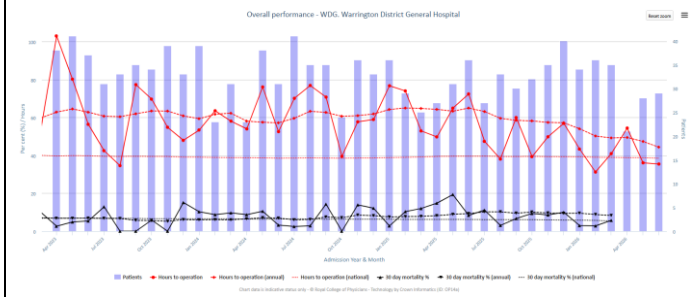
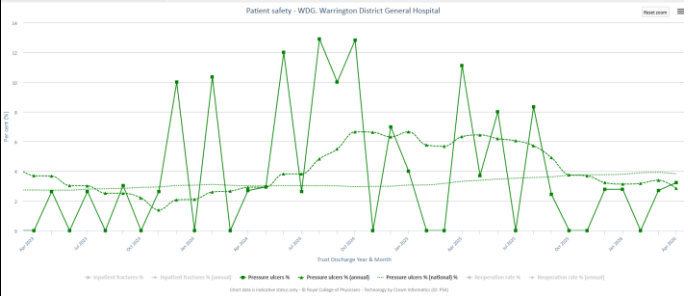
National Hip Fracture Database (NHFD) outlier responses 2025 for 30 day casemix adjusted mortality (reported calendar quarterly)

Associated annual report released 10 September 2026

Trust/Health Board	Site	Formal Trust/Executive team response	Outlier analysis period this response relates to	Outlier in the previous quarter analysis?	Outlier category following correspondence
North Cheshire and Mersey NHS Foundation Trust	Warrington District General Hospital	Thank you for your letter dated 3 July 2026 regarding the Trust's casemix-adjusted 30-day mortality for the year up to and including Quarter 4 (October–December 2025). The Trust acknowledges the updated run-chart data indicating that our unit's casemix-adjusted 30-day mortality has remained above the 3SD (99.8%) control limit for two successive quarters, with a reported rate of 9.7% for the period up to and including Q4 2025. We fully recognise the seriousness of this position and are committed to improving the quality of hip fracture care provided. The Trust has undertaken a comprehensive review of its hip fracture pathway and has completed a significant number of improvement actions over the last two quarters. These actions have resulted in a marked improvement in time to operation, a reduction in crude 30-day mortality, and a reduction in pressure ulcers over the last six months, as demonstrated by the charts below.	The year up and including December 2025. Q4 2025 analysis.	Yes	True outlier





The Trust will now consolidate these gains and seek to further improve performance through the updated summary action plan attached.

I can confirm that comprehensive mortality reviews have been undertaken for all hip fracture patients who have died within the last 12 months, and that the outputs and learning from these reviews have been reported to the Trust's Quality and Safety Committee. This work has identified data quality issues, particularly in relation to missing ASA grade data, which is likely to have adversely affected the Trust's casemix-adjusted mortality. These data quality issues have now been addressed and should be reflected in future casemix adjustment.

In relation to governance and oversight, the Hip Fracture service is designated as a Fragile Service within the Trust. Performance and progress against improvement actions are reported bi-weekly to the Medical Director, Chief Nursing Officer and Chief Operating Officer as part of the Trust's Planned Care Quality Recovery Programme; to the Executive Management Team on a

		monthly basis; and directly to the monthly Quality and Safety Committee. The Trust Board receives a report on Fragile Services, including Hip Fracture, at each Board meeting. This report is subsequently shared with the ICB Place Quality Team and discussed at our regular CQC engagement meetings. We remain committed to consolidating and building on the improvements achieved over the last six months.			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Fractured Neck of Femur Service: Executive Action Plan – Updated 21/7/26

Action No.	Action Description	Triumvirate SRO	Delivery Lead(s)	Date Due	RAG Status	Latest update
1.0 Pathway Redesign						
1.1	Transformation team to observe and audit a full trauma session, focusing on process touchpoints and delays	ADOP	JW/SFD/AH	17/04/2026	Completed	Now completed. Team observed w/c 7 Apr; outputs share with Planned Care Tri for implementation. Repeat observati study planned Q2 2026/27.
1.2	Review current bed base across Planned Care so Ward A6 can be utilised for Trauma patients, ensuring prompt time to theatre	ADOP ACNO	SFD	31/07/2026	In Progress	Target revised from 30/06 to 31/07/2026. Wider bed-base improvements agreed for implementation; action requireme be reassessed.
1.3	Review the trauma on-call model to support time to theatre within 36 hours, exploring alternative on-call arrangements	AMD	SFD/RC/DA	31/07/2026	In Progress	Target revised from 17/07 to 31/07/2026. Revised on-call model developed and discussed at T&O Business Meeting May). Awaiting decision on CSTM/PACU.
1.4	Visit high performing centres across the North West to gain insight into alternative models	ADOP AMD	TG	30/09/2026	In Progress	Linked with colleagues and MFT and introductory meetin taking place. Further centre in C&M to be identified.
1.5	Increase Trauma capacity when demand exceeds main Trauma list capacity; options appraisal to confirm agreed route of capacity and escalation	ADOP	TG/AV/SFD	30/09/2026	In Progress	Target revised from 01/04 to 31/07/2026. Touch time has been collated and analysed. Significant variation in touch ti utilisation exists which requires improvement. Modelling indicates a requirement to introduce a full day list trauma lis from a partial day, on a Sunday to support time to surgery. Planned Care Group developing plan to deliver this increas within Q2-Q3 26/27.
2.0 Mortality Review						
2.1	Comprehensive mortality review of patients who died within 30 days of admission for fractured neck of femur, over a 12-month period	AMD	AV	01/04/2026	Completed	Mortality review process established; findings presented March PSCESC and QASC. Internal reporting cycle now established and under executive oversight.
2.2	Clinical governance review of mortality results, linked to NHFD indicators	AMD	AV	25/03/2026	Completed	Review process agreed at T&O Business Meeting; outstanding cases distributed for review.
3.0 Governance and Audit						

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3.1	Local review of data submitted to NHFD, providing monthly data quality assurance reports	ADOP	IT/SFD	31/07/2026	Completed	Now completed (was in progress at submiss submitted; full review of collection and inclusio criteria and all BPT/KPIs completed. Monthly D continues as BAU.
3.2	Monthly thematic review of RCAs for all patients who breached the 36-hour surgery target	ACNO	CMc	Ongoing	Ongoing	Monthly thematic RCA review of 36-hour bre remain in progress throughout Q2 26/27 whilst monitoried.
3.3	Weekly Executive oversight of progress against the action plan, with Fragile Service update to Patient Safety Committee monthly and to Quality Assurance Committee	AMD ADOP CNO	AV/SG/CR	Ongoing	Ongoing	Weekly Executive oversight of the action pla Services update to PSCESC and QAC monthly (standing/recurring activity).

South Warwickshire University NHS Foundation Trust	Warwick Hospital	Warwick Hospital acknowledges the identification of higher-than-expected case-mix adjusted 30-day mortality for patients sustaining hip fracture during the reporting period up to Quarter 4 2025. We understand this constitutes four consecutive quarterly reports outside the expected mortality figures and actions have been taken which are documented below. Since meeting to discuss our performance concerns with NHFD Lead, Dr William Eardley, to in December 2025, a comprehensive programme of service review, governance strengthening and quality improvement has been implemented across the hip fracture pathway. This work has been undertaken collaboratively by Trauma and Orthopaedics, Orthogeriatrics, Emergency Medicine, Anaesthetics, Therapy Services and Nursing teams. The following information builds on the previous responses in March and April 2026 and demonstrates what has been implemented since. Whilst we recognise that NHFD mortality reporting reflects historical performance and therefore current improvements may not yet be evident within the published data, substantial work has been completed to understand the factors contributing to mortality and improve patient outcomes. **Review Findings** Initial review identified several opportunities for improvement across the pathway: • Absence of a formal multidisciplinary governance structure for the hip fracture service. • Lack of regular multidisciplinary review meetings focused on NHFD performance indicators. • Concerns regarding the accuracy and consistency of NHFD data submission, particularly relating to ASA grading and mobility status. • Variability in performance against recognised hip fracture quality indicators. • Delayed theatre access in a subset of patients. • No formal mortality review process specific to femur fracture patients.	The year up and including December 2025. Q4 2025 analysis.	Yes	True outlier

