

# 'Mind the gap' Challenging inequities in hip fracture care

A report from the National  
Hip Fracture Database (NHFD)

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# Report at a glance

The report shows that all our key performance indicators continue to show major variations in the quality and outcomes of hip fracture care depending on where the patient is treated. The main challenge for everyone using the NHFD is still to address the huge variation in care in different hospitals.

As people have different health needs, we must look beyond **equality** so that healthcare is provided fairly, based on need. **Equity** means avoiding unfair differences in access to healthcare and health outcomes between population groups.



We examine inequities in hip fracture care that might reflect unjust differences arising from unjust differences related to factors such as age, sex, ethnicity or socioeconomic status. **This report shows that the quality and outcomes of care are affected by 1. who a person is, 2. what bone they break and 3. when they broke it.**

**We found that where a person receives care has a much stronger influence on their survival than their socioeconomic background.**

For 30-day mortality, the gap between people living in the most deprived and the least deprived areas (the deprivation gap) was just 1%; mortality being 6.3% in the most socioeconomically deprived fifth of the population, compared to 5.3% in the least deprived fifth. **However, the gap is five times wider between hospitals, with 30-day mortality at 8.1% for the fifth of patients who were admitted to the poorest performing hospitals, compared to 3.0% among the fifth admitted to the best performing.**



We also question **4. why a person suffered a broken hip**. Age, sex, socioeconomic deprivation and ethnicity all affect someone's risk of having a fracture by affecting their risk of osteoporosis and of the physical and mental frailty that leads to so many fractures.

**Where someone lives** should not affect whether they receive Fracture Liaison Service support to avoid future fractures. At least a quarter of patients have previously had one fragility fracture, but most **had not been offered bone strengthening medication** to reduce their risk of hip fracture.

# Introduction

The [National Hip Fracture Database \(NHFD\)](#) is part of the [Falls and Fragility Fracture Audit Programme \(FFFAP\)](#) (alongside the [National Audit of Inpatient Falls \(NAIF\)](#) and the [Fracture Liaison Service Database \(FLS-DB\)](#)), commissioned by the [Healthcare Quality Improvement Partnership](#) (HQIP) and funded by NHS England and the governments of Wales and Jersey as part of the [National Clinical Audit and Patient Outcomes Programme](#) (other devolved administrations and crown dependencies also participate in the audit, funded separately).

This report sets out what the NHFD has told us of the [who](#), [what](#), [when](#), [where](#) and [why](#) of health inequality and inequity in 2025, and how this knowledge helps us to drive up the quality and outcome of care of this condition.

Every year in England, Wales, Jersey and Northern Ireland, over 72,000 people need hospital care after breaking their hip, leading to the occupation of [one in thirty of all hospital beds](#) at a cost to the NHS of [£1.1 billion](#). Many will struggle to return to previous levels of mobility and independence, so social care costs in just the first 120 days after hip fracture account for another [£1.25 billion](#).

For 17 years the NHFD has been improving the care received by every patient aged over 60 who breaks their hip in England, Wales, Jersey and Northern Ireland as part of FFFAP run by the [Royal College of Physicians \(RCP\)](#).

The RCP's '[Bridging the gap](#)' guide for NHS leaders states that 'Health inequalities are avoidable and unfair – all patients should receive equal access, outcomes and experiences of health services and lead healthy lives'. But patients do not all have the same need for care. The [World Health Organization](#) defines health equity as 'the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically'.

This raises the question of whether the NHFD's goal should be equality or equity, and whether this should be of access, experience or outcome? It is attractive to think that the answer should be 'all of them' but in this year's annual report we show how complex such ambitions will be in clinical practice.

High quality, robust data help health services to understand the populations they serve and to identify groups who are at risk of poor access to, experiences of and outcomes from healthcare, so that they can deliver targeted action to reduce healthcare inequalities.

The [NHFD website](#) provides continuously updated data, which are freely available to all, and you can find details of our eight Key Performance Indicators (KPIs) [here](#).



[This short video](#) explains how to use the website to compare care in different hospitals, regions or countries.

Clinical staff can use the NHFD website to [guide meetings](#) in which they review the care that 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 we have co-produced with the [FFFAP Patient and Carer Panel](#).

Supporting documents referenced in the report are available under the 'Downloads' and 'Supporting documents' sections on [this page](#). 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 and acknowledgements can also be read [online](#) along with [a table](#) linking key messages and recommendations from this report to clinical guidance.

We have worked with a wide group of patients, clinicians, healthcare workers and national groups to review our findings and develop recommendations aimed at improving care. These are aimed at the relevant national organisations which must encourage and support hospitals to improve clinical practice.

