals' performance data on NHFD's KPIs 0 and 1 to support them to be able to provide effective team management to patients, including adequate relief of pain (nerve block) and prompt admission to a specialist ward under the multidisciplinary team who will care for them along their whole inpatient stay.

2. **To ensure that all hospitals provide both prompt surgery and optimal peri-operative care so patients can start getting back on their feet as soon as possible.**

   NHS England and Welsh Government should use hospitals' performance data on NHFD's KPIs 2 and 3 to ensure that that surgery is planned in line with national guidelines for evidence-based cost effectiveness, without unwarranted variation.

   NHS England and Welsh Government should use hospitals' performance data on NHFD's KPIs 4 and 5 to ensure that anaesthetists, surgeons and the ward team are enabled to work together in planning post-operative care that ensures patients are physically and mentally well enough to get up by the day following their operation.

3. **To ensure rehabilitation and recovery is planned and started early, and continues beyond the hospital with measures to prevent another fracture.**

   NHS England and Welsh Government should use hospitals' performance data on NHFD's KPIs 6 and 7 to ensure that rehabilitation is planned and started early, and continues beyond the hospital.

   Hospital and community therapists, nurses and orthogeriatricians should be supported by NHS England and Welsh Government to complete 120-day follow-up so this can improve their understanding of patients' post-discharge progress, break down boundaries in the pathway, and help patients continue on bone strengthening medication to prevent further fractures.

NHS England and the Welsh Government need to address wider inequalities and inequities in patient care:

4. **By agreeing a standardised approach to the collection of ethnicity data across all patients' pathways and provider organisations.**

   NHS England and the Welsh Government should agree a policy and work with local providers to ensure that patients are supported to identify their ethnicity just once, so this can be recorded and then set against the care and outcome reported by all national clinical audits; rather than this being repeatedly requested or inaccurately recorded by staff each time patients attend hospital with different conditions.

5. **By ensuring that people with other injuries benefit from the improvements that have been pioneered among those with hip fracture.**

   NHS England and the Welsh Government support hospitals to implement the GIRFT pathway for non-ambulatory fragility fractures to ensure that patients admitted with other fractures that prevent them from walking have access to the same quality of collaborative orthopaedic-geriatric care which the NHFD has shown to be effective for people with hip fracture.

The first hours

Goal 1 – The patient is promptly made comfortable with a nerve block and admitted to a specialist ward where a team of nurses, different doctors and therapists can work together with them to plan surgery and rehabilitation.

Older people are at increased risk of falling and breaking a hip, and most people are brought to hospital by ambulance after a fall outdoors or at home, with one in six admitted following a fall in a care home.

The risk of falling is greater if they are frail or unwell, with one in thirty hip fractures happening after a fall when the patient is already in hospital for another reason. The National Audit of Inpatient Falls (NAIF) looks at how hospitals might improve care to avoid such falls and injuries.

Patients may have spent some time on the floor before being found, may have had to wait for an ambulance to reach them, or may have had to wait before moving from the ambulance into the Emergency Department (ED).

Hospital teams should work together with **ambulance staff** to improve the patient experience; for example, agreeing that they may still eat and drink before arriving at hospital (p74, FFN 2019), and should be prioritised for admission rather than remaining in an ambulance when services are busy.

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.

Hip fractures are painful when the patient moves as the sharp edges of broken bone are very sensitive. A 'nerve block' injection (like the injection given by dentists) in the groin will numb this pain and can reduce the need for strong painkillers which might make people drowsy or confused.

Hip fractures are so common that nearly all hospitals expect to admit at least one patient with this injury each day. They should plan for this and have routines in place to speed up how quickly nerve blocks are offered, and how quickly the patient is assessed and the fracture confirmed on x-ray, since hospitals record such different challenges in delivering nerve blocks.

ED and **orthopaedic teams** should run the short local audit, described in the Royal College of Emergency Medicine 2023 report, to review how they manage common problems such as pain, dehydration and pressure ulcer prevention.

How can staff in Emergency Departments help to improve care and speed admission to the right ward

All patients should be checked for delirium (confusion) using the 4A test (4AT) when they arrive. Two thirds of delirium is present on admission and its recognition will guide care to avoid problems during their time in hospital.

Our 2023 report called for hospitals to avoid a 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 and provide care.