		• Opportunity to further strengthen orthogeriatric and orthopaedic collaboration and oversight within the service. **Improvement Work Undertaken** **1. Establishment of a Dedicated Hip Fracture Leadership Group** A formal multidisciplinary leadership group has been established and meets regularly to oversee service performance and quality improvement. Membership includes: Chief NHFD Medical Lead, Clinical Ops Lead T&O, T&O Consultant Trauma Lead, T&O ACP Femur Fracture Lead, T&O Orth-Geriatrician Lead, ED Consultant Trauma Lead, ED ACP Femur Fracture Lead, Trauma Ward Manager, Femur Fracture Physiotherapy Lead, Femur Fracture OT Lead, Anaesthetic Consultant, Anaesthetic Femur Fracture Lead, Geriatrician Femur Fracture Lead, Femur Fracture T&O Co-ordinators, NHFD Meeting Administrator, Femur Fracture Pharmacy Lead. The group provides strategic oversight of pathway performance and is responsible for monitoring delivery of improvement actions. **2. Formal Performance Governance Structure** A programme of monthly performance review meetings has been implemented. The team reviews all NHFD Key Performance Indicators and monitors progress against agreed actions. Each KPI has an identified clinical lead and review schedule to ensure ownership and accountability. Areas reviewed to date: • KPI 0 Admission to specialist ward • KPI 1 Time to surgery • KPI 2 Orthogeriatric review • KPI 3 NICE compliant surgery • KPI 4 Early mobilisation This structured review process has enabled targeted quality improvement initiatives to be developed and monitored.			

		Improvements include: • Nutrition awareness pre-surgery carbohydrate loading drinks protocol • Message system on local network to identify femur fracture patients and improve • Redesigned patient MDT pathway booklet for clearer documentation and directions to complete important information Weekend theatre lists created (depending on need) to support surgery <-36 hours however remains a challenge **3. Data Quality Improvement Programme** A detailed review of NHFD data submission processes identified inaccuracies in recording of key demographic and clinical variables. Actions completed include: **ASA Classification Validation** Review of submitted ASA scores for 2025 demonstrated under-reporting of higher risk patients. Following validation for data inputted in 2026; • ASA grade 4+ patients increased from approximately 25% to 35% of submissions. **Mobility Documentation Review** Previous submissions overestimated the proportion of patients recorded as independently mobile. Following validation for data in 2026: • Freely mobile patients reduced from 51% to 33%. This work has improved the accuracy of case-mix adjustment and provides greater confidence that submitted data reflects the true complexity of the patient population. Monthly validation audits have now been introduced with a rolling review of ten randomly selected cases undertaken each month to ensure ongoing data quality.			

		4. Mortality Analysis A detailed review was undertaken of all deaths occurring within 30 days of hip fracture during 2025. Key findings included: • Patients who died were significantly older than the overall cohort. • Mortality was associated with higher ASA grades and greater frailty. • A higher proportion experienced delays to surgery beyond 36 hours. • Respiratory illness, particularly pneumonia, was the most common cause of death. • Comorbid dementia, cardiac disease and frailty were frequently identified contributory factors. The review demonstrated that many deaths occurred in an increasingly complex and medically vulnerable patient group. However, opportunities for system improvement were identified and have informed the improvement programme. **5. Introduction of Formal Mortality Review Meetings** A dedicated mortality review process has been introduced. All deaths are now subject to structured multidisciplinary review. Learning identified to date has included: **Clinical Documentation** • Improved completion of fluid balance monitoring. **Medical Escalation** • Earlier recognition and management of chest infections and respiratory deterioration. **Information Sharing** • Improved access to relevant community and primary care records to support clinical decision making. **Specialist Input**			

		• Consideration of earlier palliative care involvement where appropriate. Each review generates actions which are monitored through the Hip Fracture Leadership Group. **6. Workforce and Service Model Review** A review of staffing and service provision across the pathway has been completed. This has included comparison against recommendations within the NHFD REDUCE programme. Particular focus has been given to: • Orthogeriatric provision. • Clinical leadership. • Trauma pathway coordination. • Governance arrangements Further work to optimise the orthogeriatric shared care model is currently underway and part of wider structural re-design across Trust. **Early Evidence of Improvement** Although NHFD reporting lags current clinical activity by six to nine months, local monitoring suggests encouraging progress. Data from January to March 2026 demonstrates: • Improvement in crude 30-day mortality rates compared with performance observed during 2025. • Increased compliance with clinical governance processes. • Improved data quality. • Enhanced multidisciplinary engagement and ownership of performance. • Greater scrutiny of delays to surgery and mortality events. The Trust recognises that sustained improvement over time will be required and remains committed to continued monitoring and service development.			

		Trust level data on crude mortality for 2026 to date: For Q1 2026 the crude mortality is at 4.46%. With greater accuracy in data inputting, we believe the adjusted mortality will more accurately reflect the patient population and give an adjusted mortality within the expected boundaries. Time to theatre remains a significant challenge with 31% patients not receiving surgery <36 hours. The most common reason for this is lack of theatre capacity. **Conclusion** Warwick Hospital recognises the seriousness of the NHFD mortality outlier designation and has responded with a comprehensive multidisciplinary improvement programme. Significant progress has been made in strengthening governance, improving data quality, reviewing mortality outcomes and embedding continuous quality improvement across the hip fracture pathway. Whilst the published NHFD data reflects historical performance, the Trust believes that the actions implemented since December 2025 provide a robust framework for sustained improvement in patient outcomes, and we remain committed to working closely with the NHFD team to monitor progress and share learning.			
Mid and South Essex NHS Foundation Trust	Southend Hospital	our Senior Orthogeriatric Fellow has reviewed all the 2025 patient data entries, and corrected many of the ASA grades, with some anaesthetic input. He has recalculated the casemix adjusted mortality with the corrected ASA grades and as we discussed in March, the expected number of deaths has increased and casemix adjusted mortality has gone down, indeed to below the national average. His calculation is below and summarised on the attached PowerPoint presentation. I am sorry that this corrected figure will not be included in the NHFD annual report, but we would be grateful if a note could be added regarding the data quality issue for Southend when the annual report is published. We will be more careful about data accuracy from now on.	The year up and including December 2025. Q4 2025 analysis.	No	Coding issue

		Following the recent NHFD 30-day mortality outlier notification for SEH, I carried out a local review and recalculation of the crude and case-mix adjusted 30-day mortality using the corrected NHFD export. I would emphasise that this is a **local analytical recalculation performed by me** using the corrected export data and the best available published NHFD methodology that I could reproduce locally. **I am not a statistical expert,** and it is **entirely possible that some aspects of my calculation may not fully replicate the official NHFD process**. I also appreciate that this is a relatively **complex** analysis. However, this appears to be the nearest reproducible calculation to the submitted dataset, and the crude mortality result aligns closely with the NHFD chart itself. The overall direction and magnitude of the corrected case-mix effect strongly support the conclusion that the original outlier signal was most likely driven by data-quality issues, particularly ASA coding, rather than confirmed excess 30-day mortality. The main finding from this local review is that the raised case-mix adjusted mortality signal appears most likely to be explained by data-quality/casemix coding issues, particularly ASA grade under-recording or under-coding, rather than by a true excess in crude 30-day mortality. This interpretation is also consistent with the NHFD correspondence, which indicated that the issue did not appear to be primarily one of genuinely raised mortality, but rather that the submitted casemix data made the admitted cohort appear fitter than it actually was. This would artificially lower the expected mortality and consequently push the adjusted mortality curve above the 3SD control limit. After correction of the ASA grades and other available casemix fields, I recalculated both crude and case-mix adjusted mortality using the closest reproducible published NHFD case-mix methodology that I could identify. The primary analysis was performed on the Q1–Q3 2025 cohort, as this matches the period displayed in the NHFD chart screenshot. <u>The crude 30-day mortality was calculated as:</u>			

		Observed 30-day deaths / Total admissions × 100 For Q1–Q3 2025, this gave: 21 deaths / 402 admissions = 5.22% This is very close to the crude mortality shown on the NHFD chart tooltip (approximately 5.3%), which reassures me that the crude mortality calculation itself is internally consistent and closely reflects the submitted data. For case-mix adjustment, I used the published NHFD logistic regression model described by Tsang et al. in Bone & Joint Research: Tsang C, Boulton C, Burgon V, Johansen A, Wakeman R, Cromwell DA. Predicting 30-day mortality after hip fracture surgery: evaluation of the National Hip Fracture Database case-mix adjustment model. Bone Joint Research. 2017;6(9):550–556. DOI: 10.1302/2046-3758.69.BJR-2017-0020.R1 The model estimates the expected probability of 30-day mortality for each patient using the following variables: age group, sex, ASA grade, pre-fracture residence, pre-fracture mobility, and fracture type. These are the same key domains described by NHFD as forming the basis of its validated casemix model. Each patient therefore received an individual expected 30-day mortality probability based on their corrected casemix profile. These probabilities were then summed across the cohort to estimate the total expected number of deaths. For the Q1–Q3 2025 cohort: Observed deaths = 21 Expected deaths after corrected casemix = 36.62 Observed / Expected ratio = 21 / 36.62 = 0.57 The case-mix adjusted mortality was then calculated using indirect standardisation: Adjusted mortality = Observed deaths / Expected deaths × National average mortality Using the national average shown on the NHFD chart (5.0%): Adjusted mortality = 21 / 36.62 × 5.0 = 2.87% This corrected local adjusted mortality is therefore below the national average and well below the upper control limits shown on the NHFD chart.			