## Key findings for 2025

**Delirium** is a key preventable, treatable cause of poorer hip fracture care and outcome. People with [delirium are three times as likely to die as an inpatient and three times as likely to need to move to live in a care home](#) after a hip fracture. Despite this, some hospitals have still not established routine delirium assessment, both when patients are admitted and when they are recovering after surgery.

The NHFD's success in improving hip fracture services means that our reporting now highlights weaknesses in the care of people with other fragility fractures. The same model of continuous audit-driven improvement needs to be extended to the care of people with **fragility fractures of other bones**.

Only two-thirds of respondents to our [2025 Governance Survey](#) reported that their hospital holds a hip fracture **clinical governance meeting**, and only one-third of these said that patient feedback was discussed in such meetings.

Our '[Cause for concern](#)' work in 2025 has improved pressure sore surveillance (93% of patients documented as not having a pressure sore compared to 92% in 2024), but three hospitals still report that over one in five of their patients developed a **pressure sore** after presenting with a hip fracture.

[Each year a quarter](#) of the people who present with a hip fracture give a history of a previous fragility fracture. In spite of this, at least half of them (around 10,000 people each year) are not receiving the effective **bone strengthening medication** that might have prevented the hip fracture.

## Recommendations

- 1 NHS England and Welsh Health Boards should mandate and monitor compliance with [routine delirium screening using the 4AT](#) for all patients admitted with hip fracture, ensuring that Integrated Care Boards (ICBs) in England and Health Boards in Wales hold hospitals accountable for implementation.
- 2 Utilising NHFD data on pelvic fragility fractures, [Getting It Right First Time \(GIRFT\)](#), working with the [British Orthopaedic Association \(BOA\)](#) and [British Geriatrics Society \(BGS\)](#), should collaborate to provide the environment for excellent and equitable care of those admitted with fragility fractures, aiming to reduce unwarranted variation in care and outcomes.
- 3 ICBs and Welsh Health Boards should ensure that every hip fracture service holds [clinical governance meetings](#) at least monthly and that these routinely review:
  - > Patient feedback
  - > Patient safety events, such as [pressure ulcers](#)
  - > Their performance for [each KPI](#), questioning their position, especially if their hospital features in red on the NHFD caterpillar plots – as this would indicate significant under-performance.
- 4 NHS England, ICBs and Welsh Health Boards should ensure universal provision of effective Fracture Liaison Services (FLSs), working with the [Royal Osteoporosis Society \(ROS\)](#) and the [Fracture Liaison Service Database \(FLS-DB\)](#) to eliminate geographical gaps in [secondary fracture prevention](#), in line with the [NHS 10 Year Plan](#).

# Who has the fracture?

The [UK Equality Act 2010](#) seeks to shield people against discrimination in respect of nine 'protected characteristics'. Four of these – ethnicity, age, sex and disability – are key to questions of equality and equity after hip fracture. The below clickable table demonstrates performance on our KPIs against patient characteristics.

|                     | N      | %    | KPI0 (%) | KPI1 (%) | KPI2 (%) | KPI3 (%) | KPI4 (%) | KPI5 (%) | KPI6 (%) | KPI7 (%) | 30-day mortality (%) |
|---------------------|--------|------|----------|----------|----------|----------|----------|----------|----------|----------|----------------------|
| Total cases in 2025 | 72,623 |      |          |          |          |          |          |          |          |          |                      |
| Sex                 |        |      |          |          |          |          |          |          |          |          |                      |
| Men                 | 22,933 | 31.6 | 9        | 89       | 54       | 71       | 82       | 67       | 72       | 56       | 7.9                  |
| Women               | 49,690 | 68.4 | 10       | 89       | 58       | 71       | 82       | 68       | 76       | 63       | 4.5                  |
| Age                 |        |      |          |          |          |          |          |          |          |          |                      |
| 60-69 years         | 6,833  | 9.4  | 11       | 87       | 53       | 70       | 85       | 78       | 88       | 42       | 1.9                  |
| 70-79 years         | 18,577 | 25.6 | 10       | 89       | 56       | 68       | 84       | 74       | 82       | 59       | 3.3                  |
| 80-89 years         | 31,750 | 43.7 | 10       | 89       | 57       | 70       | 82       | 66       | 74       | 67       | 5.6                  |
| 90+ years           | 15,463 | 21.3 | 9        | 90       | 58       | 76       | 79       | 58       | 63       | 57       | 10.1                 |
| Deprivation         |        |      |          |          |          |          |          |          |          |          |                      |
| IMD Q1              | 11,466 | 15.8 | 10       | 89       | 57       | 73       | 81       | 66       | 75       | 57       | 6.3                  |
| IMD Q2              | 12,703 | 17.5 | 10       | 88       | 57       | 72       | 81       | 66       | 75       | 58       | 6.1                  |
| IMD Q3              | 14,430 | 19.9 | 10       | 89       | 58       | 72       | 82       | 68       | 75       | 59       | 5.6                  |
| IMD Q4              | 15,306 | 21.1 | 9        | 89       | 59       | 71       | 83       | 68       | 75       | 61       | 5.8                  |
| IMD Q5              | 15,560 | 21.4 | 10       | 91       | 59       | 69       | 83       | 70       | 75       | 63       | 5.3                  |



## Ethnicity

It is difficult to examine race as recording of patients' ethnicity in the NHS remains poor. Our [2025 report](#) on 2024 findings highlighted this but included work using NHFD data showing that, after adjustment, [outcomes were similar across ethnic groups](#).

