



REPORT

Managing the flow of patients through hospital from A&E

Department of Health & Social Care,
NHS England

Key facts

95%

target for the percentage of patients who go to accident & emergency (A&E) and should be admitted to hospital, transferred to another service or discharged from A&E within four hours (known as the four-hour target)

74.9%

percentage of patients who went to A&E and were admitted, transferred or discharged within four hours in 2025-26

28mn

number of attendances at A&E in 2025-26

£6.6 billion

the total amount hospital trusts reported spending on emergency services in 2024-25

10%

percentage of attendances at Type 1 A&Es (which treat the most urgent cases) and Type 2 (single medical specialty) who waited 12 hours or more from their arrival in A&E to be discharged, transferred, or admitted, in 2025-26

8.1 days

the average length of time someone admitted to hospital from A&E spent in a hospital bed in 2025-26, up from 7.3 days in 2019-20 (an 11% increase)

92%

average percentage of general and acute hospital beds occupied in 2025-26. The Royal College of Emergency Medicine considers that a level of 85% supports patient safety and achieving the four-hour A&E performance target

408,350

the total number of days (known as 'bed days') spent by people in a hospital bed after they are well enough to go home in the month of April 2026 – this accounts for 14.7% of all bed days used in this period

£2 billion

NHS England's (NHSE's) estimate of the total cost of delays to discharging people once they are well enough to go home, between August 2025 and April 2026

Summary

Introduction

1 NHS accident and emergency (A&E) services for urgent and emergency health needs are provided by around 200 organisations such as hospitals or walk in centres in England (as at March 2026). A&Es are classified into three main types, depending on the severity of the health conditions that they can treat, with many areas providing a combination of A&E types. Type 1 A&Es treat the most complex and urgent cases.

2 In 2010-11, the NHS Constitution included a maximum four-hour waiting time, aiming to have 95% of patients discharged, transferred or admitted within that time. Ninety-five percent remains the constitutional standard. However, from 2023, NHS England (NHSE) has set lower, more achievable interim targets for four-hour waits several times, including in the *Delivery plan for recovering urgent and emergency care services - 2023*. The latest is to achieve 85% by 2028-29. Each NHS trust has its own specific challenges and access to resources, which can affect their performance.

3 The NHS has found meeting the four-hour target for 95% of attendances very challenging. The last year in which it met the four-hour target nationally was in 2013-14, when it met it for 95.7% of attendances. Performance then declined to a low of 70.8% in 2022-23, before beginning to improve. In 2025-26, the NHS met the four-hour target for 74.9% of attendances.

4 NHSE has several means to improve performance in A&Es: at strategic level through improvement plans; by publishing national guidance for trusts to implement; and by providing support to individual trusts with improvement teams such as Getting It Right First Time.

Focus of our report

5 We have looked at how well patients flow through A&E into the wider hospital in England and at the support NHSE provides to trusts to improve that flow. The flow of patients is important as it affects the timeliness of an individual's care and the capacity of A&Es to deal with other patients. This report sets out:

- an overview of A&E services, targets and spending (Part One);
- an analysis of flow through hospitals and the factors that affect it (Part Two); and
- what NHSE and trusts are doing to improve performance (Part Three).

6 Good performance requires a combination of treating people in the right setting, optimising care within A&E and taking a whole-hospital approach to improving patient flow. This report looks at what happens to patients who come into hospitals through A&E. As such, it does not assess the effectiveness of services that aim to divert demand for healthcare away from A&Es, nor does it look at how well social care helps patients to be discharged from hospital. Our analysis does not look at the specific issues associated with paediatric A&Es.

Key findings

A&E performance

7 Long waits in A&E are associated with increased mortality, but the percentage of people waiting for more than 12 hours in A&E has increased. The proportion of patients waiting for 12 hours or more from their arrival in A&E to be discharged, transferred or admitted has increased from around 3% before COVID-19 to around 10% in 2025-26. The NAO estimates that, in the calendar year of 2025, 1.2 million patients waited between 12 and 24 hours, and that more than 500,000 patients waited for more than 24 hours.¹ Analysis by the Office for National Statistics suggests that people who wait 12 or more hours in A&E are twice as likely to die within 30 days of leaving A&E, compared with those who only wait two hours (paragraphs 1.9 and 1.10).