This differs markedly from the original NHFD displayed adjusted figure, which was approximately 9.9%.

The reason ASA correction appears to have such a large effect is that ASA grade carries substantial weight within the NHFD model. In the published equation, ASA 3 increases the odds of 30-day mortality by approximately 3.2 times compared with ASA 1–2, while ASA 4–5 increases the odds by approximately 6.9 times.

Therefore, if ASA is under-recorded or coded too lightly, the model assumes that patients are significantly fitter than they truly are. This suppresses the expected number of deaths and mathematically inflates the adjusted mortality, even when the crude mortality itself is not excessive.

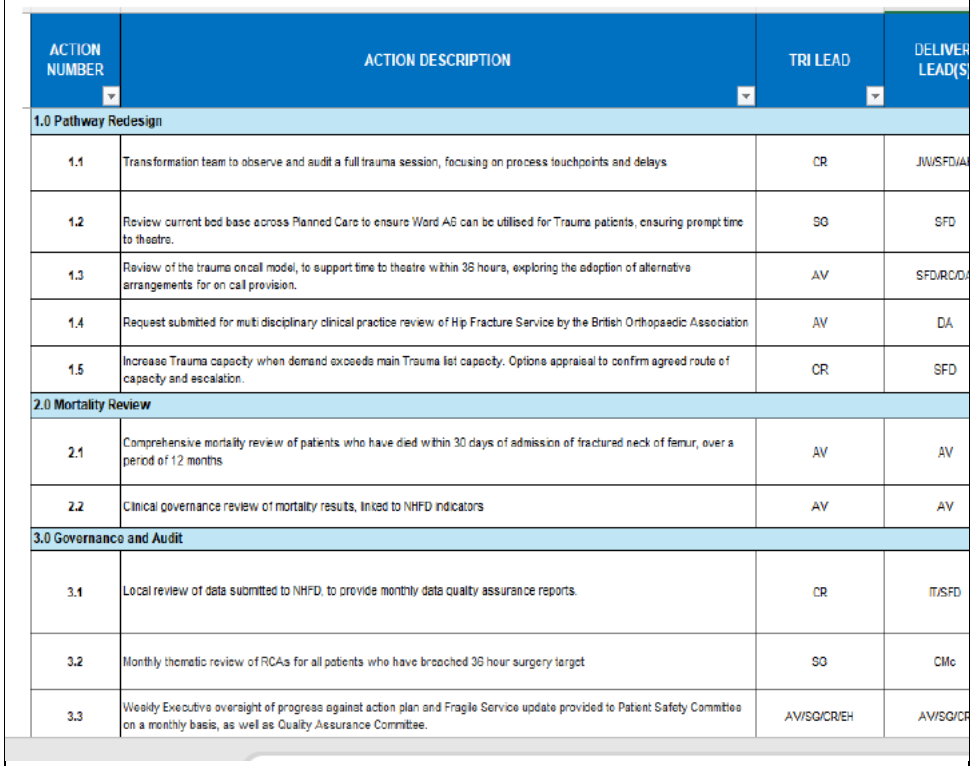
The corrected quarter-by-quarter local recalculation was as follows:

	Admissions	Observed deaths	Crude mortality	Expected deaths	Recalc adjust morta
	143	10	6.99%	11.82	4.23%
	137	6	4.38%	12.17	2.47%
	122	5	4.10%	12.63	1.98%
25	402	21	5.22%	36.62	2.87%

The attached presentation demonstrates this visually, including a comparison between the NHFD-posted line graph and the locally recreated corrected equivalent. In the corrected version, the alarm signal is no longer present, and the apparent outlier position seems to be largely explained by the original underestimation of patient risk.

In summary, the corrected local analysis supports the interpretation that SEH's apparent case-mix adjusted mortality outlier status was likely related to inaccurate casemix data submission rather than true excess 30-day mortality.

Trust/Health Board	Site	Formal Trust/Executive team response	Outlier analysis period this response relates to	Outlier in the previous quarter analysis?	Outlier category following correspondence
North Cheshire and Mersey NHS Foundation Trust	Warrington District General Hospital	Thank you for your letter dated 2 March 2026 notifying the Trust of recent NHFD casemix-adjusted 30-day mortality findings which has been shared and discussed with the Executive Management Team. We acknowledge the updated run-chart data indicating that our unit's casemix-adjusted 30-day mortality has remained above the 3SD (99.8%) control limit for two successive quarters, with a reported rate of 9.5% for the period up to and including Q3 2025. We recognise the seriousness of this position and appreciate the clarity of the information you have provided. In response, the Trust has initiated an action plan overseen by the Executive Management Team, as attached/shown below. (see next page) An external multidisciplinary clinical practice review of the Hip Fracture Service is being explored.	The year up and including September 2025. Q3 2025 analysis.	No	True outlier

		We are committed to identifying the factors driving this position and implementing the necessary improvements to maintain high standards of patient care. 			
South Warwickshire University NHS Foundation Trust	Warwick Hospital	**1. Awareness and clinical leadership oversight** SWFT has established a dedicated multidisciplinary leadership group for femur fracture care to provide oversight of the hip fracture pathway and response to the NHFD outlier position. Clinical and operational leadership is as follows: Clinical Operational Lead for Trauma and Orthopaedics, Trauma Lead Consultant, NOF ACP Lead, Orthogeriatric Leads, Emergency Department Clinical Lead, ED ACP Lead,	The year up and including September 2025. Q3 2025 analysis.	Yes	True outlier

ACTION NUMBER	ACTION DESCRIPTION	TRI LEAD	DELIVER LEAD(S
1.0 Pathway Redesign			
1.1	Transformation team to observe and audit a full trauma session, focusing on process touchpoints and delays	CR	JW/SFD/A
1.2	Review current bed base across Planned Care to ensure Ward A6 can be utilised for Trauma patients, ensuring prompt time to theatre.	SG	SFD
1.3	Review of the trauma oncall model, to support time to theatre within 36 hours, exploring the adoption of alternative arrangements for on call provision.	AV	SFD/RC/D/
1.4	Request submitted for multi disciplinary clinical practice review of Hip Fracture Service by the British Orthopaedic Association	AV	DA
1.5	Increase Trauma capacity when demand exceeds main Trauma list capacity. Options appraisal to confirm agreed route of capacity and escalation.	CR	SFD
2.0 Mortality Review			
2.1	Comprehensive mortality review of patients who have died within 30 days of admission of fractured neck of femur, over a period of 12 months	AV	AV
2.2	Clinical governance review of mortality results, linked to NHFD indicators	AV	AV
3.0 Governance and Audit			
3.1	Local review of data submitted to NHFD, to provide monthly data quality assurance reports.	CR	IT/SFD
3.2	Monthly thematic review of RCAs for all patients who have breached 36 hour surgery target	SG	CMc
3.3	Weekly Executive oversight of progress against action plan and Fragile Service update provided to Patient Safety Committee on a monthly basis, as well as Quality Assurance Committee.	AV/SG/CR/EH	AV/SG/CR