The NHFD reports how quickly patients get to the right ward with a nerve block **(KPI0)** to improve their experience in the first hours. Some hospitals achieve this for over a third of patients, but others don't achieve it at all.

It is important to try and avoid patients being placed on other wards 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, they should consider using local audit to monitor how it affects patient care.

The first days

Goal 2 – The patient has surgery by the day after admission and returns to the ward with a clear treatment plan that means they are well enough to get out of bed, free of delirium and eat a normal meal the next day.

All new patients presenting with a broken bone should be discussed by the hip fracture team early the next morning, before the start of the day's operating lists. They will then be seen by senior doctors in both **orthopaedics** and **anaesthetics**, and most are seen by a doctor specialising in the care of older trauma patients (orthogeriatrician) **(KPI1)**. It is important that patients and their families are helped to understand the reasons why different operations may or may not be performed, and supported to make decisions about what they wish to happen during and following surgery.

Talking to patients and their families about plans for surgery

Is an operation needed?

The pain of a hip fracture can be temporarily eased by a nerve block and painkillers, but surgery is the best approach for permanent relief.

Regardless of the type or location of hip fracture, comfort and dignity must be prioritised in unwell and frail patients, even if there is concern over their ability to survive the stress of surgery. These issues need frank, open discussion so that the patient and their family understand the risks and benefits of surgery or non-surgical management. Experienced trauma orthogeriatricians, anaesthetists and surgeons share in a collaborative decision-making process in these cases.

Palliative surgery, to reduce and manage pain rather than to restore mobility, can be an important part of end-of-life care planning. The risks of surgery are justified if it can minimise pain and allow dignified nursing care in the final days and weeks of someone's life.

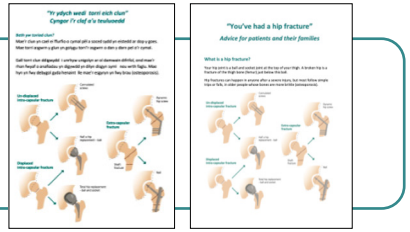
This means that almost everyone is now offered surgery. However, it is a concern that while in most hospitals all or nearly all patients receive surgery, this varies and some hospitals are still reporting that one in ten patients have not received surgery.

The benefits of surgery mean that care initially focuses on assessment of the patient's fracture, their past history, their usual medicines and any new medical problems; with a view to perform surgery on the same, or the next day **(KPI2)** with supervision by senior anaesthetic and surgical staff. Explaining the key aspects of surgical care and the support patients need is a key area for improvement, and this will be an NHFD focus into 2025.

What type of operation?

Some fractures can be repaired but this new multilingual patient advice resource provides leaflets that explain how other patients need part or all of their hip removed and replaced.

'Advice for people with hip fracture'
a multilingual patient advice resource



The importance of carrying out the correct operation for a particular patient is why the NHFD reports on how well each hospital follows the surgical recommendations **(KPI3)** made by the National Institute for Health and Care Excellence (NICE), along with a picture of surgical care for every hospital.

In most cases, the ball at the top of the thigh bone (femur) is broken off next to the socket. This part of the bone is usually replaced with a metal implant called a half hip replacement or hemiarthroplasty. A small group of patients who are particularly healthy, or have hip arthritis, will have a total hip replacement (replacing both the ball and the socket) if the surgeon feels that this larger operation would be justified by better mobility several years after operation.

All patients having these types of surgery should have the metal implant held in place by cement as this provides better initial pain relief and improves recovery of mobility, as long as attention is paid to avoiding problems when cement is inserted during the operation. These patients will all be followed up by the National Joint Registry (NJR) so that we can learn which types of implant work best for each patient.

Other groups of patients may need the broken bone to be fixed together rather than replaced. The exact position of the hip fracture may require different pieces of metal to hold the bone together as it heals; NICE guidance changed in 2023.

Talking to patients about the metalwork needed for their type of fracture

Post-operative care

The aim of surgery is to relieve patients' pain, so that they can fully weight-bear on the hip and get up and moving. In spite of this, our 2018 Physiotherapy Sprint Audit (PHFSA) found that half of the time that patients have to spend in bed following a hip fracture occurs after surgery (page 9, 2019 NHFD report).

Patients who can get out of bed on the day of, or the day after, operation **(KPI4)** increase their chances of survival and timely hospital discharge. We know that while most surgeons instruct physiotherapists to get the patient walking on day 1, this practice is not universal. We have explored why this might be, working with patients, and experts in caring for such patients to identify steps to take to improve. In addition, a new BOAST reinforces the need for full weight-bearing.