8 Overall, in the last 14 years, A&Es have become markedly more crowded with people waiting for care. In 2025-26, there were 28 million attendances at an A&E. This has increased since 2011-12, when there were 21.5 million A&E attendances. The Royal College of Emergency Medicine describes A&E crowding as the “greatest threat to the timely delivery of emergency care”. There are also high numbers of people waiting in corridors for care. In May 2026, during any 24-hour period in England, there was an average of 2,241 patients waiting in corridors in A&E, and 669 patients waiting in corridors in hospital wards. Overcrowding in A&E is detrimental for patients and has a negative impact on staff, leading to A&E staff burnout. Long waits in A&E and corridor care are also linked to increased acts of violence against A&E staff (paragraphs 1.4, 1.12 and 1.13, and Figure 1).

¹ Data on 24-hour waits are taken from data collected from NHS trusts as part of the Emergency Care Data Set. These data have not been validated. NHSE told us that it does not use the data as part of its routine national reporting and that it has concerns about data quality.

9 The NHS has not met the four-hour target for 95% of people attending A&E for any year since 2013-14, but performance after COVID-19 is slowly improving. In 2013-14, performance was, on average, 95.7%, which then declined to a low of 70.8% in 2022-23. Performance has improved gradually since, and in 2025-26 the NHS met the four-hour target for 74.9% of attendances. NHSE measures performance against the four-hour metric across all types of A&Es nationally and at trust level. It highlights that there will be variation between types of A&E depending on the complexity of patients and other factors. While Type 2 (specialties like ophthalmology) and Type 3 (urgent treatment centres for minor injuries) A&Es perform consistently at around 96% or above, Type 1 A&Es (which see the majority of patients and tend to deal with the more complex and urgent cases) have much worse performance. Type 1s' performance on the four-hour metric fell to a low of 56.7% in 2022-23, but improved to 60.9% in 2025-26 (paragraphs 1.6 to 1.8 and Figures 3 and 4).

10 Increases in A&E resources have not led to a proportionate improvement in waiting times. Staff numbers and availability of diagnostic testing have increased but there has not been a similar level of improvement in performance. This suggests that the relationship between increasing hospital resources and improving A&E performance is complex and/or that there may be other related factors limiting improvements, including levels of bed occupancy and delays in discharging people who are well enough to go home. Changes in how emergency care is delivered, such as increased use of advanced diagnostics, may also increase treatment times within A&E. Between March 2021 and March 2025, there has been an increase in the total numbers of some staff who work in A&E: hospital doctors (34%), senior hospital doctors (consultants, 26%), and nurses (23%). There have also been increases in some tests that are not for patients on diagnostic waiting lists. For example, MRI and CT scans have increased by 54% and 48%, respectively, between 2021-22 and 2025-26, indicating that there is increased diagnostic capacity in the system (paragraphs 1.14 and 1.15).²

11 The costs per patient in A&E have increased by a third between 2018-19 and 2024-25. In 2024-25, the average cost for a single attendance at A&E regardless of type was £280. This had increased by £69 from £211 in 2018-19 when adjusted for inflation. The increase was driven mainly by higher costs per attendance within all A&E types rather than changes in the mix of attendances. The cost for a single attendance at a Type 1 A&E in 2024-25 was £340. The equivalent cost for Type 2 was £157, and £114 for Type 3. Trusts' reported spending on emergency care services has increased in real terms from £4.3 billion in 2018-19 to £6.6 billion in 2024-25. Of this £6.6 billion, £5.7 billion (86.3%) was spent on Type 1 A&Es. NHSE shares cost information with all NHS trusts, to allow for analysis and comparison with other trusts; however, not all trusts make full use of this information and some may need more support to help them understand the relationship between costs, performance, patient numbers and acuity of cases (paragraphs 1.16 to 1.20 and Figure 4).