		Anaesthetic Leads, Trauma Ward Manager, Therapy Leads (Physiotherapy and Occupational Therapy) and Trauma Coordinators. This group meets monthly with a formal structure, including review of NHFD KPIs, mortality, pathway performance and agreed actions. Meetings are chaired by Clinical Operational Lead for Trauma and Orthopaedics with clinical leadership from Trauma Lead Consultant and Orthogeriatric Lead. A structured programme of sequential KPI review is in place, with each KPI allocated to a named clinical lead and reviewed in depth on a rolling monthly basis. **KPI** — **Date** — **Lead** KPI – 0 Specialist Ward — Feb-26 — ED Lead ED ACP NOF Lead KPI – 1 Orth geriatrician — March-26 — Orthogenic Lead KPI – 2 – Prompt Surgery — April-26 — Ed Trauma Consultant Theatres Lead KPI – 3 NICE Compliant Surgery — May-26 — Ed Trauma Consultant Resident Dr KPI – 4 Prompt out of bed — June-26 — NOF Therapy Lead (Physiotherap KPI – 5 Delerium — July-26 — T&O ACP NOF Lead KPI – 6 Return to residence — Aug-26 — Trauma Ward Manager OT Lead KPI – 7 Bone Medication — Sept-26 — T&O Orth-Geriatrician In addition, a dedicated femur fracture mortality review meeting is being established following agreement at multidisciplinary audit meetings, led by orthogeriatric and orthopaedic consultants, to provide detailed case based review and triangulation of outcomes. The Trust Board, NHS England and CQC are aware of the Trust's position, and this work is being progressed within established governance structures. **2. Analysis to understand contributory factors** A structured and ongoing analysis process has been undertaken, led by the Femur Fracture Leadership Team. This has included: Monthly multidisciplinary			

		KPI review meetings, Case based mortality review within Trauma and Orthopaedics, Detailed review of NHFD data input processes led by T&O ACP NOF Lead and Clinical Operational Lead for Trauma and Orthopaedics with Trauma Coordinators. Pathway mapping across Emergency Department, admission, ward care and discharge Analysis demonstrates that overall pathway performance is strong, with SWFT performing above the NHFD national average in 7 of 8 KPI domains. Targeted review has identified specific contributory factors associated with the outlier position: • Increased mortality observed in patients not admitted to the specialist orthopaedic ward • Delays in transfer from Emergency Department to the specialist ward, with an average time of approximately 6.5 hours • Variation in early pathway elements including time to imaging, communication between teams, and transfer processes • Data quality issues, particularly relating to ASA grading and completeness of NHFD submissions A focused review of ASA grading, led by T&O ACP NOF Lead and Clinical Operational Lead for Trauma and Orthopaedics, identified inaccuracies in comorbidity scoring. In a sample of deceased patients, ASA grading was frequently underestimated, and a proportion of patients had no ASA grade recorded, particularly where surgery was not undertaken. This has been identified as a contributing factor to reported mortality outcomes and is being actively addressed through revised processes. These findings have been derived through multidisciplinary review and are informing targeted improvement actions. **3. Improvement actions and monitoring** A comprehensive improvement programme is in place, aligned to NHFD standards and the REDUCE hip fracture toolkit, with clear clinical ownership and defined monitoring. Pathway reliability and standardisation:			

		• Revised femur fracture standard operating procedure implemented, led by ED Trauma Consultant and T&O ACP NOF Lead
		• Introduction of a redesigned clerking and pathway document to ensure consistent documentation, including mandatory ASA grading for all patients
		• Development of an Emergency Department proforma by ED ACP Lead and Emergency Department Clinical Lead to standardise early assessment and reduce variation
		Timeliness and flow:
		• Agreed pathway targets across the multidisciplinary team:
		  ○ X-ray within 60 minutes
		  ○ Nerve block within 120 minutes
		  ○ Transfer to orthopaedic ward within 4 hours
		• Work led by ED and Trauma teams to reduce delays, including:
		  ○ Review of nerve block processes and training
		  ○ Exploration of anatomical nerve block delivery in ED
		  ○ Improved escalation to site and bed management teams
		  ○ Introduction of direct registrar communication to Trauma and Orthopaedics via messaging system on confirmation of femur fracture, led by ED Trauma Consultant
		  ○ Ongoing work with site management and ward teams, including Trauma Ward Manager, to prioritise admission to the specialist orthopaedic ward
		• Data quality improvement:
		  ○ Revision of NHFD data input process, now led by ACPs under T&O ACP NOF Lead
		  ○ Implementation of validation checks prior to submission
		  ○ Bi-weekly senior clinical review of ASA grading involving anaesthetic and orthogeriatric teams
		  ○ Requirement for ASA grading to be recorded for all patients prior to NHFD submission
		• Governance and audit			

		○ Monthly KPI focused review meetings chaired by Clinical Operational Lead for Trauma and Orthopaedics ○ Establishment of a dedicated femur fracture mortality review meeting led by orthogeriatric and orthopaedic consultants ○ Ongoing audit of NICE compliance and implant selection led by Resident Dr with oversight from ED Trauma Consultant ○ Continued review through Trauma and Orthopaedic audit structures • Holistic care and MDT optimisation ○ Strengthened orthogeriatric input led by Orthogeriatric Lead and T&O Orth-Geriatrician ○ Development of nutritional optimisation pathway, including peri operative supplementation, led by Anaesthetic Lead ○ Improved documentation of treatment escalation planning and communication with patients and families • Service development priorities The Trust is also reviewing a number of service developments to further strengthen the hip fracture pathway in line with best practice: ○ Maximising admission of patients to the specialist orthopaedic ward (Greville), recognising improved outcomes associated with cohorting of care ○ Review of orthogeriatric provision, including consideration of extended seven day working and enhanced senior input across the pathway ○ Exploration of increased orthogeriatric ward presence, including more frequent senior review, to support optimisation, early decision making and discharge planning Impact will be monitored through: ○ Monthly NHFD KPI review ○ Ongoing NHFD data submission and benchmarking ○ Mortality review outcomes ○ Audit cycles aligned to REDUCE standards			

		4. Joint working with George Eliot Hospital (GEH) SWFT is working collaboratively with George Eliot Hospital to support shared learning and improvement. Planned actions include: ○ Reciprocal site visits in April involving clinical and operational leads from both organisations ○ Sharing of audit findings, improvement plans and data validation processes ○ Review of pathway delivery across both sites to identify variation and adopt best practice This work is being coordinated through clinical leadership teams at both organisations to ensure alignment and shared learning. **Summary** While SWFT has been identified as an outlier for hip fracture mortality, detailed review demonstrates that the overall pathway is performing strongly, with performance above the national average in the majority of NHFD KPIs. The Trust has established clear clinical leadership, undertaken structured and multidisciplinary analysis, and implemented a targeted improvement programme focused on identified areas of variation. Key areas of focus include improving timely admission to the specialist orthopaedic ward, reducing early pathway delays, and strengthening data quality processes. These actions are supported by robust governance and ongoing monitoring. SWFT is confident that this programme of work will result in measurable and sustained improvement.			

Trust/Health Board	Site	Formal Trust/Executive team response	Outlier analysis period this response relates to	Outlier in the previous quarter analysis?	Outlier category following correspondence

University Hospitals Birmingham NHS Foundation Trust	Birmingham Heartlands Hospital	We recognise the seriousness of this finding and welcome the opportunity to formally respond and outline the actions already undertaken, those in progress, and our ongoing commitment to improvement across the fragility fracture pathway. Hip Fracture Mortality has been a sustained area of focus since 2022 and are subject to regular review through Trust clinical governance structures including the Birmingham Heartlands Hospital Site Quality and Safety meeting, Group Mortality and Morbidity Review Committee and the Clinical Quality and Patient Safety Committee of the Board of Directors. You will be aware from our previous responses of the work undertaken in recent years, including an external review by Johnson & Johnson. This letter provides updates on the latest areas of work and associated action plans. **Mortality Review and Data Quality** A comprehensive mortality review process is in place. Deaths following hip fracture admission are reviewed through structured mortality review meetings, with learning triangulated against NHFD indicators and internal performance data. We have also identified data quality as a key enabler for improvement. Actions already implemented include: • Weekly NHFD data validation and reconciliation against mortality data • Improved recording of ASA4 and case mix variables, now aligned with national standards • Recruitment of a dedicated data coordinator and introduction of live performance dashboards (January 2026) **Service and Pathway Improvements** Surgical Performance • Compliance with surgery for eligible patients has improved significantly, rising from 24% in October 2024 to 75%, now above the national average • Surgery within 36 hours has improved month-on-month, with further improvement expected as capacity constraints are addressed	The year up and including June 2025. Q2 2025 analysis.	Yes	True outlier