## Age

An ageing population means that hip fracture numbers are increasing but improving public health means that this rise is smaller than might be expected, as reported in our [2025 report](#). However, [older people have poorer outcomes even after adjustment for other factors](#).

## Sex

Just [one third](#) (32%) of hip fractures affect men, but men are nearly twice as likely to die (8% in 2025, compared to 5% of women). As with the effect of age, poorer outcome in men is in part due to comorbidities, but [men do less well, even after adjustment for their poorer health](#).

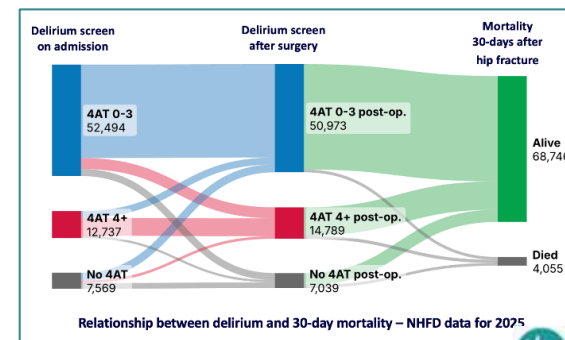
If equity of outcomes is the aim, these observations may suggest that older men should receive enhanced care following a hip fracture, for example through routine prioritisation on operating lists. However, such an approach would come at the expense of equality and may raise justifiable ethical concerns.

## Disability

Disability is another 'protected characteristic' and it is more appropriate for clinical teams to prioritise people on the basis of their underlying health problems, than their age, sex or ethnicity. The [relationship between pre-fracture residence and outcome](#) is one way in which NHFD allows us to look at the implications of disability. Another is to consider the care and outcome of people with dementia, cognitive impairment and delirium.

Delirium is a common consequence of the injury, hospitalisation and operation. It is the commonest complication and, crucially, it is preventable. However, it is often poorly recognised by staff. 4AT screening is a way of identifying a key group of high-risk patients for specific management and for prioritisation to ensure health equity. In 2014 the NHFD adopted the [4AT assessment](#), asking for this in all patients after surgery to encourage screening and improve recognition and understanding of delirium.

[Work using NHFD data](#) has shown that patients with a 4AT score of 4+ after surgery were half as likely to get up by the next day and three times more likely to need to move to a care home or to die as an inpatient.



This clickable chart demonstrates the implications of a patient's admission 4AT for increased mortality, showing that most people who have delirium after hip fracture surgery already had an abnormal 4AT score when they first presented.

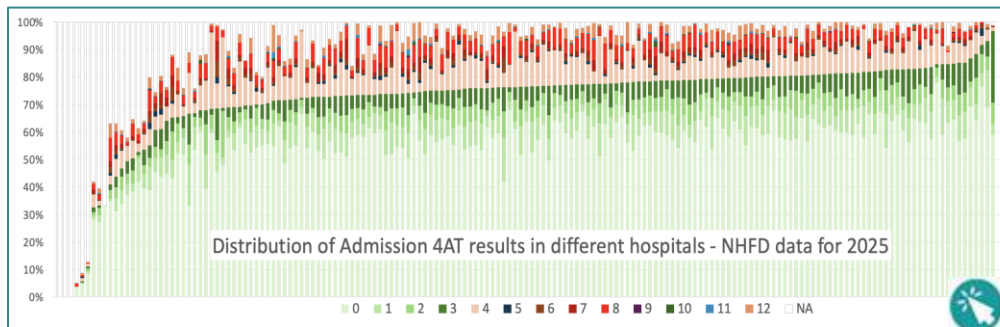
**Recommendation 1** – NHS England and Welsh Health Boards should mandate and monitor compliance with routine delirium screening (4AT) for all patients admitted with hip fracture, ensuring that ICBs in England and Health Boards in Wales hold hospitals accountable for implementation.

The [RCP](#), [Royal College of Emergency Medicine](#), [Society for Acute Medicine](#), [British Geriatrics Society](#) and [NHS England standards for the first 72 hours of hospital care](#) all require every older patient presenting as an emergency to be assessed for delirium within 30 minutes of arrival.