² This is indicative, as non-waiting (i.e. the published reported total activity after subtracting the published reported waiting list activity figure) will include a mix of unscheduled and planned diagnostic activity, and cannot be fully attributed to diagnostic activity in A&E.

Hospital flow

12 The performance of the wider hospital affects the speed at which patients can be admitted from A&E to a hospital bed. A&E is part of a wider system of care which includes primary care, community healthcare services and social care. Hospitals have different departments, wards and specialties. Blockages or bottlenecks that prevent people from moving through one part of this system to another can cause delays in A&E (paragraphs 2.2 and 2.3 and Figure 5).

13 In 2025-26, patients admitted to hospital from A&E were spending nearly an extra day in hospital on average compared with 2019-20, meaning there is less available capacity. The amount of time patients who were admitted via A&E spend in a hospital bed, known as average length of stay, has increased by 11%, from 7.3 days in 2019-20 (excluding March 2020 to remove the impact of the COVID-19 pandemic) to 8.1 days in 2025-26. The extent to which the increase is due to a reduction in operational efficiency is not clear, but the effect is a reduction in hospital capacity, which then impacts how quickly other patients can be admitted from A&E. NHSE considers that the increase in length of stay could be caused partly by its efforts to have patients with less complex needs treated elsewhere, such as Type 3 A&Es, but there are no data to show this impact (paragraphs 2.9 and 2.10).

14 Patient flow is affected by the availability of beds and inefficiencies in the treatment and discharge of patients. The waiting times within A&E and for patients to be admitted to a ward have increased. This is associated with small increases in A&E attendances and admissions, larger changes in the percentages of beds in hospitals that are occupied, and delays in discharging patients who are well enough to leave (delayed discharge). These factors can impact on A&E performance as they delay the flow of patients from A&E into a bed on a hospital ward. There have been increasing numbers of people who require an admission from A&E to a bed in a hospital ward (from 3.7 million patients in 2011-12 to 4.8 million patients in 2025-26). In addition, average bed occupancy in hospitals increased from 87% to 92% nationally, which means fewer beds were available in the right places at the right time. In 2025-26, 14.2% of stays in hospital involved a delayed discharge, and 3.7% of stays in hospitals involved a delay of seven days or more. In April 2026, the total number of bed days used by patients who no longer needed hospital care was 408,350.³ NHSE has estimated that this cost the NHS £229 million in just one month and an estimated £2 billion for the nine months between August 2025 and April 2026 (paragraphs 2.1 to 2.14 and Figures 8 and 9).

3 This figure relates to hospitals that have a Type 1 A&E.

15 NHSE does not collect national-level data to allow it to routinely assess how well patients progress through hospital. It measures some parts of the patient journey and focuses on measuring outputs such as how long people wait in A&E. For example, it has national data on why people's discharge from hospital is delayed, but only for people who have been in hospital for seven or more days. Until 2020, NHSE required trusts to provide reasons for the delayed discharge of all patients, not just those who have been in hospital for seven days or more. In 2023, NHSE changed the data that trusts needed to provide on delayed discharge. These data now only record the reasons for delay for patients who have been in hospital for seven days or more and exclude patients with shorter stays in hospital. NHSE gets some patient feedback through the Care Quality Commission (CQC), which runs a survey every two years of patient experiences of Type 1 and Type 3 A&E services, collating responses from 46,000 patients. CQC also runs a survey of patients who have stayed in hospital for at least one night.⁴ However, other than these surveys, NHSE does not routinely or regularly collect feedback from patients on their experience or on the timeliness of in-patient treatment. Trusts will have their own specific challenges that impact patient flow and blockages, such as demographics and geographical location. While trusts may have local level data on flow, NHSE does not require them to report these data to help quantify the challenge nationally (paragraphs 2.13 and 2.14 and Figure 9).