		Mortality Trend • Although adjusted mortality remains elevated due to rolling averages, we are seeing a downward trend in crude 30-day mortality • We anticipate this improvement will be reflected in adjusted runs as earlier periods roll out of the calculation **Capacity and Flow Challenges** We have identified delays in ED transfer, ward capacity constraints, and inter-site transfer inefficiencies as significant contributors to pathway delay and risk. Actions underway include: • Review of the Birmingham Heartlands Hospital bed base for NOF patients (January 2026) • Development of a dedicated NOF "hot bay" and ACP-led Fracture in Bed (FIB) service (February 2026) • Review of cross-site NOF transfer pathways with QE and Good Hope Hospitals These actions are overseen at Executive level and tracked through a formal action plan. **Orthogeriatric and Workforce Mitigation** We acknowledge that limitations in orthogeriatric coverage have contributed to risk within the pathway. Significant progress has been made, including: • Successful locum recruitment and appointment of a senior fragility fellow • Agreement of terms of reference between Orthogeriatrics and Trauma & Orthopaedics • Active recruitment to expand orthogeriatric provision from 1.5 WTE to 4.5 WTE by April 2026, including conversion of posts and pipeline candidates via CESR Job planning and rota redesign are ongoing to ensure sustainability. **Ongoing Assurance and Next Steps**			

		A detailed action plan with named leads and timelines is in place and subject to regular Executive oversight. Progress is reported through Trust governance committees and will continue to be monitored closely. We appreciate the NHFD's support and challenge and remain committed to working collaboratively to ensure safe, effective, and timely care for our hip fracture patients.			
George Eliot Hospital NHS Trust	George Eliot Hospital	NHFD Action Plan for Clinical Audit 2025.pd	The year up and including June 2025. Q2 2025 analysis.	Yes	True outlier
Mid Yorkshire Teaching NHS Trust	Pinderfields General Hospital	**Hip Fracture Improvement Group – Improvement Plan for Hip Fracture** This plan has been developed by the Hip Fracture Improvement Group (HFIG) in response to outlier concerns from National Hip Fracture Database (NHFD) - Greater then 3SD above national average mortality – for 2 consecutive quarters - Excess patients as non weight bearing status post surgery High mortality rates are rightly a significant concern to the NHFD, the Trust Board and to us working in the hip fracture service. Best Practice Tariff (BPT) rates have also fallen which raises concerns about the overall quality and efficiency of the hip fracture service This document will describe a plan of reforms and changes to the hip fracture service with the goal of reducing mortality along with improving the quality and efficiency of the service for our patients Basis for recommendations MidYorks NHS Trust admits between 550-600 patients / year with hip fractures. Many of these patients are frail with extensive comorbidities and are at a significant risk of poor outcome. This is true of all NHS hospitals and reflects the nature of patients who are admitted with hip fractures. Some weighting is taken into account for local population casemix – MidYorks does have a slightly higher proportion of patients who have restricted mobility pre-op compared with other Trusts. This weighting is not enough to solely account for our outlier status – this implies the mortality problem is a result	The year up and including June 2025. Q2 2025 analysis.	No	True outlier

		of our pathway and systems and these need to be the focus of improvement efforts. Evidence supports some key interventions as having associations with improved mortality. These interventions are: early surgery and early mobilisation. These metrics are gathered by the NHFD for the Best Practice Tariff (BPT) and Key Performance Indicators (KPIs) and will be the focus of our efforts in this improvement plan. These KPIs are also targeted as there has been a fall in our performance year on year and when compared to over hospitals We will also be targeting admission time from Emergency Department to the orthogeriatric ward – ward 42. This is because we perform very poorly on this metric and because streamlined quick admission to the ward will improve patient journey and experience and reduce a variety of complications resulting from prolonged waiting for admission Success of this project will be measured by the following NHFD metrics : - KPI 0 : Time to admission to the ward - KPI 2 : Time to surgery - KPI 4 : Time first mobilised - Mortality at 30 days from admission. This data is collected continuously by the NHFD with monthly KPI data and annualised mortality data released every quarter **<u>Improvement plan</u>** **1.Hip Fracture Improvement Group** Cross division group with anaesthetics, orthopaedics and orthogeriatrics – meeting every 1-2 months to coordinate improvement activity in hip fracture & maintain standards and BPT performance. This group is meeting regularly with the goals of improving KPIs 0,2 & 4 and mortality Development and oversight of this improvement plan – some changes already enacted (see below) **2. Learning from other Trusts**			

		Highly successful visit to Sheffield Hospitals to learn from their experience as a mortality outlier in the past. Similar sized Trust in terms of numbers of hip fractures admitted per year Sheffield demonstrated the benefits of cohorting hip fracture patients together without other medical patients – creates an atmosphere more focused on rehabilitation. Much better nursing staffing ratios associated with more time for nursing care and rehabilitation – Sheffield have 1:10 vs our ratio of 1:17 Advantages / disadvantages of a visit from the British Orthopaedic Association (BOA). There is the option to have a visit from the BOA where they will analyse the service and give recommendations about changes to improve. This may bring new ideas and also provide an outside opinion about the proposed changes to the hip fracture service. This could provide additional reassurance to the Trust Board if they wish. The cost of a BOA visit is approximately £30k. I have also had discussions with the clinical lead for the NHFD. He recommended we start interventions based on NHFD KPIs as these are evidence based method is improve mortality. His recommendation was not to wait for results of an audit into deaths and start changing the service whilst the audit is completed **3. Weight bearing status post op** Patients are usually able to fully weight bear after their hip operation. Occasionally, there may be reasons that the patient is instructed not to mobilise post op eg multiple injuries, instability in the repair. The NHFD monitors the number of patients with restrictions to their post op mobility and has identified MidYorks as an outlier in this metric This has been discussed at orthopaedic governance – failure to follow recent BOAST guidance for documentation of post op mobility status. This has been noted before at orthopaedic governance – instruction given to all Consultants present to follow the guidelines. A new audit has been started to assess adherence to the guidelines. **4.Changes to the orthogeriatric ward & ED admissions (KPI 0)**			

		Ward 42 is a 45 bed ward – mixture of hip fracture patients and general geriatric admissions – approximately 50/50 split between patient groups – usually 3 qualified nurses on duty. Ward 42 has been split into 2 ward and is part of the exemplar ward project – 42a : 20 beds for hip fracture, 42b : 25 for general geriatric patients – 2 qualified nurses per half of the ward. This improves nursing ratio from 1:17 to 1:10 for hip fracture patients. Admissions to the hip fracture ward are controlled by a new SOP with the patient flow team – use extra capacity patients in 42b to create space on 42a to admit directly from ED. Rapid admission from ED avoids multiple complications eg pressure sores from trollies, dehydration from delayed IV fluids, missed usual medication, missed analgesia, increased delirium and poor patient experience. Early admission also promotes early surgery as the patient is in the right bed for orthogeriatric assessment, easy transfer to surgery and avoids complications from going to an outlier ward where they are not as familiar with pre-op patients. Cohorting hip fracture patients together also brings benefits – patients see others getting out of bed, progressing with mobility and moving towards discharge. Patients are also not distracted by unwell medical patients in the same bay. The end goal is a culture shift for all patients to be out of bed every day with rehabilitation seen as the norm. This will take time to embed fully. **5. Rapid access to surgery (KPI 2)** Time to surgery within 36hrs is the main cause of patients not meeting BPT standard and the principle reason for the decline in BPT rates over the past year at MidYorks. Delay to surgery beyond 48hrs is associated with an increased mortality. Some patients will not be able to have surgery quickly due to other medical issues such as poor kidney function combined with anticoagulation with DOACs. Some patients need medical optimisation for a few days before surgery and a small number will never be fit for an operation. This is why we will never achieve 100% for this metric.			

