

Road to Recovery

Urgent and Emergency Care and the Elective Backlog: The Cost of Inaction



In January the government reaffirmed its commitment to addressing the elective backlog by announcing a target of 65% of patients meeting the 18-week standard for elective treatment by March 2026. With almost 7.5 million cases on the waiting list there is no denying that a focus on elective backlog recovery is crucial, however, these efforts will be derailed and progress hindered if there is not an equal operational focus on the urgent and emergency care (UEC) system. In-patient bed occupancy remains dangerously high, and 2024 saw a record number of 12-hour waits. These issues cannot be resolved in isolation.

Key insights

- There is an unignorable correlation between high UEC demand and cancelled elective operations.
- Bed occupancy remains dangerously high (96%)
- There is an urgent need for Unscheduled Care to be firmly embedded in plans to tackle the elective backlog. Future surges in demand must be accounted for or recovery will be derailed.
- Seasonal trends are predictable, and resilience must be built into the system
- More than 1.7 million patients waited 12 hours or more in an emergency department in 2024, with two thirds of these patients awaiting admission into a bed.
- The risk of death for a patient waiting 12 hours or more is twice that of a patient who waits two.

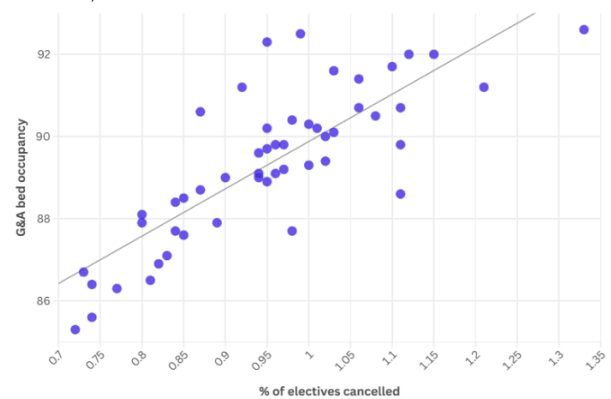
Impact on the Elective Backlog

The elective backlog has reached historic heights following the Covid-19 pandemic. Since then, no meaningful indent has been made in waiting lists, with 6.28 million individuals currently awaiting surgery. The scale of the challenge should not be underestimated, however, this issue cannot be considered in isolation. For the most part, elective care and unscheduled care share the same bed base, meaning high demand in UEC often displaces elective procedures, leading to cancellations and delays.

Graph 1 below shows the strong positive linear relationship between the two variables: general and acute bed occupancy in major hospitals and the percentage of electives cancelled each quarter over the last 14 years excluding the height of the pandemic. This is by no means a new

phenomenon, yet there seems to be little consideration or mention of UEC from policymakers in plans to recover the backlog.

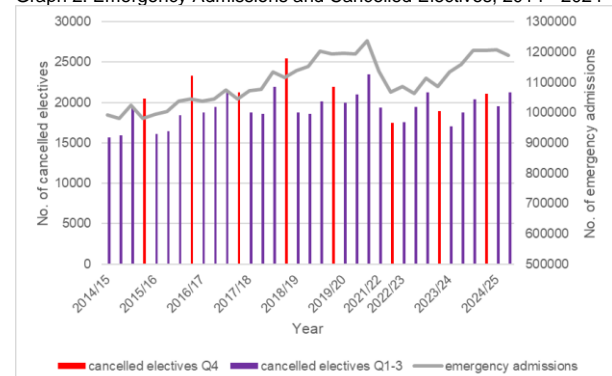
Graph 1: General and Acute Bed Occupancy and the Percentage of Electives Cancelled, 2010 - 2024



Seasonal Trends

The term 'seasonal pressures' seems rather redundant given the year-round strain in the system with little to no respite. Nevertheless, there are predictable trends that can be planned for and mitigated, to ensure resilience in the system. The graph below shows that the spike in cancelled electives, which typically occurs in quarter 4, is predictably preceded by an increase in emergency admissions. When beds are scarce the system is forced to borrow from one area to cover another.

