National Audit Office

REPORT

Managing the flow of patients through hospital from A&E

Department of Health & Social Care,
NHS England

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Managing the flow of patients through hospital from A&E

Department of Health & Social Care, NHS England

Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

26 August 2026

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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.

Part One

Accident and emergency overview and performance

1.1 This section of the report provides an overview of accident and emergency (A&E) services, types of A&Es, and A&E waiting times, targets and performance. It also examines trusts' spending on A&E.

1.2 NHS A&Es in England provide urgent and emergency healthcare for people. A&Es are funded by the Department of Health & Social Care (DHSC) through NHS England (NHSE), which provides funding for the NHS through local organisations known as Integrated Care Boards (ICBs). ICBs commission NHS services, including A&E services, from individual NHS trusts which manage the hospitals and centres that provide A&E services.

1.3 NHS A&E services for urgent and emergency health needs are provided by around 200 NHS 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 cases that they can treat, with many areas providing a combination of A&E types:

- Type 1 A&Es include Emergency Departments or multiple medical specialty A&Es. Around 121 NHS organisations provide these 24-hour services to treat the majority and most complex and urgent cases, including resuscitation. These include 24 Major Trauma Centres which have the resources to manage severely injured patients 24 hours a day.[5]
- Type 2 A&Es are single medical specialty A&Es (such as dental and ophthalmology A&Es), provided by 37 NHS organisations.
- Type 3 A&Es, such as urgent treatment centres. These are provided by 172 NHS organisations to treat more minor illnesses and injuries, such as sprains.

5 These 24 Major Trauma Centres include centres that treat both adults and children but excludes those that solely treat children.

Demand for A&E

1.4 A&Es have become markedly more crowded with patients waiting for treatment in the past 14 years. In 2025-26, people went to A&Es in England 28 million times (the NHS refers to these as 'an attendance'). Attendances have increased most years since 2011-12, when there were 21.5 million attendances at A&E (**Figure 1** on pages 16 and 17). The Royal College of Emergency Medicine describes A&E crowding as the "greatest threat to the timely delivery of emergency care". **Figure 2** on page 18 shows there have been large increases in the use of A&Es across all age groups compared with 2012-13 (when comparable data are available).

1.5 There is evidence that the types of injuries and illnesses presenting at A&E have become more complex.[6] Many more people, particularly older people, need treatment for several conditions. Increasing numbers of older people living with frailty attend A&E and this is predicted to increase as the population ages. The increasingly complex case mix often leads to more investigations and tests and to more intensive treatment per attendance, which places additional demands on hospitals.

Performance and targets

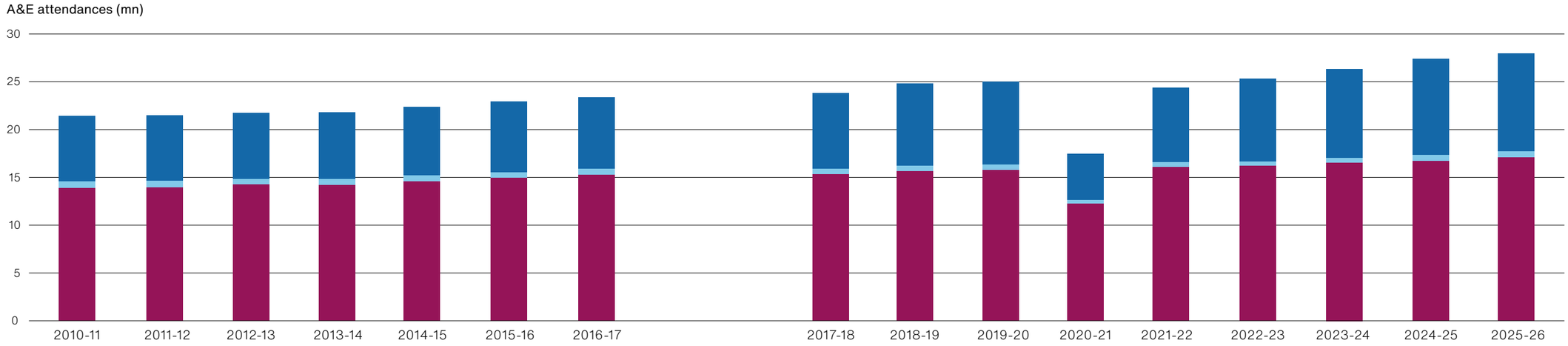
1.6 In 2010-11, the NHS Constitution included a maximum four-hour waiting time, aiming for 95% of patients to be discharged, transferred or admitted within that time. Ninety-five percent remains the constitutional standard. The NHS has not annually met the four-hour target for 95% of attendances since 2013-14 but performance after COVID-19 is slowly improving. The last year the NHS met this target was in 2013-14, when performance against the four-hour target was on average 95.7%. Performance then declined almost each year to a low of 70.8% in 2022-23. Performance has been improving since, and performance in the whole of 2025-26 against the four-hour target was 74.9%. 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 they serve and other factors.

6 The Strategy Unit, *Waiting Times and Attendance Durations at English Accident and Emergency Departments*, 2019.

Figure 1

Number of accident and emergency (A&E) attendances by A&E type in England, 2010-11 to 2025-26

Type 1 A&Es (which deal with the most urgent cases) saw the majority of people who turned up at A&E in 2025-26



	Financial year														
	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Type 1 (major) A&Es	13,931,715	14,013,922	14,252,068	14,213,148	14,584,736	14,960,805	15,262,758	15,372,467	15,679,999	15,810,686	12,287,284	16,137,559	16,202,978	16,525,835	16,763,266	17,121,495
Type 2 (single medical specialty) A&Es	660,777	637,996	625,526	628,604	630,846	603,670	606,300	573,853	577,803	567,073	359,478	463,028	492,576	528,762	587,969	611,420
Type 3 (minor injury) A&Es	6,788,493	6,829,484	6,861,043	6,936,905	7,139,199	7,355,960	7,493,243	7,883,800	8,569,180	8,639,357	4,782,797	7,774,380	8,653,288	9,266,472	10,016,363	10,243,110
Total attendances (mn)	**21.4**	**21.5**	**21.7**	**21.8**	**22.4**	**22.9**	**23.4**	**23.8**	**24.8**	**25.0**	**17.4**	**24.4**	**25.3**	**26.3**	**27.4**	**28.0**

Notes

1 Type 1 A&Es are 24-hour consultant-led emergency departments intended to treat the most urgent cases of the three main A&E types including resuscitation.

2 Type 2 A&Es are consultant-led single medical specialty departments such as dental and ophthalmology A&Es.

3 Type 3 A&Es are all other A&Es including urgent treatment centres and minor injury units and are intended to treat more minor illnesses and injuries such as sprains.