		Additionally, hip fractures are priority cases for surgery, but not the only priority cases as infections and “life and limb” cases will go first. The importance of early prioritisation for hip fracture patients has been emphasised to orthopaedic teams and assistance added in the form of an orthogeriatrician attending the trauma meeting whenever possible (currently 4days / week). This improves communication channels to avoid unnecessary cancellations due to medical concerns and enables orthogeriatrics to review a patient, deal with any problems and still keep them listed for surgery in the afternoon. **6. Immediate surgical aftercare** A protocol for management of a hip fracture patient in PACU is under development. There is currently no standardised approach to assessment of fitness to return to the ward from PACU. Many anaesthetists use a Hemocue for an instant haemoglobin value post op but this is not routine practice. Introducing a standard assessment tool ensures patients are identified if they need a transfusion more quickly and that fluids are prescribed for when returned to the ward. Early blood transfusion and avoiding dehydration will help recovery, avoid acute kidney injury and increase chances of mobilising the day after surgery **7. Early mobilisation (KPI 4)** BPT targets for therapy were assessment on day of or day after surgery – KPI 4 requires the patient to actually mobilise out of bed. The main reasons for not mobilising on day 1 post op are usually medical eg uncontrolled pain, delirium or low blood pressure (usually from dehydration or needing a transfusion). A new analgesia pathway is under development with the pain team. This is in response to MHRA guidance restricting the use of modified release opiates such as MST or MR oxycodone. Immediate release opiates are permitted but are labour intensive for nurses to give due to double signature requirements. The role of opiate patches is also under consideration. Better pain control will			

		improve mobilisation and patient engagement and confidence in rehabilitation. There is a 7day service for review of post op patients. First therapy review is done with the HCA in that area to learn how to mobilise the patient with confidence **8. Specialist step down ward at Dewsbury – Ward 8** Ward 8 has been developed as the ward to specialise in hip fractures who have been stepped down to Dewsbury Hospital. It has the same therapy ratio as on ward 42 + excellent facilities for rehabilitation (although it is NOT a rehabilitation ward). Nurses have had training for after care issues with hip fracture and we have easy access for them to contact ward 42 in event of needing advice. Ward 42 Consultants are doing some sessions on ward 8 to help deal with any hip fracture related problems and drive forward with discharges. The objective is to make moving to ward 8 as a positive step forward in the patient journey – patients no longer need to be in Pinderfields and have recovered enough to go to a quieter ward, has good therapy team to keep progressing with mobility, can have bone treatments and catheter care as required + feel like they are progressing towards home. Some patients and relatives will refuse step down to Dewsbury. Alternative step down beds are available at Pinderfields but will not have the same level of therapy input for patients **9. Audit of deaths** An audit is underway looking at all deaths over the past 5 quarters. This audit examines for any common themes of mortality and any stand out cases with specific lessons to learn. Most of cases reviewed so far have shown very frail and unwell patients who's deaths were not entirely surprising eg end stage dementia and severe post op infection, patient diagnosed with a stage 4 cancer during admission. Some are due to random unavoidable events eg massive aspiration on induction of anaesthetic, cardiac arrest in theatre ?cement reaction + sudden unexplained deaths post op from pulmonary embolus and heart attacks			

		No obviously avoidable deaths have come to light so far. There is an expectation that there may be some avoidable deaths as there is a case of a mismanaged insulin sliding scale that lead to a death last year. This has already been investigated and managed alongside other recent insulin errors. The audit is also checking the quality of our data submitted to the NHFD to ensure our performance is correctly assessed. Several other audits are also underway around the topic of hip fracture: - Orthopaedics are auditing if the presence of a Consultant orthopaedic surgeon in theatre has an impact of mortality - Anaesthetics are auditing cases around the topic of fitness for surgery **10. Additional improvement activity in hip fracture** There are several projects ongoing in hip fracture from earlier in 2025 - Updated patient and relative information packs - Additional equipment for ward 42 – patient chairs are on order - "cheat sheet" for nurses to assist with perioperative medications Improving Together / PMU are also doing some background data based work for hip fracture: -Plan to follow 20 patients through the pathway to examine the patient journey for opportunities to improve care With this plan, the Hip Fracture Improvement Group intends to provide reassurance to the NHFD and Trust Board that we have an effective plan for addressing the concerns of high mortality and excess non weight bearing post op. The plan aims to improve several sections of the pathway and should lead to additional benefits such as reductions in delirium rate, complications related to immobility, length of stay and improved patient experience and BPT performance			
South Warwickshire	Warwick Hospital	**NHFD review & Actions:** 1. Identify leads. 2. Establish regular meetings (accountability)	The year up and including June 2025. Q2 2025 analysis.	No	True outlier

University NHS Foundation Trust

3. Review data inputting process (Amy and Paul to meet with Melba and Vicky about process)
4. Find/collect data on admission/ED (after establish ED lead)
5. Audit ASA grading.
6. Audit implant selection / NICE guidance.
7. Look at posts/roles within trauma service and match to REDUCE toolkit.

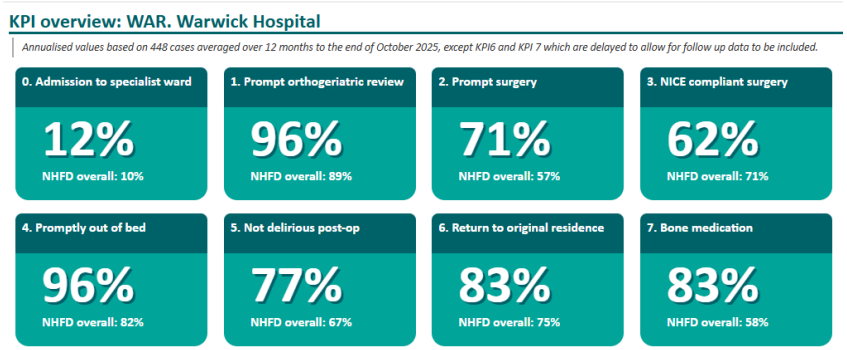
Utilise https://theros.org.uk/healthcare-professionals/clinical-quality-hub/clinical-quality-toolkits/hip-fractures/reduce-hip-fracture-service-implementation-toolkit/.

Review of Data:
*** Since meeting with NHFD clinical lead we have looked at addressing the above actions.
This has been hampered by Xmas break and Trust declaring critical incident with recent winter pressures however progress has been made as presented below.
Positively there has also been an improvement notice in recent BPT performance:
For Q3 2025/26 the BPT criteria was met 88.4% of patients, increase of 28.2%.

New BPT Criteria	Number of patients discharged	Number meeting BPT criteria	%	Quarter %
July	34	22	64.7%	60.2%
August	31	15	48.4%	
September	33	22	66.7%	
October	39	38	89.7%	88.4%
November	33	28	84.8%	
December	23	18	78.3%	

Current process:

- All patients that die are reviewed at monthly departmental audit.
- Review of NHFD KPI – 6 of 8 we are above national avg.
- ED/admission and NICE compliant prosthesis 2 we under perform.
- SWFT KPI performance above national average in 7 of 8 domains



2. Regular Meeting with Key Leads

Monthly meetings scheduled starting February date TBC. Meetings will be recorded and attended by senior T&O operational team.
Agenda:

- Review deceased
- BPT Performance
- Pathway Review Schedule:

KPI	Date	Lead	Pathway Update
KPI – 0 Specialist Ward	Feb-26	ED Lead ED ACP NOF Lead	
KPI – 1 Orth geriatrician	March-26	Orthogenic Lead	

KPI – 2 – Prompt Surgery	April-26	Ed Trauma Consultant Theatres Lead		
KPI – 3 NICE Compliant Surgery	May-26	Ed Trauma Consultant Resident Dr		
KPI – 4 Prompt out of bed	June-26	NOF Therapy Lead (Physiotherapist)		
KPI – 5 Delerium	July-26	T&O ACP NOF Lead		
KPI – 6 Return to residence	Aug-26	Trauma Ward Manager OT Lead		
KPI – 7 Bone Medication	Sept-26	T&O Orth-Geriatrician		

Agenda advised by REDUCE: Location of discussion will overlap with current monthly ward meetings and T&O Audit.

The standing monthly agenda can include review of, and matters arising from:

a) Minutes of the last meeting and matters arising

b) Ward activity and developments (e.g. new staff, equipment, ward routines)

c) Therapy activity (physiotherapy and occupational therapy)

d) Outliers (patients not on home ward): numbers, reasons, matters arising

e) Theatre activity

f) Complaints, PALS reports, SWARMS, In-Phase reports (see section 4 below)

g) Patient feedback (Friends and Family Feedback for the ward; NHFD patient feedback 120- day questionnaire (see section 5 below))

h) Update on any new hospital policies with relevance to hip fracture care

i) Hip fracture research (if applicable)

j) Agree decisions, actions and dissemination plan

3. Data review:

We have met with and understood our current process for inputting data to the NHFD website and identified critical errors that may contribute to poor performance. These mostly focus on ASA grading.