Graph 2: Emergency Admissions and Cancelled Electives, 2014 - 2024



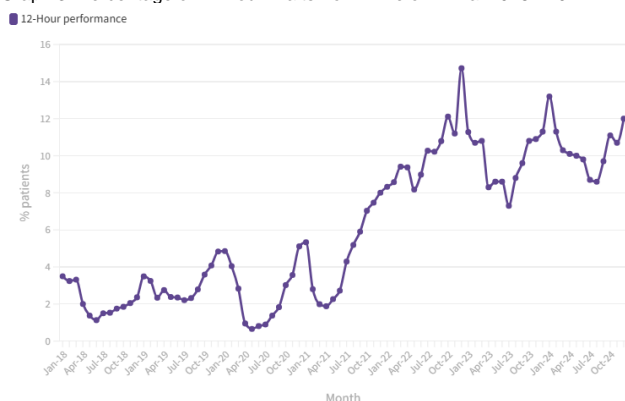
With trends such as these, it is paramount that policymakers winterproof the system in good time, eschewing decisions that favour the present and that embed a culture of short-termism. We cannot justifiably experience another winter of “unprecedented” pressures – this occurs every year and we know it.

The Cost of Delays for Patients

In December 2024, there were 100,480 general and acute beds, 414 fewer than the previous year. Additionally, weekly Situational Reports show that bed occupancy is around 96% despite rates above 85% putting safety and efficiency at risk. The lack of available beds is in part because, compared to the OECD, the UK has a very low total number of hospital beds relative to its population. This is not helped by the fact that the beds we do have are not being used efficiently. Reaching 85% would require there to be 10,000 additional available beds, yet this could be achieved without having to open *new* beds. On average at any given time, there are around 13,000 beds taken up by patients who are medically fit to go home, but remain in hospital, usually due to a lack of appropriate social care.

What ensues is the domino effect of gridlocked patients and lengthy delays right throughout the system. More than 1.7 million patients waited 12 hours or more in an emergency department in 2024, with two thirds of these patients awaiting admission into a bed. There is irrefutable evidence that long waits are associated with avoidable harm and death. The risk of death for a patient waiting 12 hours or more is twice that of a patient who waits two.

Graph 3: Percentage of 12-hour Waits from Time of Arrival 2018 - 2024



This does not even begin to include the harm caused to patients who are waiting for a delayed ambulance because of handover delays. The

marginal improvements in four-hour performance can be attributed to the operational focus that has been put on this standard. One could argue that it has been at the expense of the sickest patients who are waiting longer than ever before. Were there to have been genuine recovery in efficacy and patient flow the expectation would have been an improvement for all patient groups.

Patients are suffering on both sides of this story. The cancelled elective operations standard is a pledge in the Handbook to the NHS Constitution which states all patients who have operations cancelled for non-clinical reasons should be offered another binding date within 28 days. At present this is not happening for almost a quarter of patients whose operation has been cancelled. Just five years ago, it was only the case for 9% of patients. The implications of this are vast – not only must these patients continue to wait for their treatment after what was likely a lengthy wait to begin with, but any complications as a result of their delay may lead to an emergency attendance or admission.

Addressing the elective backlog without a parallel focus on UEC is unsustainable, as system-wide pressures will continue to disrupt recovery efforts, and ultimately it is patients who pay the price. Collaborative planning and resource allocation are essential to ensure both parts of the health service can function effectively with resilience preemptively built in.

Recommendations:

- Increase bed capacity to achieve 85% bed occupancy. At present this requires an additional 10,000 available beds.
- Implement effective whole-system winter planning to mitigate season pressure and ensure year-round system resilience
- Invest in social care service to reduce delayed discharges.
- Place equal operational importance on 12-hour stays as the four-hour standard to improve patient flow and reduce the risk of harm