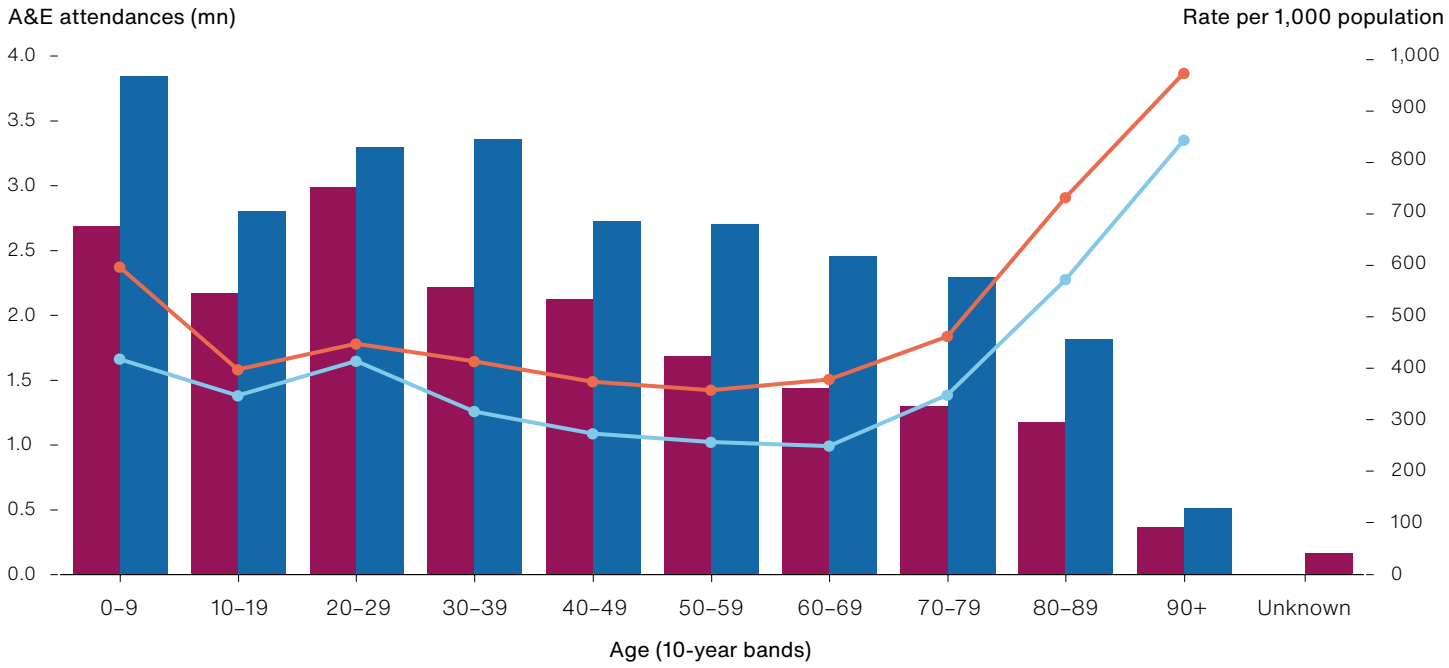
4 In the figure, total attendances are shown in millions and to one decimal place.

Source: National Audit Office analysis of NHS England's published statistics

Figure 2

Accident and emergency (A&E) attendances in England by 10-year age band and rate per 1,000 population, 2012-13 and 2024-25

A&E is being attended more, by all age groups, in 2024-25 and there are also more attendances per 1,000 population than in 2012-13



	0–9	10–19	20–29	30–39	40–49	50–59	60–69	70–79	80–89	90+	Unknown
Attendances 2012-13	2,689,315	2,171,832	2,991,651	2,221,746	2,120,807	1,682,794	1,440,061	1,299,918	1,175,972	366,539	168,261
Attendances 2024-25	3,842,748	2,804,900	3,299,188	3,361,404	2,729,409	2,701,398	2,452,653	2,298,428	1,814,141	514,967	3,029
Rate per 1,000 population											
Rate per 1,000 population 2012-13	416	345	412	315	272	256	248	346	569	838	–
Rate per 1,000 population 2024-25	594	396	445	411	372	356	376	459	727	967	–

Notes

1 The Office for National Statistics population estimates are mid-year for 2012 and 2024.

2 The 'Unknown' age category is when the age of the person attending has not been recorded.

3 The total attendances in figure 1 and figure 2 differ as they are from different data sources.

Source: National Audit Office analysis of NHS Digital Hospital Accident & Emergency Activity, 2012-13 and 2024-25 and the Office for National Statistics population estimates

1.7 From 2023, NHSE has set lower, more achievable interim levels for four-hour waits.

- 76% by March 2024.
- 78% by March 2025.
- 78% by March 2026.
- An annual average of 85% by 2028-29.

However, most of these targets apply to the month of March which does not reflect the seasonal nature of A&E performance. A&E performance against the four-hour target shows seasonal trends, and performance in winter is usually worse than at other times of year. **Figure 3** overleaf shows the monthly performance against the performance targets for March 2024, March 2025 and March 2026. Performance reached 77.1% in March 2026, below the interim expectation of 78%, and well below 95%.