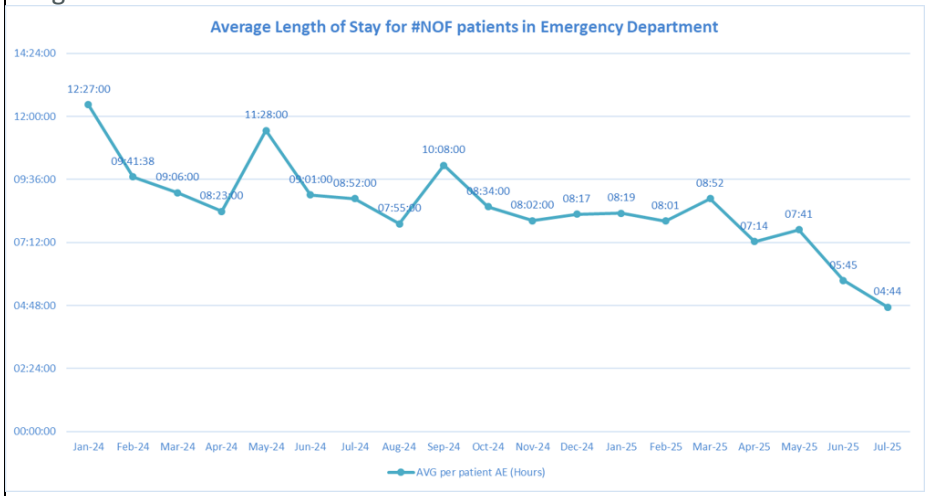
		Firstly, we reviewed ASA Grading (co-morbidities) and found inaccuracies; on a sample of 6 random patients who passed-away after NOF, 5 of 6 were underscored by at least 1, taking them to ASA 4 in 4 cases. Although a very small sample this is clearly an issue we must correct: **ACTION** – bi-weekly reviews of Fractured NOF cases starting Feb 2026 for ASA grading with senior clinical team to ensure accurate grading. We also have identified that 18% of deceased patients were input without an ASA grade given. These patients who were ungraded were all unfit for surgery or surgery was deemed not necessary, suggesting they were medically unwell and unlikely to survive surgical intervention. **ACTION**: met with trauma co-ordinators who input data to NHFD to learn why; 'U' is registered when no operative record available as this is only place in notes currently that ASA recorded; Pathway paperwork to be revised to include ASA grading in pathway regardless of if patient goes to theatre and no patients to be inputted until ASA grade is provided by Anaesthetist. **ACTION**: Anaesthetists to review and data to be inputted by end of January 2026. **4. ED Engagement** Meeting held on 16th Jan 2026 with Lead ED Consultant team. Discussed areas for improvement and motivation for greater engagement between teams. **ACTION:** key stakeholder identified to meet February with agenda to discuss gathered data on i). Time in ED, ii). Time to Xray/diagnosis along with REDUCE toolkit guidance: *1. **Nerve blocks** (typically femoral or fascia iliaca) Action: Nerve block trolley set up for hip fracture cases Target: At least 70% of hip fracture patients offered a nerve block pre-operatively* *2. **Pain score Action**: Routine use of pain scores (e.g. PainAD score) Target: Protocol in place: 100% patients scored and managed pre-operatively* *3. **Pre-operative energy supplement juice drink** prescribed Action: Prescribe 100mls at 06:00 ready for morning list, repeat at 10:00 for afternoon list Target: Protocol in place: 100% patients prescribed pre-operatively*			

		*4. **Treatment plan discussed with patient AND those close to them** (i.e. family/friends) on admission Action: Not just operation consent, but discussion re medical, nursing, physio management, treatment escalation (e.g. RESPECT form), expected recovery and rehab pathway Target: Documentation of discussion in 100% patients Patient experience feedback indicated discussions are valuable* *5. Ensure a reliable system is established to **promptly notify orthopaedic/orthogeriatric/nursing** admitting team(s) when a patient with hip fracture is identified in the ED* *7. After prompt assessment and management (including of pain), hip fracture admissions should **move directly to an orthopaedic ward from the ED within 4 hours** of presentation to hospital Target: >95% admitted directly to orthopaedic ward (vs. outlying ward) Pre-hospital notification systems for expected hip fracture presentations may help expedite assessment (and prompt pain management). Establish a dedicated hip fracture ward to which patients can be admitted direct from ED Target: >95% admitted directly to hip fracture ward (vs. outlying ward)* **POSSIBLE ACTION:** Once data reviewed further actions sanctioned with potential to have ACP NOF (AC) adopt a fast-track role working in ED rather than from ward. **5. Data Review** 1/1/2024 – 31/11/2025 = 943 NOF# Mean age of deceased 88 years. 44 ungraded for ASA (5%) Of those that deceased: 103 (10.9%) – 18 of which ungraded ASA (18%) **6. Surgical Compliance:** NICE guidance shared amongst Consultant and Registrar teams by (Ortho Consultant). Audit started by Registrar to review compliance with NICE guidance with presentation March @ T&O Audit and April @ NOF#MDT 2026.			

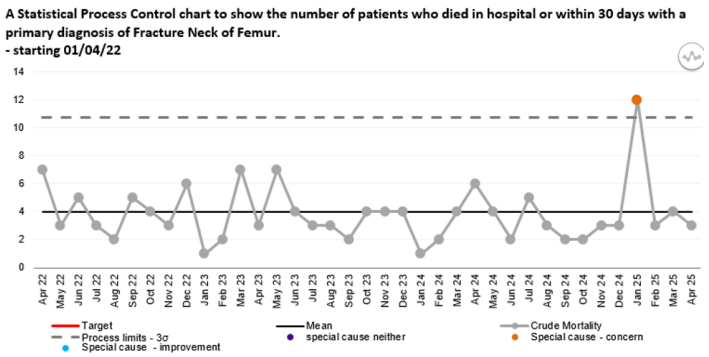
		7. Review against REDUCE guidance: Key Roles: Orthogeriatric – Achieved Orthopaedic - Achieved Anaesthetic - Achieved Orthopaedic clinical (co-)lead for hip fracture services - Achieved. Anaesthetic clinical (co-)lead for hip fracture services - Achieved. Physiotherapy - Achieved Nursing - Achieved Occupational therapy - Achieved. Pharmacy - TBC			

Trust/Health Board	Site	Formal Trust/Executive team response	Outlier analysis period this response relates to	Outlier in the previous quarter analysis?	Outlier category following correspondence
University Hospitals Birmingham NHS Foundation Trust	Birmingham Heartlands Hospital	The Trust has been regularly monitoring casemix adjusted mortality at its Heartlands site and was aware of the concerns expressed in your letter. The concerns have been reviewed by the Chief Medical Officer, Clinical Governance & Patient Safety Team alongside the Fragility service who are currently working towards improved performance. There is an established QIP programme in place to improve the quality of care provided across our fragility fracture service pathways. Progress against the programme of work is next scheduled for presentation at the Trust Mortality and Morbidity Review Committee in November 2025. Detailed are some of the actions that have either been implemented to date or are in progress:	The year up and including March 2025. Q1 2025 analysis.	Yes	True outlier

		1. Improved data submission. We now have a dedicated data clerk to ensure the quality of coding, particularly comorbidity, is more accurate. This has clearly been an area of deficit following the end of the pandemic. 2. Ortho-Geriatric input: Due to a lack of capacity in the service the Ortho-geriatric input for all hip fracture patients during their admission at Birmingham Heartlands Hospital needs to be strengthened. A business case to increase the capacity has been approved for 3 additional posts. The leadership teams are also working together to review the current on-call rota and to complete the recruitment of the posts which have been advertised. There is further work being underway to review the resident doctor workforce in ortho-geriatric with a view to adding further capacity. 3. Cemented vs Uncemented prostheses: BHH appears to be using more uncemented implants that other comparable UK units. This is partly driven by individual surgeon and anaesthetic preferences based on historical concerns around “cement syndrome”. The clinicians in the service will reduce the use of uncemented implants and compliance with this is being monitored weekly as well as part of the monthly data validation of implants used. 4. Usage of femoral Nails: BHH’s usage of femoral Nails needs to fall by 25% (of Heartland’s previous figures) to be in line with National practice. This has been communicated to the service and usage is being monitored on a weekly basis. Metrics with real-time data are currently being built to improve visibility of this data. 5. Capacity within the fragility service: Provision of adequate resource for the size of the unit at BHH is poor. Two new consultants have recently joined the fragility service and recruitment for two additional TNP/ACP posts and an additional data-coordinator are underway. The latter post will also support the improvements required in the accuracy of our data submissions. 6. Surgery within 36hours: The team have reviewed all cases between March 2025 – May 2025 (327 patient were eligible for surgery at BHH) to see how many had surgery within 36 hours and found 64% did. Each case has been analysed to identify the reasons for the delay to theatre and found several reasons, with the highest being delays in transfer due to lack of ringfenced			

		beds. The QIP is identifying ways to address the reasons for the delays. As an interim measure to improve the access to surgery within 36 hours of admission on the BHH site, the trust has agreed to enable surgery at the GHH and QEHB sites when patients are unlikely to be transferred within an acceptable timescale. The Fragility service is arranging for an external review via the British Orthopaedic Society in the coming weeks to support in identifying any other improvements. The Trust is committed to ensure our mortality rates improve, and progress will continue to be monitored by via the Trusts Quality and Safety governance which includes oversight via the Integrated Quality Report to the Clinical Quality Committee and Trust Board.			
Wye Valley NHS Trust	County Hospital Hereford	Since the implementation of the ring-fenced or protected femoral fracture bed on our specialist ward, the Trust has significantly reduced the average length of stay for any patients with a suspected or confirmed femoral fracture. Prior to implementation, the average length of stay in the Emergency Department was over 9 hours to admission, this has been almost halved over the past couple months to 4hrs 45mins. The provisional data for August continues show further reductions. 	The year up and including March 2025. Q1 2025 analysis.	No	True outlier