In 2025 the NHFD adopted the 4AT as our standard admission cognitive test, requiring hospital teams to complete this delirium screening assessment in place of the abbreviated mental test (AMT) score.

It is a concern that [rates of admission 4AT screening](#) range from 0–100% in different hospitals. Seven hospitals in England and four hospitals in Wales reported screening less than two-thirds of their patients on admission. The NHFD will be challenging and supporting the clinical and executive teams in these hospitals to make sure this practice changes in 2026.

ICBs and Health Boards should ensure that every hip fracture team should review admission 4AT screening for their patients in monthly clinical governance meetings. Clicking on the figure below will allow teams to benchmark the quality, results and implications of 4AT screening in their unit against those in other units.



Units at either extreme of the above clickable chart should question the approach taken to 4AT screening and look to provide appropriate training to address underlying problems in completion rates or assessment technique.

## Socioeconomic deprivation

This is not a ‘protected characteristic’, but it is a key question to examine when considering equality and equity in risk, care and outcome of hip fracture.

In work funded by the [Royal Osteoporosis Society \(ROS\)](#), members of the [REDUCE study](#) team examined how the NHFD might challenge inequity in care and outcomes after a hip fracture, using NHFD data linked to hospital data for all hip fracture patients in England and Wales from 2016-2019.

The team looked at KPIs 1-4 that capture important time points, processes or outcomes associated with improved patient care; investigating how these and 30-day mortality were affected by patients’ age, sex, ethnicity and socioeconomic deprivation.

After taking into account the interplay between certain factors such as age, sex, deprivation, ethnicity, type of hip fracture, previous residence and mobility, [ASA grade](#), [Charlson morbidity score](#), frailty and hospital characteristics; the analysis highlighted a number of preliminary findings:

- > Older patients received prompt surgery (KPI 2) more often, but this was less likely to meet NICE compliance (KPI 3).
- > Men did less well for KPIs 2, 3, 4 and 30-day mortality. This may be because men face delays in care and poorer outcomes for other reasons that could not be examined.
- > Patients’ ethnicity and socioeconomic position was not associated with the care received, except that non-White patients were less likely to get up on the day after surgery. This fits with [previous work using NHFD data](#) and argues for the provision of [patient information in appropriate languages](#) as well as the proactive involvement of patients’ families in day one physiotherapy.

# What type of fracture?

In 2020, we extended our data collection to over-60-year-olds with other fractures, using these to offer NHSE's financial incentive (Best Practice Tariff) to people with fractures of the shaft and distal femur (thigh bone). We also collect data for peri-prosthetic femur fractures (PPFFs) – an increasing issue for the many people who have received hip or knee replacements or other forms of surgery to the femur.

In 2024, NHS England's [Getting It Right First Time \(GIRFT\)](#) programme highlighted the disparity that has arisen between the care received by someone with a hip fracture and that provided to someone admitted with another type of non-ambulatory fragility fracture.

[Pelvic fractures have been described as 'orphan injuries'](#), reflecting a lack of consensus over how these patients should be cared for, and by whom. For every three patients that a hospital is managing for a hip fracture, there will be a fourth: someone who has sustained a fracture of the pelvis. Such patients are at risk of poorer care, even though they need a similar programme of coordinated multidisciplinary assessment, rehabilitation and secondary prevention.



[Watch our webinar](#) on expanding the NHFD to pelvic fractures

In many hospitals, people admitted with pelvic fractures find themselves in non-specialist wards where they, and their multidisciplinary team, have limited access to advice about mobilisation and weight-bearing, appropriate pain management, falls assessment and secondary prevention in collaboration with a Fracture Liaison Service (FLS).

From January 2026, NHFD data collection was extended as a pilot to include over-60-year-olds with any type of pelvic fracture\*; using this injury as a model for other fractures which may not need surgery but still needs effective inpatient management and secondary fracture prevention.

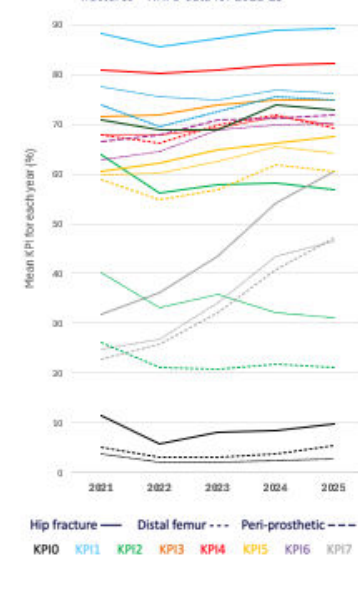
\*The Pelvic Fracture Expansion was supported by UCB Pharma Ltd who provided financial support

**Recommendation 2** – Utilising NHFD data on pelvic fragility fractures, Getting It Right First Time (GIRFT), working with the British Orthopaedic Association (BOA) and British Geriatrics Society (BGS), should collaborate to provide the environment for excellent and equitable care of those admitted with fragility fractures, aiming to reduce unwarranted variation in care and outcomes.