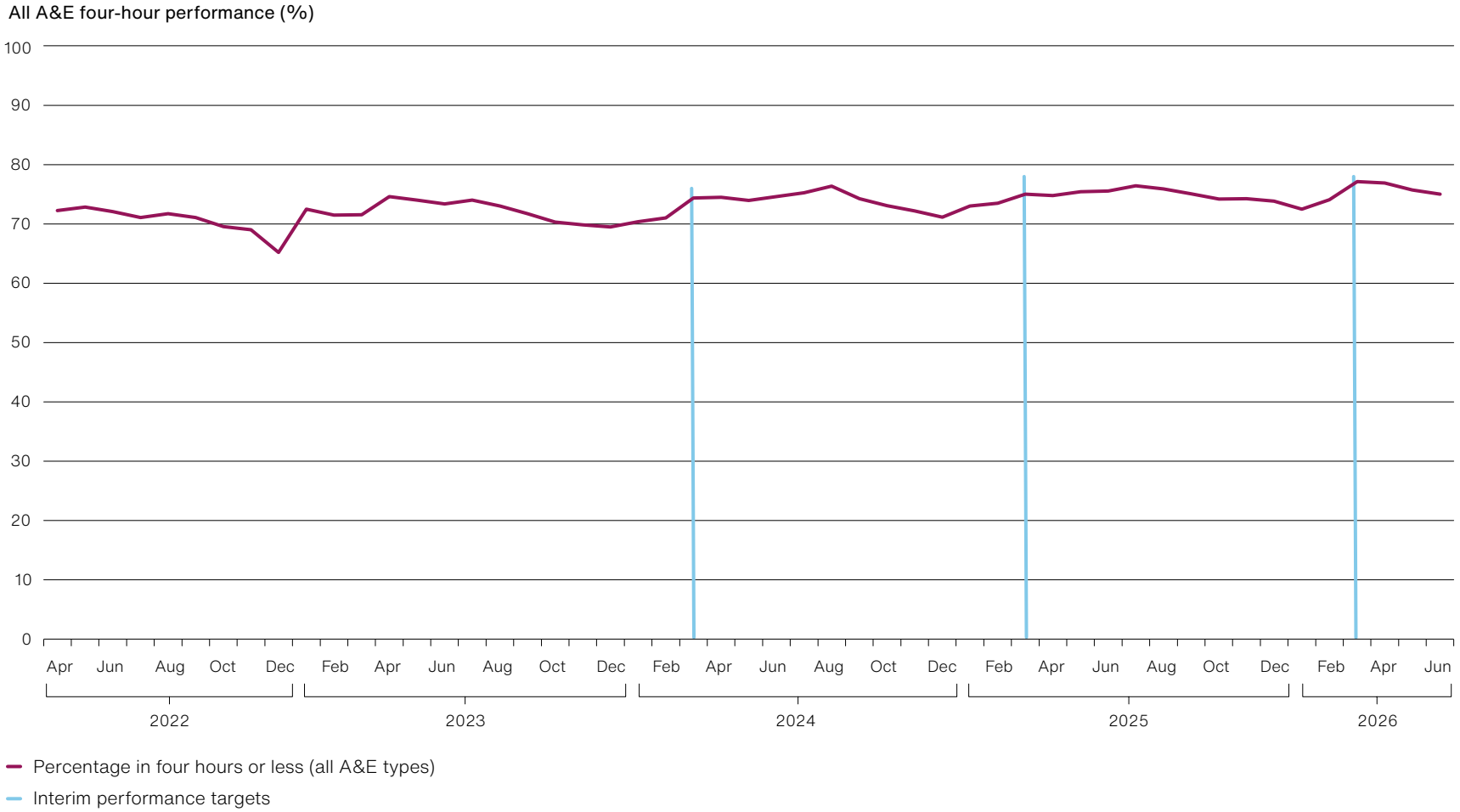
1.8 Performance varies by type. Type 1 A&Es which tend to deal with the more complex and urgent cases, have had consistently lower levels of performance since 2010-11. Type 1s' performance on the four-hour metric fell to a low of 56.7% in 2022-23, and improved to 60.9% in 2025-26 (**Figure 4** on page 21). In contrast, Type 2 (specialties like ophthalmology) and Type 3 (urgent treatment centres for minor injuries) performed better and were consistently at around 96% or above.

1.9 Twelve-hour waits in Type 1 A&Es, which is when patients wait 12 or more hours from their arrival in A&E to be discharged, transferred, or admitted, are particularly concerning. Twelve-hour waits are associated with higher mortality. Analysis by the Office for National Statistics suggests that those waiting 12 or more hours in A&E for care are twice as likely to die within 30 days of leaving A&E as those who waited only two hours. The Royal College of Emergency Medicine estimates that there is one additional (excess) death for every 72 patients who spend eight to 12 hours in A&E. Performance on 12-hour waits in Type 1 A&Es deteriorated gradually before COVID-19 and markedly since 2020-21. NHSE set a numerical target for 12-hour waits for the first time in the *2025 Urgent and emergency care plan* (the 2025 plan) that no more than 10% of attendances at A&Es should involve waits of 12 or more hours. This target was met in 2025-26.

Figure 3

All accident and emergency (A&E) four-hour performance, monthly in England, April 2022 to June 2026

The overall percentage of people who go to A&E and are admitted to hospital, transferred to another service or discharged from A&E within four hours is seasonal, but the interim performance targets apply to March rather than an average over the year



Note

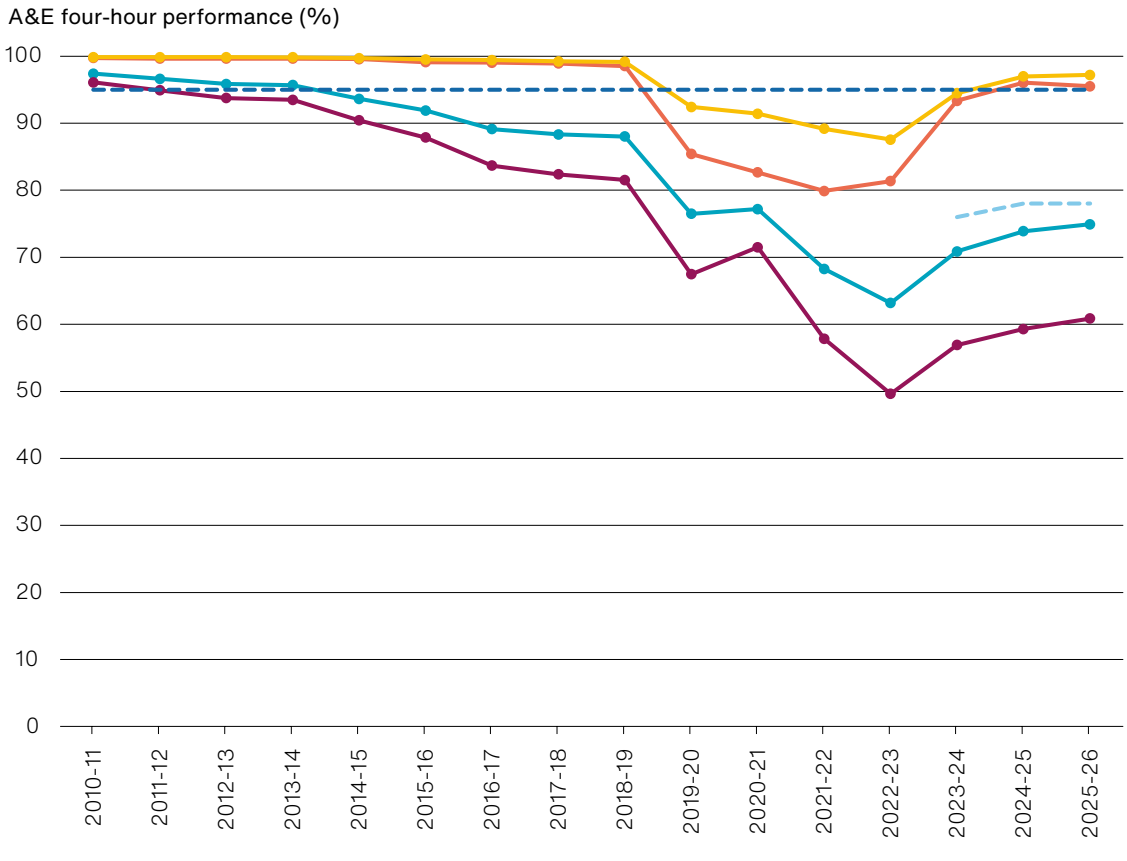
1 The interim targets were 76% in March 2024, 78% in March 2025 and 78% in March 2026.