People may find it difficult to get out of bed due to pain, confusion and low blood pressure. These barriers are predictable and should be targeted for intervention before therapy assessment.

How can physios get the most from NHFD data?

Early **physiotherapy** assessment is key, but work at the James Paget Hospital shows how the whole **hip fracture team** can work together to improve patients' chances of getting out of bed promptly, using local NHFD data to drive improvement.

Anaesthetists can help to avoid such problems on the day after surgery by giving advice on pain control and fluid management, ideally by offering the 'Ready to leave recovery' advice to ward teams, that was described in our 2023 annual report (page 9).

James Paget Hospital, Great Yarmouth
'Out of bed project'

Rehabilitation

Patients with a hip fracture view returning home as their main priority. Our Physiotherapy Sprint Audit (PHFSA) improved understanding of rehabilitation and led the Chartered Society of Physiotherapy to create Hip Fracture Standards which all physiotherapists should try to meet.

Work based on the PHFSA audit showed that patients who received more than 2 hours of therapy in the week after surgery were more likely to return to their normal mobility and be able to return to their home.

Work using NHFD data has shown how important it is that patients continue to receive physiotherapy at weekends (Almilaji *et al* and REDUCE), but weekend staff availability is often a barrier to this. Hip fracture teams should use the REDUCE Hip Fracture Service Toolkit to help build the case for investment in local therapy, including services that provide physiotherapy at the weekend.

The first weeks

Hip surgery and anaesthesia are now so successful that it is unusual for a patient's recovery to be held back by problems with the operation. Instead, progress is more likely to be affected by two other challenges that are very often noticed first by concerned relatives and carers.

Nutrition

Frail and older people often have problems with eating and nutrition even before they come to hospital. Their **family and carers** play a vital part in helping the hospital team to understand such problems, and eating and drinking for recovery is the topic of one of the guides on our website.

Patients' families and carers may be very aware of the importance of eating well, but some hospital staff appear much less aware of the need to recognise, and respond to, poor nutrition in their patients.

The NHFD requires hospitals to record the results of a nutritional screening test for all patients admitted with a hip fracture. In 2023, nearly all patients were tested, however the care and accuracy with which this was performed varied enormously. Some hospitals recorded that all of their patients were at risk through malnutrition while other hospitals failed to identify anyone.

A goal that patients should be able to get up to eat a normal meal as soon as possible reflects the importance of nutrition to patient recovery. The simplest way for **nurses**, **carers** and **dietitians** to improve someone's recovery is by helping them to eat, build their strength, and maintain their morale to improve their outcome.

Helping people to eat, to improve recovery after hip fracture

Mental wellbeing

The most common serious complication faced by people admitted to hospital after a hip fracture is delirium (confusion). Two thirds of the people who develop delirium already show signs of this when they are admitted. For some, this reflects the stress of a fall – time on the floor, waiting for someone to come, being in pain, and delays in getting to hospital. It is difficult to imagine what goes through someone's mind after a fall – on the floor, unable to move, uncertain when, or whether, anyone will find them.

Such an experience will worsen their risk of developing delirium in hospital. In addition, a fear of falling again may limit some patients' willingness to engage with physiotherapy and may even limit their wish to return home.

People with memory problems will find it difficult to understand a complex, busy and noisy ward, and may become bewildered by this. Factors such as pain, pain killers and infection can make this worse, and confusion can even affect people who had not had memory problems before. Members of staff can also lack confidence in dealing with someone who has dementia, or who has become delirious after breaking their hip.

Healthcare Improvement Scotland have created a range of information about delirium for patients, their families and carers, and the NHFD provides advice about delirium prepared with our Patient and Carer Panel.

The NHFD reports hospitals' success in screening for and prevention of delirium after surgery **(KPI5)**. In 2024, we introduced the new requirement for all patients to also be assessed when they first present. Members of staff need to become familiar with the 4A test (4AT) to help them to recognise delirium. This will help the whole team to work with the patient, their family and carers to correct the many factors causing it.

Using the 4AT to recognise and help people with delirium

The first months

Goal 3 – The patient is back in their original home and receiving follow-up support to continue with bone strengthening treatment to avoid future fractures; and so their experience in hospital can be used to improve the care of future patients.