Efforts to improve performance

16 Between 2023 and 2025, NHSE prioritised reducing or diverting demand, increasing resources in A&E and targeting funding at delayed discharges.

In January 2023, NHSE and the Department of Health & Social Care (DHSC) published the *Delivery plan for recovering urgent and emergency care services* (the 2023 plan). The main objective of the two-year 2023 plan was to deal with reduced patient flow through hospitals resulting from increased bed occupancy rates, which NHSE saw as the "key driver" of falling A&E performance. The 2023 plan was to increase capacity in A&E, as well as expanding care people can access without going to hospital, such as community care. Changes included extending the availability or use of virtual wards, urgent community response services, and mental health support through NHS 111. NHSE allocated £1.6 billion through the discharge fund to Integrated Care Boards (ICBs) and local authorities across 2023-24 and 2024-25 to help reduce delayed discharges (paragraphs 3.4 to 3.8 and Figure 11).

⁴ Care Quality Commission, *Urgent and Emergency Care survey, 2024, and 2025 Adult Inpatient Survey*.

17 Despite NHSE achieving many of the aims set out in its 2023 plan, this has only translated to modest gains in A&E performance. The 2023 plan contributed to an increase in the proportion of A&E patients being admitted, transferred or discharged within four hours of arrival from 71.5% as at March 2023 to 74.3% by March 2024, but this fell short of the plan's interim target to reach 76% by March 2024. While NHSE achieved most of the aims it set out in the 2023 plan, the intended improvements in outcomes did not fully materialise. NHSE evaluated the effectiveness of the discharge fund and found that the fund only had small impacts due to uncertainty about future funding, its narrow focus on discharge from hospital, and the quality of data. People who organise health and care services highlighted the importance of long-term investment, joined-up holistic care and flexible funding to better support patients and communities (paragraphs 3.11 to 3.14 and Figure 11).

18 NHSE's approach is to help the lowest performing trusts to reach the level of the top performers. Variation between Type 1 A&Es has increased significantly since 2011-12, when performance on the four-hour metric for Type 1 A&Es varied from 74% to 99%. In 2025-26, the gap in performance had widened to 44% to 92%. Since 2022, NHSE has placed lower-performing trusts into two tiers, offering these trusts additional support to improve performance. Support can include on-site reviews and monitoring. It is in the process of changing this tiering system so that regional teams, rather than the national NHSE team, monitor and oversee performance. NHSE offers support via Getting It Right First Time, a programme which aims to share best practice within the NHS by providing short-term consultancy-style support to trusts. However, Type 1 A&E performance on the four-hour metric has not recovered to 2011-12 levels, suggesting that sharing of good practice alone will not be sufficient to improve performance (paragraphs 3.9 and 3.10, and Figure 10).

19 Performance improvements are better enabled with whole-of-hospital systems, end-to-end approaches and strong leadership. A higher-performing hospital we visited had a patient records system that detailed and followed the patient from admission to discharge; showed the status of resources and bed availability; and gave visibility to everyone across the hospital of what to prioritise or reassign to facilitate flow. In Scotland, a poorer-performing hospital had seen marked improvement with £14.5 million of funding deployed to implement a whole-of-system approach. This prioritised community and rehabilitation capacity, and the hospital leadership maintained a strong focus on end-to end performance across the emergency department, acute care and discharge services. The Royal College of Emergency Medicine supports the notion of the focus of this work being on the "back door" of the hospital rather than predominantly on the front (paragraphs 3.15 to 3.22).

20 NHSE is aiming to accelerate improvement so that 85% of attendances at A&E are admitted, transferred or discharged within four hours by 2028-29, and it is challenging hospital leaders to rapidly implement key service developments.

NHSE is establishing a stronger system of accountability, financial incentives and a greater emphasis on local leadership. It is promoting the use of the NHS App and other tools to support better navigation, scheduling and triage and investing in the Single Patient Record and more joined-up data to support clinical care and system management. New pieces of national guidance emphasise practices like same-day emergency care, which can help patients receive treatment without needing to be admitted to a hospital bed. It has also set an intermediate care framework for patient recovery following discharge. There remains scope for NHSE to target the root causes of poor flow and delayed discharges from within the hospital. Stakeholder suggestions include greater use of 24/7 consultant-led working in A&Es and allowing community pharmacists to deal with prescriptions written in hospital (paragraph 3.28).