Source: National Audit Office analysis of NHS England's published statistics

Figure 4

The percentage of accident and emergency (A&E) attendances discharged, transferred or admitted within four hours, by A&E type, annually from 2010-11 to 2025-26

Overall A&E performance declined from 2010-11, it reached its lowest point in 2022-23 and has since improved



	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Four-hour metric (95%)	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95
Interim targets	–	–	–	–	–	–	–	–	–	–	–	–	–	76	78	78
Total attendances less than four hours	97	97	96	96	94	92	89	88	88	76	77	68	63	71	74	75
Type 1 A&Es	96	95	94	93	90	88	84	82	82	67	71	58	50	57	59	61
Type 2 A&Es	100	100	100	100	100	99	99	99	99	85	83	80	81	93	96	96
Type 3 A&Es	100	100	100	100	100	100	99	99	99	92	91	89	88	94	97	97

Notes

1 The interim targets were 76% in March 2024, 78% in March 2025 and 78% in March 2026.

2 Type 1 A&Es are 24-hour consultant-led emergency departments intended to treat the most urgent cases of the three main A&E types including resuscitation.

3 Type 2 A&Es are consultant-led single medical specialty departments such as dental and ophthalmology A&Es.

4 Type 3 A&Es are all other A&Es including urgent treatment centres and minor injury units and are intended to treat more minor illnesses and injuries such as sprains.

Source: National Audit Office analysis of NHS England's published statistics

1.10 Waits of over 24 hours indicate serious difficulties and delays in moving people out of A&Es. NAO analysis estimates that in 2024-25 and 2025-26, 3% of attendances to A&E waited for over 24 hours to be discharged, transferred or admitted. 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. National Audit Office analysis estimates that in 2025, 1.2 million attendances to A&E waited for care between 12 and 24 hours and more than 500,000 waited more than 24 hours.[7] NHSE documents state that there should be a zero tolerance for waits of over 24 hours, describing this as a "red-line safety standard".

1.11 NHSE 2025-26 operational planning guidance included an ambition to improve category 2 (emergency calls that require urgent assessment and intervention) ambulance response times to an average of 30 minutes. Average category 2 ambulance response times have improved since a peak of 50:00 minutes in 2022-23 to 30:04 minutes in 2025-26. Response times remain above levels before COVID-19 (2017-18 to 2019-20 saw an average response time of 23:49 minutes).

Other indicators of problems

1.12 Other indicators of problems can be seen elsewhere in the system:

- Increasing numbers of patients waiting in corridors for an available ward bed (known as corridor care). NHSE published data on corridor care for the first time in June 2026. These data showed that in May 2026, in England, during any 24-hour period there was an average of 2,241 patients waiting in corridors in A&E, and 669 patients waiting in corridors in hospital wards. Age UK has highlighted that corridor care disproportionately affects older patients and has estimated that over 60% of all instances of corridor care are experienced by people aged over 65 years, for whom the impact can be more harmful.
- Clinical negligence claims relating to emergency medicine increased from 1,151 in 2020-21 to 1,623 in 2025-26. In 2024-25, NHSE spent £254 million on settling emergency medicine claims.

7 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.

1.13 Overcrowding in A&E has a negative impact on staff. The Royal College of Emergency Medicine has highlighted how overcrowding is one factor in increased workloads which contributes to A&E staff burnout. The Royal College of Nursing has argued that long waits in A&E and corridor care are linked to increased acts of violence against A&E staff. It reported that, based on Freedom of Information requests to 89 trusts, incidences of physical violence against A&E staff had almost doubled, from 2,093 in 2019 to 4,054 in 2024.[8] On one case study visit, we heard of staff experiencing violence and aggression from patients whom they were unable to discharge. This led to high rates of staff sickness.

Resources for emergency care

1.14 A&E resources have increased but this has not led to a proportionate improvement in waiting times. Some elements in the hospital that could improve A&E performance include healthcare staff working in A&Es, infrastructure such as the space to treat patients, and the availability of diagnostic equipment. Since 2021, some of these elements have increased substantially:

- Between March 2021 and March 2025, there have been increases in the total numbers of some of the staff who work in A&E: hospital doctors (34%), senior hospital doctors (consultants, 26%) and nurses (23%), and a slight reduction in care providers (including ambulance workers, scientific staff and support workers, -1%).
- Increases in advanced diagnostic testing for non-waiting list tests (MRI and CT scans, 54% and 48% respectively between 2021-22 and 2025-26) indicating that there is increased diagnostic capacity in the system.[9]

1.15 Despite these increases in resources, there has not been a proportionate level of improvement in A&E waiting times, with an increase in attendances to all A&E Types waiting more than four hours to be discharged, transferred or admitted increasing from five million in 2021-22 to seven million in 2025-26. This suggests that the relationship between increasing hospital resources and improving waiting times is complex and/or that there are other related factors limiting improvements in A&E performance. Changes in how emergency care is delivered, such as increased use of advanced diagnostics, may also increase treatment times within A&E.

Spending

1.16 NHSE provides funding for emergency care services via ICBs. ICBs commission emergency care services such as A&E from within their overall budget. During the COVID-19 pandemic funding was provided from ICBs to trusts under a fixed payment based on recent past expenditure. From 2026-27, emergency care payments to trusts will consist of a fixed element based on a planned estimate of how much emergency care a trust will need to provide, plus a variable element.

8 Figures on violence against staff relate only to the largest A&E department within each trust.
9 This is indicative as non-waiting (i.e. the published reported total activity 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.

1.17 NHSE carries out an annual mandatory data collection process known as the National Cost Collection, including how much trusts spend on emergency care, through trusts' submissions. These data are available to all NHS trusts via an online tool which allows data on spending to be compared between different trusts and regions, as well as breaking down data by different factors such as deprivation level. 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. Our analysis suggests there is no correlation between a trust's Type 1 four-hour performance and on the overall amount a trust spends on A&E services, and that there is a weak correlation between a trust's four-hour performance and the cost of A&E services per patient (between higher levels of Type 1 A&E performance and lower cost per A&E patient).[10]

1.18 According to the latest available data from the National Cost Collection, in 2024-25, the total amount trusts spent on emergency care services was £6.6 billion (**Figure 5**). This had increased from £4.3 billion in 2018-19 (when adjusted for inflation). Of this £6.6 billion, £5.7 billion (86.3%) was spent on Type 1 A&Es.

1.19 The costs per patient have also increased. After a peak in 2020-21 during the COVID-19 pandemic, the cost for a single attendance at A&E regardless of type was £280 in 2024-25, an increase of £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. Figure 5 shows that cost per attendance increased rapidly during the COVID-19 pandemic before falling, and has been relatively flat since 2021-22, when cost per attendance was £284. 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. These cost data are based on the day-to-day spending on providing courses of treatment within an A&E, including resources such as the cost of staff and equipment, as well as any related overheads such as corporates services like Human Resources and finance.