It can be easy for a hard-pressed hospital team to lose sight of an individual patient when they move on from one ward to another or leave hospital. NICE guidance recognises, however, that it is vital for patient care to be considered as a single journey. Hospital teams should use and learn from patient follow-up to drive improvement in their collaboration with community rehabilitation teams.

Continuing rehabilitation

The proportion of people known to be back in their usual home 120 days after hip fracture **(KPI6)** ranges from 49% to 91% in different hospitals.

Our physiotherapy audit showed gaps in hospital teams' knowledge of local community services. Care pathways were complex with huge national variation – on average, hip fracture patients waited 15 days to start rehabilitation at home, but some waited up to 80 days.

A clear and consistent process of clinical handover between teams is vital to continuity throughout a patient's journey. The Hip Fracture standards recognise how important it is for the next stage in rehabilitation to start within 72 hours of a patient leaving the acute hospital.

NICE guidance highlights the importance of community rehabilitation: hip fracture standard 6 requires hospital, rehabilitation ward and community therapy staff to all meet regularly to improve their local pathways.

One in ten people who sustain a hip fracture do so in a residential home. Our 2018 PHFSA audit showed that over 10% of services were unable to continue rehabilitation for such patients when they returned there from hospital. The REDUCE study saw fewer readmissions when hospital teams understood delays between discharge and starting community therapy.

Bone strengthening treatment

A quarter of people will break another bone within 5 years of an initial broken bone and it is well known that osteoporosis medication can prevent this from happening. However, while 120-day follow-up in the best hospitals shows four out of five patients continuing on bone strengthening drugs, several hospitals still report that none of their patients receive this protection **(KPI7)**.

In 2023, we called upon teams to offer more of their patients Zoledronate (a long-lasting medication, given in the form of a drip) before they leave hospital. This 'call to action' has been hugely influential, and is contributing to a dramatic rise in KPI7 from average 36% in 2022 to 43% in 2023, and 47% by December 2023. This rise continues in 2024 but means that in 2023, 5,000 more people will have started and been supported to continue and benefit from bone protection.

A number of other bone strengthening treatments may be suitable for some patients and they will need to be supported to continue these in the long-term.

Improving use of osteoporosis drugs to prevent future fractures

Hospital teams should look at how follow-up is provided. Links to a local Fracture Liaison Service (a team specialising in patients who suffer a fragility fracture, such as one sustained after a simple fall) will ensure that patients are seen to discuss whether they would benefit from being offered, and supported to continue taking, bone strengthening medication. The work of such services is the focus of our other audit, the Fracture Liaison Service Database (FLS-DB).

Listening and talking to patients

Learning from patient feedback

The REDUCE study found that hospitals that held regular **multidisciplinary clinical governance team meetings** were better at restoring patient mobility and had shorter lengths of hospital stay.

Using the REDUCE study to improve care

The REDUCE implementation toolkit defines how to run these meetings. **Physiotherapist** attendance is associated with 3% lower mortality, and **orthogeriatrician** attendance with a cost saving of £356 per patient. The REDUCE study also showed better results in units which routinely ask for and discuss patients' comments on the care they received.

The NHFD quarterly governance tool provides simple guidance so that trainees or others who are not familiar with the NHFD website can review and present local data to the team.

Quarterly governance review of local NHFD data


How are you doing?

We would like to know how you are getting on after your fracture, to help us improve the care we offer to future patients

1. Have you been back into hospital since then for any reason?

No ☐ Yes ☐ (if 'Yes' then please give details)

2. How do you usually get around now?

☐Freely mobile without any aids
☐Mobile outdoors with one aid (stick or crutch)
☐Mobile outdoors with two aids or frame
☐Some indoor mobility but don't go out without help
☐Unable to mobilise except with a wheelchair

3. Where are you now living?

Hospital No:

The NHFD postal follow-up template allows teams to use patient feedback in governance meetings and to help patients continue on bone protection treatment. It also checks their success, and that of community teams, in helping people to regain their previous mobility and return to their original home, so that figures for KPI6 and KPI7 are as complete and accurate as possible.

Fairness

The multiple medical, psychological and social problems that underpin frailty explain why people with hip fracture benefit from multidisciplinary orthogeriatric care, and why each person needs a personalised approach.