The extension of the NHFD seeks to examine this variation in care and drive the development of effective pathways for pelvic fracture, but the improvement work it stimulates should not be confined to people with this injury.

Our website continues to focus on the care received by people with hip fracture, but each year's annual report includes detailed spreadsheets profiling care of people with [fractures elsewhere in the femur](#).

Trends in KPIs for hip, distal and peri-prosthetic femoral fractures – NHFD data for 2021-25



This clickable figure shows how their care has already responded to improvement work that was primarily focused on people with hip fracture (KPI 3 is specific to NICE guidance on hip fracture).

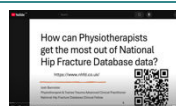
In future, the NHFD website will benchmark the care of these patients and those with pelvic fractures against that received by people with hip fractures.

# When did the fracture happen?

Work with NHFD data has examined how the [time of day](#) at which someone presents with a hip fracture affects the quality of the care they receive.

Hip fracture patient presentations to Emergency Departments are not equally distributed across a 24-hour period – patient numbers increase sharply after 8am and only reduce again after 6pm. This has a marked effect on patients' surgery within 24 hours, but much less inequality in whether they achieve the [NICE recommendation guideline](#) of surgery by the next day (NHFD's KPI 2).

Someone's risk of hip fracture, the care they receive and its outcome also [vary across the week](#). Work with NHFD data has not been able to demonstrate a benefit of orthogeriatrician support at weekends, but weekend working by physiotherapists can [improve both costs and outcomes](#). Our [2022 facilities survey](#) showed that 30% of hospitals only provided physiotherapy for their patients Monday – Friday. [A new physiotherapy audit tool](#), and the video below, will help teams to capture weekend physiotherapy provision to see if they are meeting this recommendation.



[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.

Access to physiotherapy should not be dictated by the day of the week. Our [2025 report](#) recommended that all inpatients should receive at least one session of physiotherapy each weekend, as recommended in the [CSP hip fracture standards](#). We would encourage all teams to [examine their practice](#) and use the [REDUCE toolkit](#) to build a business case for this.

The NHFD first described seasonal variation in the risk of people having a hip fracture in our [2022 annual report](#). The [time of year](#) at which someone presents will also affect the quality and outcome of the care that they receive.

The quality of care and outcome a patient can expect are therefore affected by the time, day and date on which they present, but the NHFD's set of eight KPIs has shown little variation from year to year, except in respect of [KPI 2](#) and [KPI 7](#).

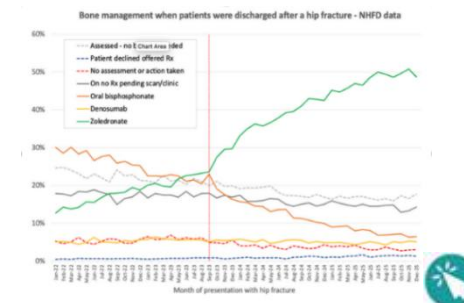
[KPI 2, the proportion of patients who receive surgery by the day after presentation with a hip fracture](#), is designed to minimise how long someone has to wait for theatre. [Time to theatre](#) has worsened from 33.6 hours in 2020 to 39.3 hours in 2025, reflecting changes in public health, fracture numbers and pressure from other specialties since the COVID pandemic.

But the time a patient waits in hospital does not capture the whole extent of their experience. In response to this, from January 2026, we started collecting data to define how long it takes a patient to reach hospital after first phoning for an ambulance. This is part of [new NHFD audit work to improve pre-hospital care](#).

[KPI 7, the proportion of patients on bone strengthening medication 120-days after hip fracture](#), was introduced in 2020 and designed to promote the use of effective bone strengthening medication as secondary prevention.