		In addition to this, we have also observed a continued reduction in the time to surgery for these patients. **Time to Theatre**: Month: July: Cases: 30 Average Time To Surgery:31hrs 28mins Month: August: Cases: 11: Average Time To Surgery: 24hrs 56mins To support all of our improvement work, we continue to monitor and review all cases, in alignment with our pathway standards, at our monthly Femoral Fractures meeting. All deceased patients are subject to our local Structured Judgment Review process with any learning shared with the key stakeholder groups, including our Learning from Deaths Committee. There is a significant amount of effort being made by all the teams involved to drive quality improvement and outcomes for patients with a femoral fracture. This has been reflected by the substantial improvement in our key performance measures in our local data, and hope that this will be reflected in the national datasets when the data covers this period. We expect the impact of our improvement to take effect in the national datasets later this year due to the time lag in reporting. At Wye Valley NHS, we utilise the SHMI along with the crude mortality rates to monitor key areas, including fractured neck of femur. During January 2025, we observed a significant spike in the number of deaths for femoral fractures, which had 12 deaths in a single month. Our average number of deaths per month for this area is 4. This is highlighted in the chart below.			

		 Due to the nature of the SHMI, which is calculated over a 12 month rolling period, Wye Valley will remain at a 'higher than expected' mortality level until January 2025 is removed from the dataset. In the months leading up to and after January 2025, we have maintained a level that is below our monthly average. We will continue to monitor this area closely for any further spikes, and where appropriate, further investigation and improvement will be instigated.			

George Eliot Hospital NHS Trust	George Eliot Hospital		**Standards / KPIs for concern** *These are standards **not** already highlighted by the report's recommendations that GEH are below average for. Actions need to be put in place to improve performance. (12 month ending April 2025)*	**Are these Met Y/ N/ Partially/ Planned**	**Comments** *Examples of good practice or deficiencies identified.*	**Action Required / Action Planned**	**Timescale** *Date for actions to be implemented.*		The year up and including March 2025. Q1 2025 analysis.	Yes	True outlier
			1.	**Admission to specialist ward within 4 hours with a FIB**	GEH – 44% NHFD – 9%	Collaboration with ED staff. Identified new NOF champion in ED. Processes reviewed and	NOF patients identified and admitted directly to resus or Side room 10. Inform trauma CNS. Prompt transfer to	Implemented			

						implemented. Radiology invited to NOF governance meeting to improve pathway & review Radiology policy. Capacity is working well with ED to implement 4 hr to specialist ward. Night admissions seem to experience delay. ED looking at training and capacity	Radiology for diagnosis & FIB administration. Band 7's in ED to have IRMER training to improve Xray request time. Ortho team on call to receive notification and direct transfer to allocated NOF room on Coton ward to complete clerking and admission once ED pathway is complete and patient is deemed safe for transfer.	Ongoing and review				

						surrounding FIB administration.	Capacity issues overnight Time for FIB delay at night.				
		2.	**Prompt Orthogeriatric Review**	GEH – 92% NHFD – 89%	Orthogeriatric team notified on the day or day after patient admission. Weekends & Bank holidays not consistently covered. Good Practice	Improved due to patients now in one area. Discuss capacity of Ortho Geri team. One consultant led service with other commitments, need to discuss within medicine for a weekend cover for NOF patients. Consultant's cover to be	3-month review				

						confirmed. At present no allocated ortho-geriatric consultant. Staffing issue discussed with general manager, an extra weekend /bank holiday shift has been added and will be further discussed with 2nd on call OG team.					
		3.	**Prompt Surgery**	GEH – 56% NHFD – 57%	Allocation of cases taking priority over NOF patients and theatre capacity is key. Consider cancelling	Discuss with Orthopaedic surgeons regarding prioritising NOF patients. Protected theatre time for NOFs. Consultant Anaesthetic assessment/decision before	3-6 months				

						electives to facilitate high demand of NOF surgeries. Management of theatre time allocated and clinicians decisions on priorities. Patients are prepared and ready for theatre by 8:30. Best practice shared improvements identified monthly by informati	8:30 to avoid delays. Early identification of patients requiring optimisation before surgery. Figures and reasons for delay shared monthly with all teams involved. Review of risk register CSS to help identify how efficiency can be improved. Theatre teams are implementing a working group to help identify how collaborative working can improve this. Check on progress for					

						on sharing. Delays are documented and Datix on risk register. Reason for delays documented.	Business Case for 2nd Theatre Thursday & Sunday Strategic cancellation or rescheduling of elective cases to prioritise fracture NOF.				
		4.	**NICE Compliant Surgery**	GEH – 68% NHFD – 70%	Review practices and clinical decisions.	Operating surgeons to review practice so we are compliant with best practice and NICE compliance. Nailing V DHS, It's surgeon's decision.	3 months				
		5.	**Prompt Mobilisation**	GEH – 80% NHFD – 82%	Good practice. Some capacity issues and	Improve weekend provision for physiotherapy staff.	Ongoing				

						new team members. Pathway is imbedded within the team. Weekend cover is not always MSK team. Hypotension and low Hb correlation from audit Education to be implemented to Dr's once process is agreed.	Education is being done so weekends are covered, and best practice is known. Anaesthetic team audit complete. Implementation of 'Safe recover' sticker to be implemented after discussion with Haematology and blood transfusion team.	Complete				
			6.	**Non-Delirious Post-Op**	GEH – 68% NHFD – 68%	Nutrition and hydration	Looking at pre op nutrition supplements	3 months				

						Good pain management Family input Continuity of OG assessment scoring for post-operative 4ATs can differ from assessor to assessor. This requires more training to new doctors.	Discuss with Ward manager about use of volunteers to help prompt patients with cognitive impairment. Educating HCSW on ward regarding risk of delirium Re starting snack rounds Inviting families to support and help with nutrition and hydration Carers passport to be communicated with all families. Teaching sessions planned for staff about				

						patient deconditioning. Education board displayed within ward area already. Risk of delirium added to consent forms.					
		7.	**Return to Original Residence**	GEH – 82% NHFD – 75%	Good practice	Endeavour to enable all patients to return to their own homes if safe to do so. GEH have no access to any rehabilitation service or assessment areas to help enable patients who need a little more time to return home. Therefore, patients remain in	Ongoing				

						hospital for up to 6 weeks if 24 hr care is needed. Complex discharge team are aware of this situation. No funding available for this.					
		8.	**Bone Medication**	GEH – 50% NHFD – 56%	Compliance is reviewed with 120 day follow up data collection. Time for DEXA scan averages 3 months. IV Zoledronate implications around monitoring and	Review data for patient compliance. Consider capacity improvement for DEXA scan time & Rheumatology review No Fracture Liaison service at GEH Discuss with SDEC for IV Zoledronate to be administered	3 months				

				yearly follow up.	on admission or patients to return for yearly administration and who monitors this. Discuss with Ortho-Geriatric & Rheumatology consultants in meeting about giving IV Zoledronate to all NOFs before discharge and leave follow-up bone plan with GPs.				

Key Concerns: Mortality Risk. Improvement plan discussed with clinical effectiveness manager who is putting Information together. Each patient is discussed in M&M meetings.
Associate chief medical officer led NOF improvement action plan.
Theatre Delays
Documentation in NOF pathway.
Ortho Geri continuity of care and delay in assessment. OG Cover over the weekends/bank holidays. No OG Consultant cover at present.
Physio continued rehab on ward reduced due to staffing.
DOAC policy required for post-operative NOF patients.

		Key actions: RESUS Team teaching to be implemented around RESPECT communication and documentation. Referral to Palliative care if patients are high risk of mortality pre/post op. Prep time for theatre to avoid delays. Ward nurses asked to prioritise checklist completion for first case and flow chart for admission to ward completed to ensure ECG & Bloods are checked on admission.			