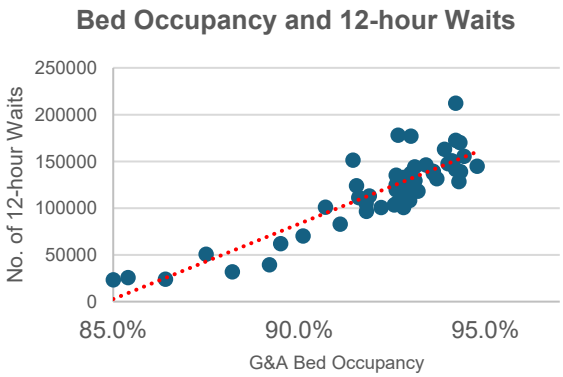
Road to Recovery

Urgent and Emergency Care

Exit Block

In 2024, general and acute (G&A) bed occupancy averaged 93.3%, exceeding the clinically safe threshold of 85%. Despite the addition of 1,816 G&A beds between 2023 and 2024, occupancy increased by a further 0.2 percentage points, underlining the severity of system-wide pressures.

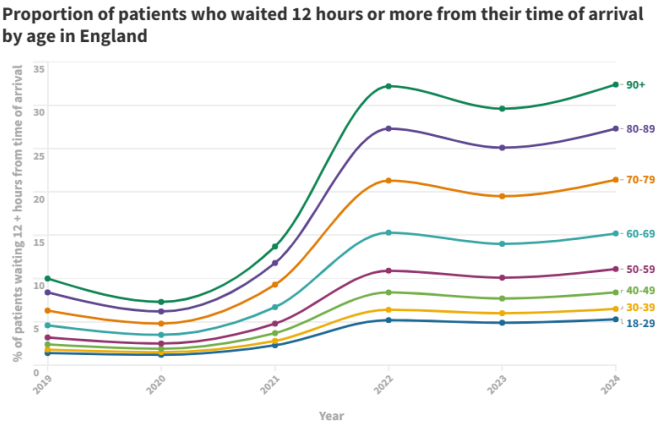
A key driver of this high occupancy is delayed discharge. On any given day in 2024, approximately 12,600 beds were occupied by patients who were medically fit for discharge but unable to leave hospital—most commonly due to a lack of appropriate social care. This means over 50% of patients deemed ready for discharge remained in hospital each day, preventing flow through the system and contributing to wider inefficiencies.



The graph above shows the strong positive correlation between bed occupancy and 12-hour waits. 67% of 12-hour waits in the ED were patients awaiting admission in 2024. Yet this is not an issue of significantly more patients being admitted – between 2019 and 2024, the number of type-1 admissions rose by almost 16,000. In the same time frame, 12 hour waits rose by 1.2 million. If it was simply about more patients getting admitted, these numbers would not be so starkly different.

It would currently require an estimated 8,134 additional available beds to bring occupancy down to levels of 85%. Yet much of this increase could be achieved without opening *new* beds, if a sharp focus was placed on eradicating the 12,600 delayed discharges. **It would only take a 65% reduction in delayed discharges and 85% bed occupancy would be met without the need to open new beds,** inevitably reducing long waits in the ED and patient harm.

The longest waits often affect the most vulnerable patients, As the graph demonstrates below, a patient's likelihood of waiting 12 hours or more is directly correlated with age. Not only that, but the likelihood of delay is increasing for all age groups, it is increasing the quickest for the eldest patients. In 2024, almost a quarter (22.1%) of over 60s waited 12 hours or more, compared to just 5.4% of under 60s.



Emergency Mental Health

In a recent multi-stakeholder joint statement the College has raised concerns about the proposed amendments to Sections 135 and 136 of the Mental Health Act, which place additional responsibility on already overstretched medical teams. The proposed amendments would transfer powers currently held by police – such as detaining individuals experiencing a mental health crisis – with the aim of reducing criminal justice involvement in healthcare. However, without adequate staffing, specialist training, and clearly defined guidelines, the proposed changes could not only delay urgent responses to mental health crises but also place clinicians in risky situations. Without the necessary preparation or protection, these amendments risk

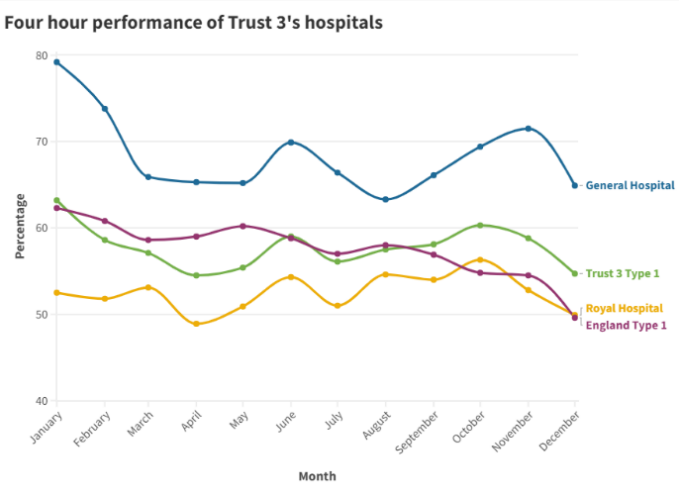
undermining both patient care and clinician safety, while blurring lines of accountability in high-risk situations.