Conclusion on value for money

21 The NHS is beginning to improve the performance of A&Es after the severe impact of COVID-19, but improvements have been smaller and slower than hoped. Patients are still waiting too long for the emergency care that they need. NHSE has made significant investment into A&E, but so far this has only resulted in modest gains, with the result that spending has grown without achieving equivalent improvements for A&E patients. This may indicate that the solution is not only a question of more resources, but also how those resources are deployed. Experience to date suggests that, alongside efforts to provide care in alternate settings, success also rests on the need to effectively manage patient flow throughout the whole hospital system, enabled by electronic patient record systems and strong leadership.

22 The NHS will not meet the overall A&E performance standards without very substantial improvement in many Type 1 A&Es. Such improvement will require systemic intervention. Some of the main reasons for slow flow are in the control of hospitals themselves, but there is also significant potential with better integrated support for patients leaving hospital. There are some promising initiatives locally and new national guidance, but these will not necessarily lead to the big improvements needed without NHSE providing more support to trusts to reprioritise resources and scale up the best approaches. There is not sufficient visibility or national measurement of whether patients get the right treatment at the right time once admitted to hospital, or the reasons why discharges from hospitals are delayed.

Recommendations

23 For NHSE and the DHSC to improve how patients flow through the hospital we make the following recommendations.

- a** Through its current remit, NHSE influences trusts' A&E performance by providing guidance and support to the trusts who need it most, and through its oversight of trusts' performance in the round, although it is not the service quality regulator. In light of the limited improvements over the last five years, NHSE and DHSC should consider how they can better use their levers and accountability mechanisms to encourage trusts to adopt best practice in all hospitals.
- b** Many of the solutions to improving hospital flow and A&E processes are known, but implementation is not consistent. NHSE should support this by developing the evidence base on how to achieve successful implementation, including improving delivery capacity, leadership and culture.
- c** NHSE should identify, evaluate and spread proven good practice to enable all trusts to learn more rapidly from successful approaches elsewhere. It should identify trusts that have achieved sustained improvements; evaluate which operational practices contributed to those improvements; produce practical implementation support for other trusts; and use NHSE's regional oversight arrangements to encourage and monitor adoption where performance remains persistently weak.
- d** NHS trusts need to more consistently use end-to-end hospital flow management tools and approaches, building on the rollout of electronic patient records, rapid developments in data insights and tools for optimising flow and use of resources. NHSE should support greater take-up of tools through sharing of best practice in how to deploy digital infrastructure and tools, including embedding them into normal working practices.
- e** NHSE needs to ensure the patient experience in hospital is routinely heard and measured, including in performance monitoring. This could be by capturing patient feedback on the timeliness of treatment and quality of care while admitted to hospital, and on patient outcomes. We heard examples where frail patients deteriorated in hospital because of delayed discharge.
- f** NHSE needs to support trusts to help them reduce the delays in discharging people once they are well enough to leave the hospital, with a greater focus on patients who suffer the worst outcomes from these delays, such as deconditioning or loss of independence, including older patients and people with frailty. As part of this support, NHSE should consider and implement the most impactful improvements in the collection of data on discharge delays. For example, which metrics will encourage regular discharge of patients throughout the day.

- g** DHSC and NHSE need to ensure that governance arrangements at local and system level ensure the effective commissioning of services across emergency care, which extend into community healthcare and social care. DHSC and NHSE need to support trusts and systems in this work, particularly through the development of social care, shared digital infrastructure, workforce models, and clinical working patterns. DHSC and NHSE should be active in identifying and tackling national barriers, with the aim to achieve demonstrable gains.
- h** NHSE should support trusts to better understand the relationship between costs, performance, patient numbers and acuity of cases to improve value.