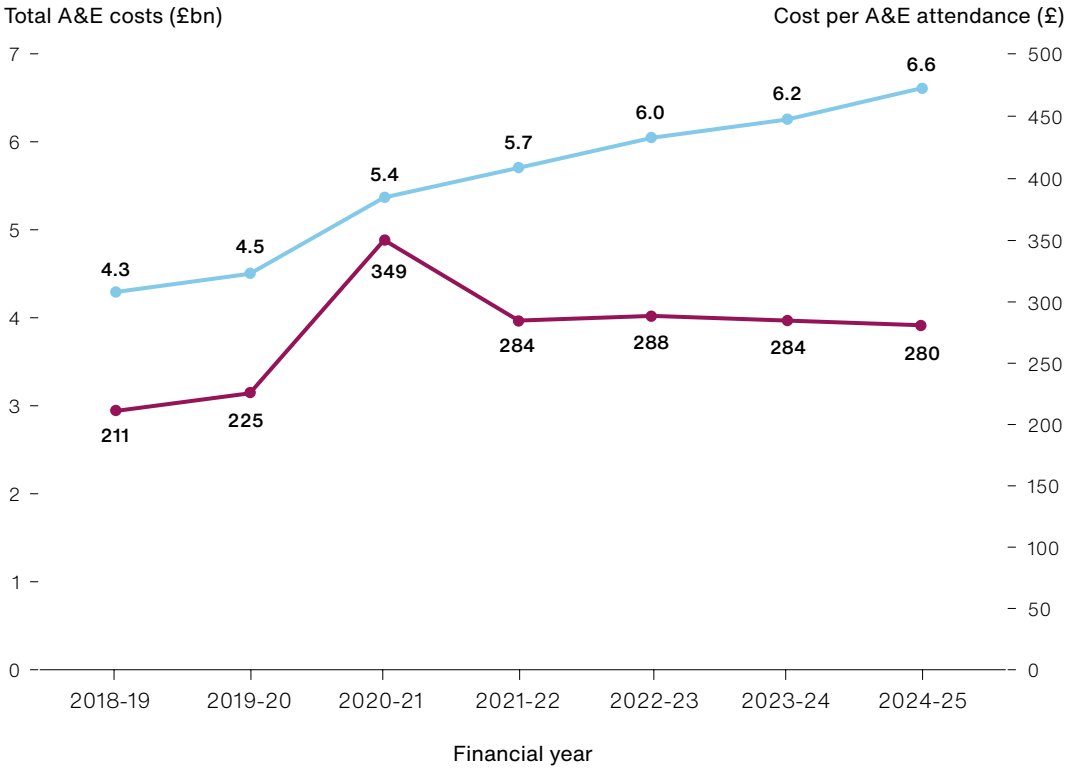
1.20 The 2025 plan allocated £370 million of capital investment to support around 40 new same day emergency care units and urgent treatment centres, as well as expanding emergency mental health services and shared patient records. Other aspects of NHSE's improvement agenda for emergency care have not been specifically costed, such as the Model Emergency Department, which states that it will encourage ICBs to use their existing capital allocation to expand emergency care in the form of same day emergency care provision, but does not promise any additional funding.

10 Weak correlation of r= -0.32.

Figure 5

Emergency care spending and cost per accident & emergency (A&E) attendance, 2018-19 to 2024-25

Spending on emergency care has increased in real terms from £4.3 billion in 2018-19 to £6.6 billion in 2024-25 while cost per attendance has remained broadly stable after peaking during COVID-19



Notes

1 Data have been adjusted for inflation using March 2026 GDP deflators.

2 Data go up to 2024-25 as these are the latest available data.

Source: National Audit Office analysis of NHS England's National Cost Collection data

Part Two

Hospitals as a system

2.1 This section of the report looks at the flow of patients through hospital and why effective flow is important. It examines the trends in, barriers to and indicators of patient flow through accident and emergency (A&E) and the wider hospital.

Why hospital flow is important

2.2 Hospitals are part of a wider system of care which includes primary care, community healthcare services and social care. All these services can affect the numbers of people who come to A&E and their timely discharge out of hospital. Good performance needs a combination of treating people in the right setting, optimising care within A&E and taking a whole-hospital approach to improving patient flow. Hospitals are systems with different departments, wards or specialities that often overlap, and link to other types of services working with finite resources to deliver care. Patient flow is the journey that people take as they go to A&E, need further care, are admitted to a hospital bed and then discharged when well enough to leave the hospital. Our 2023 report on access to unplanned or urgent care set out how hospitals work as a system and how delays in how people flow through the system cause bottlenecks and impact overall performance.[11] **Figure 6** shows how patients flow through A&E.

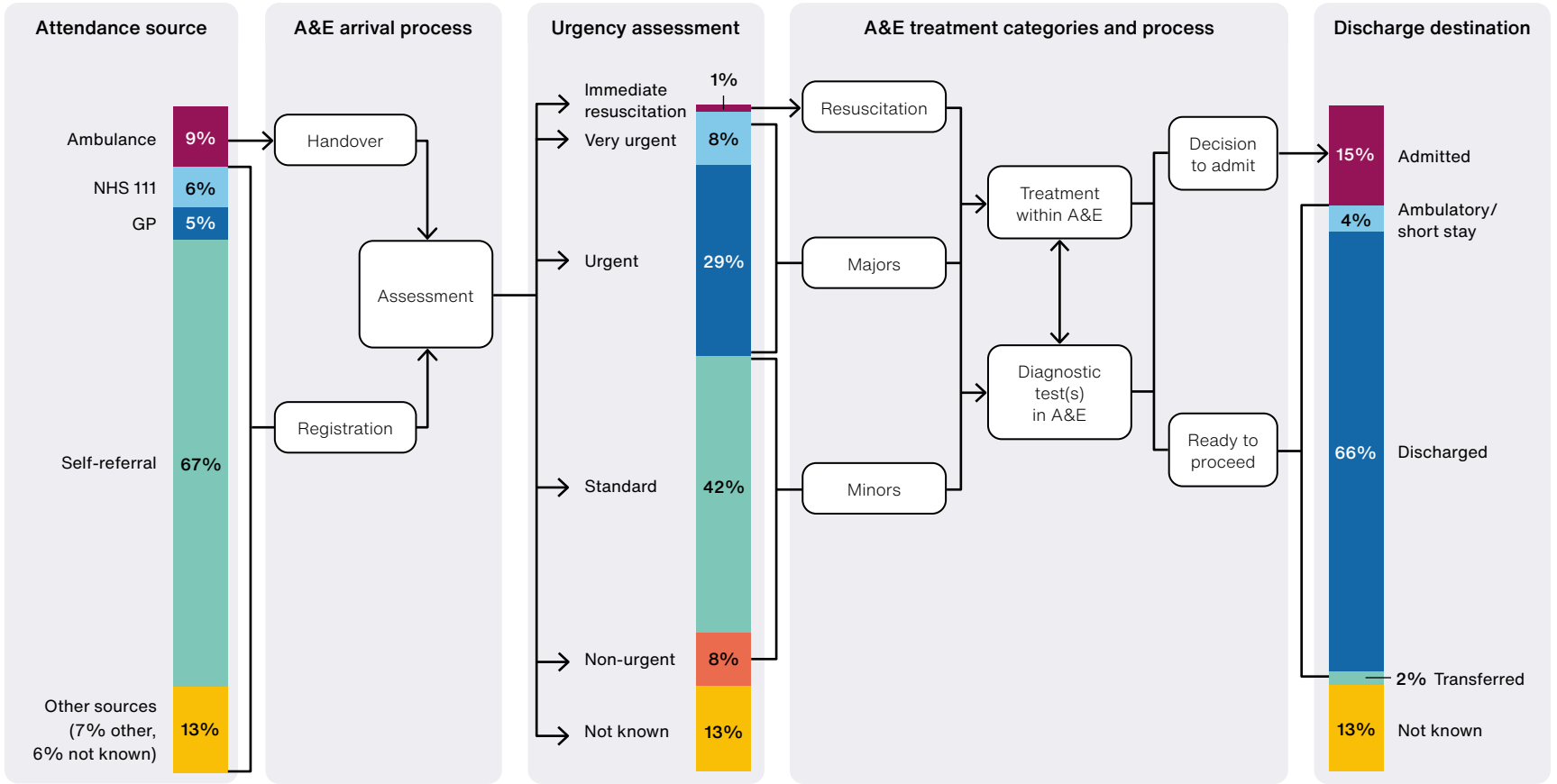
2.3 The efficient flow of patients through the hospital is important for the effective and timely treatment of the 15% of attendances at A&E who are admitted to the hospital (Figure 6). However, 66% of attendances are people discharged without needing to be admitted. NHS England (NHSE) has several initiatives to manage demand for A&E which focus on this group of patients. For example, it requires all Type 1 A&Es to provide same day emergency care services 12 hours a day, seven days a week. These services allow specialists to assess, diagnose and treat patients within a day, without needing to admit them to hospital. NHSE also aims to have more people treated in Type 3 A&Es (urgent treatment centres) than Type 1s.