Trauma Registry Strategy

For several years, care of seriously injured patients was supported by a trauma registry (TARN) which has been subsumed into NHSE's Outcomes and Registries Program (ORP). This used to provide data driven quality assurance and improvement, as well as a valuable research tool. While NHSE and the clinical registries are being reorganised, there has been no information fed back to clinicians about trauma care for over two years. This has adverse implications for our ability to provide excellent trauma care in the event of a sustained increase in seriously injured patients. We recommend that the strategy for registries is examined closely so that clinicians can improve trauma care with a data driven approach. This is also relevant to military medicine.

Data Transparency

Currently, emergency department data is published at trust-level, and therefore underperforming hospital data is masked by its aggregation. 35% of NHS Trusts have more than 1 ED, making it nearly impossible to accurately discern the worst performing departments that need support, or the better performing departments from which we can learn. 57% of emergency department performance is masked by publishing in this manner.

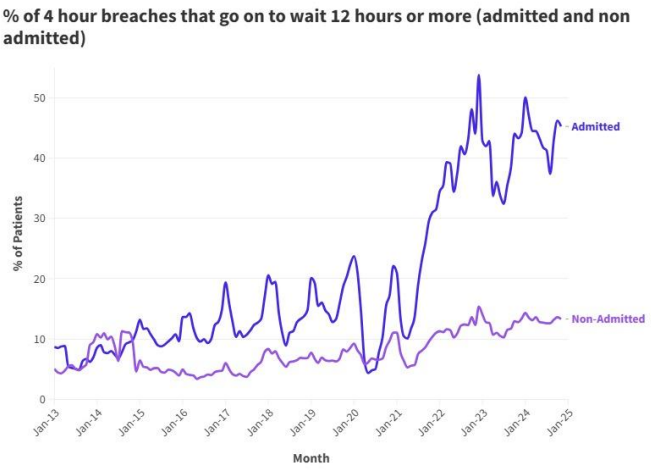


The graph shows the aggregate data for **'Trust 3'** is not truly representative of its two type-1 departments. While **'Trust 3'** mostly follows the national average, one of its departments consistently underperforms, while the other sits far above the average. Any opportunity to understand *why* is lost due to the current format in which the data is published. Data transparency is crucial in successfully evaluating progress and providing meaningful accountability.

The Wrong Standard

As stated in the NHS constitution, at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. However, NHS England's 2024/25 planning guidance continues to set this target at 78%. This is failing to drive flow in hospitals.

Setting such a low standard creates unintended consequences. Trusts can end up prioritising patients who can be processed quickly helping to meet this unambitious target - to the detriment of those who may be very sick. When the operational focus is shifted on to those 'quick wins', the cohort of patients requiring admission - and who are more likely to breach the four-hour target - end up staying even longer.



This is demonstrated in the graph above which shows the percentage of four-hour breaches that go on to wait 12 hours or more, split by admitted and non-admitted patients.

While it has always been the case that patients requiring admission are more likely to wait a long time, in the last few years this likelihood has tripled. In 2024 the average percentage for patients who met the four-hour target was 59%. This is an improvement on 2023, but by less than one percentage point. Conversely, the average proportion of patients waiting 12 hours or more in

2024 was 10.5%, equal to 1.7 million patients and the highest year on record. Experience from March 2025, where hospitals were incentivised by the capital incentive scheme shows that this problem is often fixable at a local provider level, but is not made a priority.

More than a quarter of these patients went on to wait over 24 hours. It is well evidenced that longer waits are associated with an increased risk of mortality. In 2024, when there were fewer long waits, there were over 300 excess deaths a week associated with long waits in EDs.

Recommendations

1. Institute single site public reporting of performance figures.
2. Provide equal performance focus on the 12-hour waiting time as the four-hour access standard. Commit to an actual performance standard for 12-hour stays of no more than 2%.
3. Adopt a whole system approach to improving ambulance handovers, rather than unilateral rapid handover protocols, such as W45.
4. Improve flow through acute hospitals with consistent reporting of long stays and delayed discharges.
5. Increase the number of available beds by at least 8000 through:
    a. Improving delayed discharges
    b. Opening new staffed available beds
6. Review the strategy for disease registries (including the National Major Trauma Project) to allow clinicians and clinical services to be data driven and accountable to improve their service.
7. Block the House of Lords amendment allowing any registered professional to be able to apply sections 135 and 136 of the Mental Health Act.