|                                                                  | 2020   | 2021   | 2022   | 2023   | 2024   | 2025   |
|------------------------------------------------------------------|--------|--------|--------|--------|--------|--------|
| N                                                                | 63,204 | 65,951 | 72,349 | 72,451 | 72,204 | 69,995 |
| All fractures                                                    | 27.0%  | 26.7%  | 22.7%  | 11.5%  | 10.7%  | 6.4%   |
| Anteroposterior or Caudal                                        | 4.9%   | 3.3%   | 3.3%   | 3.6%   | 3.6%   | 2.4%   |
| Distal femoral                                                   | 5.1%   | 5.0%   | 5.2%   | 5.7%   | 5.2%   | 4.0%   |
| Proximal femoral                                                 | 0.1%   | 0.1%   | 0.1%   | 0.1%   | 0.1%   | 0.0%   |
| Proximal humeral                                                 | 4.4%   | 5.2%   | 4.8%   | 4.9%   | 4.9%   | 3.7%   |
| Proximal humeral                                                 | 0.1%   | 0.0%   | 0.1%   | 0.1%   | 0.1%   | 0.2%   |
| Proximal humeral                                                 | 0.1%   | 0.0%   | 0.1%   | 0.1%   | 0.1%   | 0.1%   |
| Proximal humeral                                                 | 9.2%   | 13.0%  | 16.3%  | 24.3%  | 38.0%  | 47.2%  |
| Missing data                                                     | 0.0%   | 0.0%   | 1.0%   | 0.0%   | 0.0%   | 0.7%   |
| No assessment or action taken                                    | 6.9%   | 6.0%   | 5.2%   | 5.0%   | 3.8%   | 3.2%   |
| Assessed - no bone protection medication needed/supergate        | 24.3%  | 24.1%  | 22.9%  | 20.5%  | 18.2%  | 16.7%  |
| Informed decline - patient decided not to take offered treatment | 0.4%   | 0.4%   | 0.2%   | 0.7%   | 0.9%   | 1.2%   |
| On no treatment - pending DXA scan or bone clinic assessment     | 17.3%  | 18.0%  | 17.6%  | 17.4%  | 15.6%  | 14.5%  |
| All end                                                          | 31.5%  | 30.9%  | 27.0%  | 22.3%  | 22.8%  | 7.0%   |
| All rejected                                                     | 14.1%  | 16.40% | 21.0%  | 10.7%  | 14.0%  |        |
| Total treated on discharge from hospital after a hip fracture    | 50.8%  | 50.80% | 52.4%  | 55.3%  | 60.4%  |        |

This led to progressive improvement that accelerated in 2023 with the publication of our [‘Call to action’](#).



This paper provided a clear pathway to address a series of constraints that had previously prevented patients being treated (click on the above images for more details).

In 2025, half (48.5%) of all patients received zoledronate treatment before they left hospital after care for a hip fracture. An additional 13% were started on other forms of treatment and 14% were referred to clinic or for a bone scan: around 75% of patients were therefore being treated or followed up. Many of the remainder are not suitable for bone treatment, but the NHFD continues to challenge those [hospitals in which treatment rates are still very poor](#). As a result, the UK now leads the world in rates of secondary prevention after hip and other femoral fractures.

# Where were they cared for?

## National, regional and inter-hospital variation

A patient's country or region has implications for the quality and outcome of the care that they receive. The below clickable table demonstrates performance on our KPIs against geographical regions.

|                      | N      | %  | KPI0 (%) | KPI1 (%) | KPI2 (%) | KPI3 (%) | KPI4 (%) | KPI5 (%) | KPI6 (%) | KPI7 (%) | 30-day mortality (%) |
|----------------------|--------|----|----------|----------|----------|----------|----------|----------|----------|----------|----------------------|
| Total cases in 2025  |        |    |          |          |          |          |          |          |          |          |                      |
| Country              |        |    |          |          |          |          |          |          |          |          |                      |
| England              | 65,954 | 91 | 10       | 91       | 59       | 71       | 83       | 69       | 75       | 61       | 5.8                  |
| Northern Ireland     | 2,329  | 3  | 11       | 86       | 11       | 68       | 83       | 47       | 75       | 74       |                      |
| Wales                | 4,340  | 6  | 12       | 68       | 53       | 71       | 76       | 56       | 72       | 49       | 5.5                  |
| Region               |        |    |          |          |          |          |          |          |          |          |                      |
| Channel Islands      | 78     | 0  | 28       | 27       | 66       | 61       | 96       | 63       | 72       | 53       | 0                    |
| East Midlands        | 5,039  | 7  | 6        | 87       | 46       | 71       | 80       | 65       | 72       | 66       | 6.0                  |
| East of England      | 8,099  | 11 | 11       | 94       | 62       | 69       | 85       | 75       | 79       | 60       | 5.7                  |
| London               | 6,177  | 9  | 8        | 92       | 62       | 69       | 80       | 62       | 75       | 65       | 4.6                  |
| North East           | 3,776  | 5  | 13       | 95       | 67       | 77       | 87       | 67       | 75       | 51       | 6.2                  |
| North West           | 9,530  | 13 | 9        | 88       | 56       | 71       | 83       | 68       | 74       | 52       | 5.8                  |
| South Central        | 4,745  | 7  | 11       | 90       | 59       | 70       | 78       | 64       | 73       | 67       | 5.3                  |
| South East           | 6,141  | 8  | 6        | 96       | 66       | 72       | 80       | 72       | 72       | 66       | 5.8                  |
| South West           | 8,393  | 12 | 16       | 94       | 59       | 72       | 84       | 70       | 77       | 61       | 5.7                  |
| West Midlands        | 7,295  | 10 | 7        | 86       | 54       | 70       | 81       | 70       | 75       | 62       | 6.6                  |
| Yorkshire and Humber | 6,681  | 9  | 9        | 86       | 56       | 75       | 82       | 72       | 76       | 60       | 6.2                  |