11 Comptroller and Auditor General, *Access to unplanned or urgent care,* Session 2022-23, HC 1511, National Audit Office, June 2023.

Figure 6

How people move through accident and emergency (A&E)

People arrive at A&E, are assessed and possibly treated, they are then discharged from A&E, admitted to hospital or transferred to another service



Notes

1 Percentages are taken from the 2024-25 Emergency Care Data Set (ECDS) and relate to all attendances at all types of A&Es, from walk-in-centres through to major A&Es.

2 Percentages at each stage relate to all A&E attendances, therefore the figure does not represent a continuous patient pathway.

3 This figure shows a simplified A&E process. For example, people may leave A&E before their initial assessment or before receiving treatment.

4 Percentages may not add to 100% owing to rounding.

Source: National Audit Office analysis of NHS Digital Hospital Accident & Emergency Activity and A&E processes

What affects hospital flow

2.4 The performance of the wider hospital affects the speed at which patients can be admitted from A&E to a hospital bed. To move patients from A&E effectively, there needs to be enough staff to complete the transfer from A&E to a ward, and staffed hospital beds available on a specific ward that can treat the patient. The availability of beds and staff on these wards is affected by factors inside and outside of hospitals including:

- the number and complexity of patients who go to A&E and subsequently need admitting to hospital (i.e. emergency admissions);
- the capacity of the hospital to deal with patients (including bed occupancy, which is the percentage of beds within hospitals that are currently occupied by a patient); and
- the ability of services inside and outside of the hospital to treat and discharge patients in a timely way (the speed of hospital care and the availability of, for example, social care can cause delays in discharge).

Figure 7 on pages 29 and 30 shows where the factors that affect patient flow act on the process of patients moving through hospital and how queues can build up within A&Es and hospitals.

2.5 While individual patients admitted from A&E move from a bed on a ward to being discharged, the factors affecting total flow within A&E departments move in the opposite direction. High levels of bed occupancy result in an inability to move people out of A&E, long waits in corridors, delays in treating people in A&E, and longer waits in A&E waiting rooms. There is no specific metric of patient flow, so we analysed trends in the factors that affect flow for which data are available. These include:

- attendances;
- admissions;
- bed occupancy;
- length of stay; and
- delays in discharging people when they are well enough to leave hospital (known as delayed discharge).

Figure 7

Factors affecting patient flow through hospitals and indicators of poor patient flow, 2021-22 to 2025-26

Delays in accident and emergency (A&E) and the wider hospital can reduce patient flow and result in queues forming at earlier points. The indicators of poor patient flow have grown at a faster rate than the factors affecting patient flow