We know that men fare less well, as do people with dementia or those from a poorer socioeconomic background. Work with NHFD data is looking at how patients' ethnic background affects care and recovery, but our 2022 hospital facilities survey showed that only a quarter of teams provide written information in languages suited to their local population.

The NHFD's success in transforming the care and outcome for people with a hip fracture should be celebrated, as should the way in which work with this group of patients has helped us to understand aspects of patient care (such as delirium and nutrition) that are so important across all services.

But this spotlight on hip fracture risks leaving other patients with similar injuries behind. It is not equitable that those with a hip fracture should access better, faster, more successful care than people with another fracture.

Since 2020, the NHFD has included people with fractures anywhere else in the femur (thigh bone): shaft of femur, distal femur, and fractures around orthopaedic implants such as knee or hip replacements. Our reporting of other fractures has helped improve their care; for example, in 2020 just a fifth of people with distal femoral fracture received prompt orthogeriatric care which increased to three quarters in 2023.

However, people with fractures of other bones or other injuries (for example pubic ramus fractures) still don't receive these standards of care. Opportunities to replicate the NHFD's success – capture data to improve patient care and recovery – should be sought by the NHFD, Getting it Right First Time (GIRFT), NHS England and the Welsh government.

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 looking after these patients could feel helpless to deal with their complex physical, mental and social problems. Thankfully, this is no longer the case.

30-day survival was 94% in 2023.

This means that an extra 8,435 people have survived the injury over the 16 years since the NHFD was set up.

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 pain relief and a chance to regain independence that it offers.

Pre-existing medical illnesses mean that some patients do face problems in the following weeks, but the number who now die in the month after a hip fracture has halved from 11% in 2007 to a current figure of 6%, meaning that 94% of patients survive beyond the first month after injury.

Helping to improve survival figures

Our website now shows rates of survival for each hospital over 2023. We would like to congratulate Manchester's Wythenshawe Hospital which recorded very high survival figures across the whole year. Hospitals should aim to learn from such examples and our 2024 Spring conference allowed teams to share their experiences, as well as providing case studies.

Our reporting on survival also helps hospitals to monitor their own success. Every 3 months, the NHFD checks its data against the death register to see how many people in each hospital have died in the month following a hip fracture. The NHFD then sends this information to our analyst team at 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 might like to read more information on how we do this.

Each quarter, the NHFD team review the 30-day mortality charts that allow staff in each hospital to monitor the success of the care they provide. Some of the 174 hospitals in England and Wales will show unusually low or high numbers of deaths, and these units will be notified of this straight away. Details of when and how this happens can be found in our outlier policy based on HQIP's policy.

Using the NHFD website to monitor survival

In 2023, we identified 7 hospitals as 'outliers'; notifying clinical teams and hospital managers that they were recording higher numbers of deaths than we would have expected, given the patients they had admitted. The NHFD clinical leads have since worked to support the staff in these units – three have already improved and are no longer a cause for concern.

Building on the NHFD

The NHFD's success reflects the enthusiasm and energy of teams around the country, who have provided high quality data to drive improvement, national initiatives and research.

Access to NHFD data to drive audit, QI and research

We would like to thank everyone who has contributed to this work, and encourage you to use and share this report so that everyone can access data that will help us to continue improving the care patients receive after this and other injuries.

The Royal College of Physicians (RCP)

The Royal College of Physicians is a registered charity that aims to ensure high-quality care for patients by promoting the highest standards of medical practice. It provides and sets standards in clinical practice, education and training, conducts assessments and examinations, quality assures external audit programmes, supports doctors in their practice of medicine, and advises the government, the public and the profession on healthcare issues.

Healthcare Quality Improvement Partnership (HQIP)

The Falls and Fragility Fracture Audit Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges and the Royal College of Nursing. Its aim is to promote quality improvement in patient outcomes and, in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage and develop NCAPOP, comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes.

Falls and Fragility Fracture Audit Programme (FFFAP)

The NHFD is run by the Care Quality Improvement Directorate (CQID) of the Royal College of Physicians (RCP). It is part of the Falls and Fragility Fracture Audit Programme (FFFAP); one of three workstreams, alongside the Fracture Liaison Service Database (FLS-DB) and National Audit of Inpatient Falls (NAIF). The programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and works within a governance structure that includes the programme's Board, Advisory Group and Patient and Carer Panel.

Acknowledgements

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References

The references for this and previous annual reports are all available in the references file.

Get in touch

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

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