However, the most important source of inequality in the care someone will receive remains the hospital to which they present. For instance, our [KPI 2 caterpillar chart](#) shows that someone's chance of receiving hip fracture surgery by the day after presentation varies from 22% to 94% in different hospitals around England, and from 15–69% in hospitals in Wales.

Our [2025 facilities survey](#) indicated that 97.8% of hospitals provide a geriatric assessment on admission by an orthogeriatrician for patients presenting with a hip fracture. In contrast, provision of this assessment is considerably lower for other fractures: 54% for patients with other femoral fractures, 31% for those with other types of bone injuries and 25% for pelvic fractures. This disparity highlights a significant variation in access to specialist geriatric input, suggesting that while pathways for hip fracture care are well established, equivalent provision for other fracture types remains inconsistent.

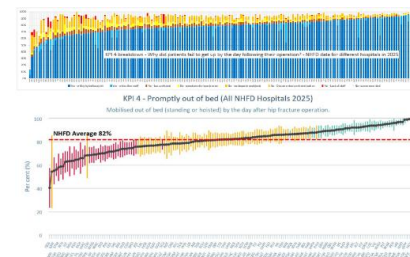
All eight of our KPIs show this dramatic pattern of inequality. Hospital teams, trusts, ICBs in England, and Health Boards in Wales should look at our NHFD 'caterpillar plots' which show each hospital's performance for each KPI, and question their own position, especially if their hospital features in red – indicating significant under-performance.

**Recommendation 3** – ICBs and Welsh Health Boards should ensure that every hip fracture service holds clinical governance meetings at least monthly and that these routinely review patient feedback, patient safety events, such as pressure ulcers, and their performance for each KPI

The NHFD [clinical governance tool](#) was designed to help implement this recommendation and to identify areas in which local improvement work should focus. However, only two-thirds of respondents to our [2025 Governance Survey](#) reported that their hospital holds a hip fracture clinical governance meeting, defined as: 'An improvement-focused meeting, attended by at least the leads for orthopaedics, anaesthetics and orthogeriatrics, and held monthly or more frequently'. Such meetings provide a forum for clinicians and stakeholders to review quality outcomes and plan service improvement. Hospitals undertaking them achieve better recovery of mobility and [shorter hospital stays](#).

These meeting must also discuss patient feedback from the ward and at 120-days. [REDUCE](#) demonstrated how discussion of patient experience feedback at hip fracture clinical governance meetings was associated with 10% lower mortality. Such feedback can be collected using these [NHFD follow-up resources](#).

Our [2025 governance survey](#) found that only 30% of hospitals routinely discussed patient feedback in such meetings. The [REDUCE toolkit](#) provides hospitals with the foundations for setting up and maintaining monthly clinical governance meetings.



Clinical governance meetings should also examine [KPI 4: the proportion of patients who got out of bed by the day after surgery](#), to identify the reasons leading to their patients failing to achieve this objective.

The [mobilisation reason breakdown graph](#) (and the clickable image) shows performance for all NHFD hospitals on the reason patients were not mobilised by the day after surgery and local teams should examine it to see the reasons for their own performance. Hospitals that are indicated in red as significantly underperforming should collaborate with better performing neighbouring units to learn from their experiences and approach.

## Supporting improvement

In addition to encouraging hospitals to identify and address underperformance in respect of KPIs, in 2025 the NHFD also identified and offered support to hospitals where we noted practice which gave us '[cause for concern](#)'.

We reviewed the frequency with which different hospitals took a non-operative approach to their patients in [2024](#) and challenged those, in which this was unusually common. The picture in [2025](#) improved and was more consistent.

We also challenged five hospitals in which pressure ulcer surveillance appeared poor. [In 2025 we have seen an improvement in the completeness of data submissions](#) with 93% of patients recorded not to have a pressure sore in 2025 compared to 92% in 2024.

However, pressure ulcer incidence remains a concern, with three hospitals reporting that over 20% of their patients developed a pressure sore in 2025. [These hospitals](#) have been contacted to question their reasons for this and highlight this as a focus for local QI.

Pressure care is just one way in which patients will benefit from getting out of bed. The attention paid to [post-operative weight-bearing instructions](#) in our [last report](#) led to improvement over [2025](#): 95% of cases were documented as being allowed to fully-weight bear after surgery, compared to 94.5% in 2024 and 93.8% in 2023) Just one unit remains a cause for concern and is being supported to improve.