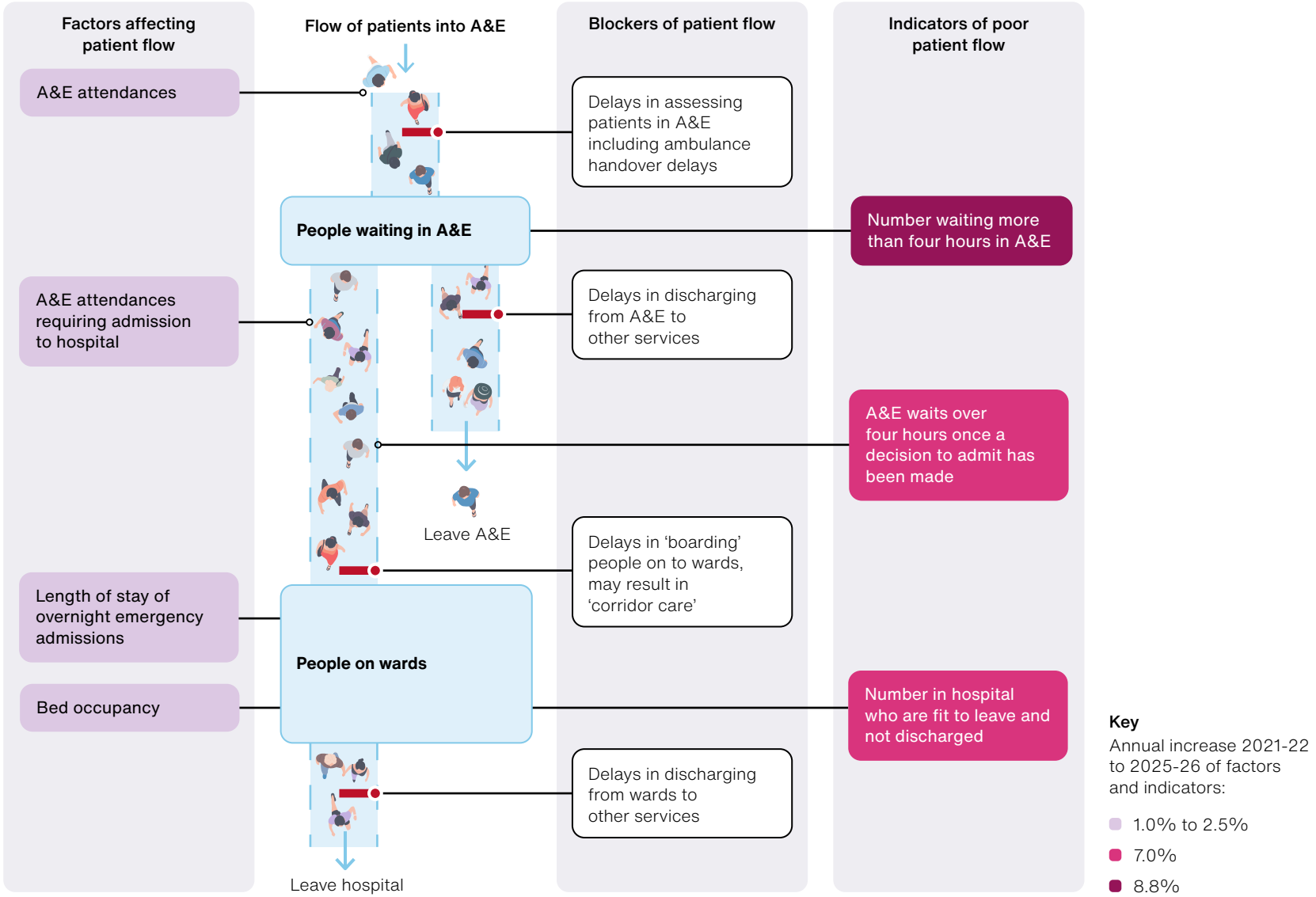


Figure 7 *continued*
Factors affecting patient flow through hospitals and indicators of poor patient flow, 2021-22 to 2025-26

Notes

1 Annual increases shown are calculated as compound annual growth rates.

2 Patient complexity and the ability to identify and treat a greater number of conditions may also affect the speed at which individual patients are able to move through A&E and be admitted to wards. Patient complexity can be measured through patients' comorbidities, costs and frailty. Across four measures, NHS England estimates that the average complexity of an admitted patient has increased by 12% to 13% between 2018-19 and 2023-24, an increase of between 2% and 3% per annum.

Source: National Audit Office analysis of NHS performance statistics

2.6 **Figure 8** shows that, after the COVID-19 pandemic, there were large increases in delayed admissions from A&E into hospital (i.e. admissions delayed by more than four hours after a decision has been made to admit a patient to a ward). In addition, there were large increases in patients who were in hospital for too long (delayed discharge). These increases may be linked to a surge in demand for health care services after the COVID-19 national lockdowns ended. From 2023-24, there were seasonal variations in delayed admissions and delayed discharges, but, overall, levels remained high. A smaller increase was seen in the number of occupied beds in hospitals, which is limited by total capacity. This suggests that the availability of beds and delays in discharging patients are some of the key modifiable factors associated with poor patient flow.

Admissions and bed occupancy

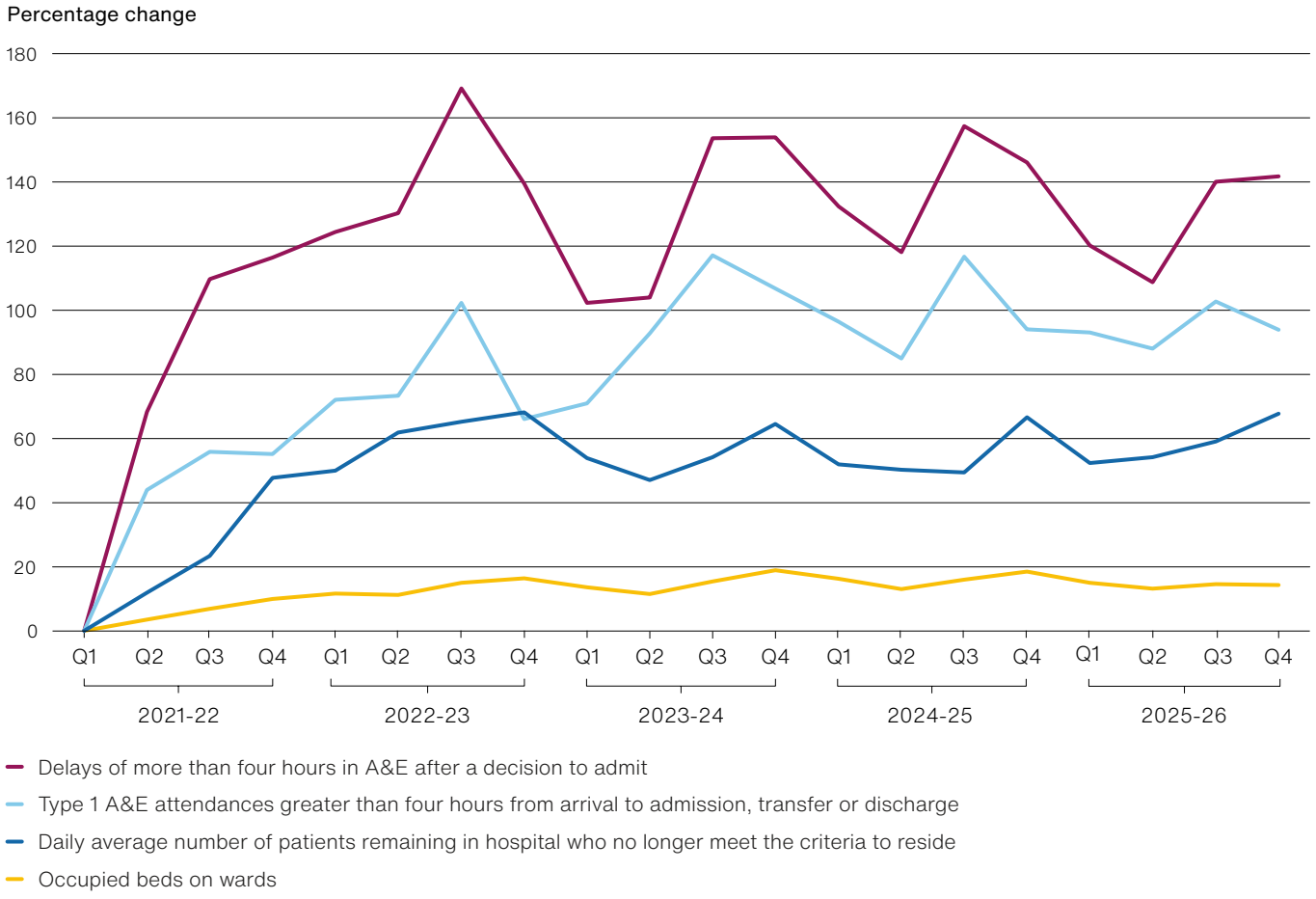
2.7 Delays in admitting people to a bed on a ward and patients experiencing corridor care both result from the hospital being unable to accommodate people who need to be admitted from A&E, usually because there are not enough staffed beds available. There have been increasing numbers of people who need admitting from A&E to a bed on a hospital ward (from 3.7 million patients in 2011-12 to 4.8 million patients in 2025-26) while bed occupancy increased from 87% to 92%, which means fewer beds were available. In the last four winters (Quarter 4 of 2022-23 to 2025-26), the occupancy level has been above 92% which is the level NHSE considered 'safer and more efficient'. The Royal College of Emergency Medicine considers that an average bed occupancy of 85% supports patient safety and achieving the four-hour A&E target for 95% of attendances. It should be noted that bed occupancy can also vary between wards and trusts depending on factors such as the particular medical specialty.[12]