## Review of our 2025 mortality outlier process

Our website now shows [rates of survival](#) for each hospital over the whole of 2025. 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 within 30 days of a hip fracture. Our analysts at the [University of Bristol](#) then perform statistical analysis and adjustment to take into account 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 this is done.

The NHFD team then review the [30-day mortality charts](#) so that staff in each hospital can monitor their performance. Some of the 167 hospitals participating in the NHFD 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](#).

Every hospital which was identified as an outlier in 2024 has now returned to normal performance. In 2025 the NHFD contacted clinical teams and hospital executives in [seven hospitals](#) to inform them that they were recording more deaths than we would have expected. In one case this reflected problems with the quality of the data they were reporting to the NHFD. All seven hospitals received support from the NHFD clinical leads to help them understand their position, investigate the likely causes and develop and put an [improvement plan](#) in place.

[This short video](#) explains how teams can use the NHFD to monitor survival figures in their hospital and use this as a stimulus to improve the services that they are providing.

# Why did the fracture happen?

The main source of inequity in hip fracture care and outcome is [where the patient was cared for](#). Despite the work of the NHFD, there remains a ‘postcode lottery’ with extreme variation in care and outcome between different hospitals.

The most concerning example of this relates to ‘Why did someone suffer this fragility hip fracture in the first place?’. Most people now receive bone strengthening medication *after* a hip fracture, but this should not prevent teams challenging the inequity of the ‘postcode lottery’ in failure of prevention *before* the injury.

The first thing surgeons and geriatricians do when they meet a patient is ask about their past history. Just one in eight people are on bone strengthening osteoporosis medication when they present with a hip fracture, even though at least a [quarter](#) have previously suffered another fragility fracture.

This means that at least 10,000 people each year have not been offered this bone treatment after a first fragility fracture that might have avoided this hip fracture.

All clinical staff have a [duty of candour](#) that requires them to be open in their dealings with their patients: a duty which ought to lead to the recognition that bone protection could have reduced their risk of sustaining this hip fracture.

Many parts of the UK now have a well-established Fracture Liaison Service (FLS): a coordinated programme to identify all patients who have a fragility fracture and ensure that they are offered, and supported to continue taking, effective bone strengthening medication. However, the [FLS-DB](#) shows that nearly half of England’s NHS trusts operate with no FLS at all and, where these do exist, their quality is inconsistent and often well below the standard patients should expect.

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**Recommendation 4 – NHS England, ICBs and Welsh Health Boards should ensure universal provision of effective Fracture Liaison Services (FLSs), working with the Royal Osteoporosis Society (ROS) and the Fracture Liaison Service Database (FLS-DB) to eliminate geographical gaps in secondary fracture prevention, in line with the NHS 10 year plan.**

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The NHFD’s new pelvic fracture pilot audit aims to encourage collaboration between local hip fracture and FLS teams in case finding for a group of people at imminent risk of hip fracture. Many are frail individuals who will struggle to access effective bone treatment as outpatients, but who might be particularly suitable for the zoledronate that has proven so successful in response to the NHFD’s KPI 7.

## Next steps

This report has demonstrated that the most important source of inequity in hip fracture care and outcome is the persistent ‘postcode lottery’ – extreme variation in care and outcome between different hospitals which we continue to challenge.

Within individual hospitals, it is reassuring that most variation in care appears to reflect patients’ frailty and comorbidities rather than discrimination in respect of protected characteristics. This is perhaps unsurprising, since key decisions are made in the morning X-ray meeting, by staff who are unaware of the patient’s socioeconomic status, with black-and-white imagery and major comorbidities dictating patient care.

However, socioeconomic variation in factors such as alcohol, smoking, cardiovascular and cerebrovascular disease underpin many key comorbidities. Such inequity will therefore still have an indirect, hidden impact on care and outcome for hip fracture patients so it is important for us to examine and challenge this through work such as the REDUCE study.

In addition, there is obvious inequity in [why](#) many patients were put at avoidable increased risk of sustaining the hip fracture in the first place, especially in areas where there is no FLS to reduce the chance of this devastating injury. We welcome the work of the FLS-DB and other national clinical audits in challenging the inequity, including in hip fracture risk, that arises from factors such as socioeconomic deprivation.

Social deprivation is associated with higher risk of having a hip fracture, so the least deprived men are half as likely to break their hip as the most deprived. [Over 8,500 hip fractures would be avoided each year](#) if all men had the same risk as those least deprived, with an even bigger total for women. The NHFD cannot directly address such sources of inequity but we continue to reduce their impact by working to improve hip fracture care and outcome for everyone.

## Get in touch

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

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