12 The National Institute for Health and Care Excellence notes that 'optimum occupancy levels may vary with the size and type of the hospital, case mix, the degree of predictability of bed availability from different wards and seasonal effects (winter period with more infections)'.

Figure 8

Percentage change in factors and indicators associated with patient flow, 2021-22 to 2025-26

Post COVID-19 accident and emergency (A&E) waits, hospital bed occupancy and discharge delays increased rapidly between 2021-22 and 2022-23 and then show seasonal variations although levels remained high



Source: National Audit Office analysis of NHS England's published NHS performance statistics

2.8 The total number of general and acute beds was similar in 2025-26 (at a quarterly average of around 103,000) as it was in 2011-12 (at a quarterly average of around 106,000). NHSE's analysis, based on past patterns of performance, suggests that if bed numbers were between 115,000 to 120,000 then, with current levels of demand, bed occupancy would be below 87% in winter and overall four-hour performance might return to 95% of patients to be admitted, transferred or discharged. Any additional beds would likely need increases in staff and possibly changes to the configuration of hospital buildings. NHSE has not calculated the cost of making these changes.

Length of stay

2.9 While the number of beds on wards has remained broadly the same there are other factors which can increase the occupancy of those beds. These factors include how much healthcare each admitted patient requires and the 'length of stay' of the patients in these beds. This 'length of stay' measures how long a patient who is admitted onto a ward will stay in hospital before leaving. When average length of stay increases, this can impact A&E performance as it delays the flow of patients from A&E into a bed on a ward. NHSE estimates that the medical conditions of patients have become more complex and as a result, these more complex patients may need more healthcare and stay longer in hospital, thus increasing the pressure on A&E.

2.10 The long-term trend in total length of stay for all patients in hospital, both for emergency and planned care, has reduced from 5.3 days in 2011-12 to 4.7 days in 2024-25. However, NHSE has also calculated that the average length of stay has increased for emergency admissions that are longer than one day, from 7.3 days in April to February 2019-20 (excluding March 2020 to remove the impact of the COVID-19 pandemic) to 8.1 days for the full financial year of 2025-26. The extent to which the increase is due to a reduction in operational inefficiency 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.

Delays in discharging patients

2.11 A delayed discharge is when a patient in hospital has been assessed as being well enough to leave hospital but has not yet left because of non-medical reasons. This can be due to, for example, not having the care arrangements in place that would allow the patient to leave hospital safely, or waiting for the appropriate prescription to be filled. Staying in hospital longer than necessary causes patients harm, including increased risks of deconditioning, delirium and infection. Age UK has highlighted how older people and those living with frailty are at particular risk of poor outcomes from delayed discharge and are disproportionately affected.[13] 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. Delayed discharges can impact A&E performance as they delay the flow of patients from A&E into a bed on a ward. In April 2026, the total number of bed days used for patients who no longer needed hospital care was 408,350. This accounts for 14.7% of all bed days used in April 2026.[14] 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.[15]

13 Age UK, *The Longest Wait to Leave: Tackling the delayed discharges that help to drive corridor care*.
14 These numbers relate to hospitals with a Type 1 A&E.
15 NHSE estimates an average additional cost of £562 a day for patients' use of hospital services and has published an estimate of the total cost from August 2025.

2.12 NHSE considers that the actions needed for timely discharge of patients are well known but inconsistently applied by trusts. In response, in July 2026, it introduced new guidance for a standardised approach to discharge, with discharge planning beginning at admission and continuing throughout a patient's stay.

2.13 There are several reasons for delayed discharges, some of which are in the control of hospitals, such as timely completion of clinical action, discharge activity, provision of prescriptions, and arrangement of transport. Some are not, notably availability of social care and housing provisions. NHSE 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 considers these data to be more useful than previously as these are linked to other information about the patient's care. Hospital trusts we visited identified several factors that can affect the flow of patients through hospital, many of which are related to discharge (**Figure 9** overleaf).

2.14 NHSE has also noted the importance of bed capacity to improving the flow of patients through hospitals. 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 rather than on measuring whether patients get the right treatment at the right time. For example, NHSE has data on why some patients' discharge from hospital is delayed (see paragraph 2.13). NHSE gets some patient feedback through the Care Quality Commission (CQC) which runs a survey every two years to gain patient feedback on their experiences of using 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.[16] 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. In July 2026, NHSE reported plans to create a Directorate of Patient Experience to help ensure feedback is used to improve care. Trusts will have their own specific challenges that impact patient flow and blockages, such as demographics and geographical location. Trusts may have data on flow at local level, but NHSE does not require them to report these data to help quantify the challenges nationally.

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

Figure 9

Examples of practices and factors that affected the flow of patients in the five hospitals we visited

On our five hospital visits we saw examples of practices and factors that may affect the flow of patients through hospital

Category	Practices/factors that may affect flow
Complex patient needs	• More patients with complex needs, including frail and older people • Challenges finding or arranging care for patients with mental health issues
Internal operational inefficiencies	• Space constraints in the hospital design • Data quality/availability • Waiting for clinical action • Clinical staff's reluctance to use other forms of care, such as virtual wards • Waiting for an empty bed to be prepared for a new patient • Delays in getting 'take-home' medication • Delays/difficulties in arranging transport
Constraints outside of the hospital	• Patients' housing not suitable or needing adaptations for patients' needs • Capacity of care homes and constraints in when new residents can be 'admitted' • Delays or difficulties negotiating packages of care between NHS and social care • Community and social care capacity
Fragmented working with external partners	• Limited or lack of co-location between social care and NHS staff • Unnecessary bureaucracy • Misaligned incentives, meaning the patient's needs may not always come first
Behaviour of people	• Patient and family wishes and constraints in families' ability to help when people are discharged

Note

1 These examples may not be relevant to all the hospitals we visited.

Source: National Audit Office visits to hospitals, interviews and observation

International insights

2.15 Aspects of the challenges the NHS faces relating to emergency performance appear relatively common across health systems. For example, the French Audit Office (Cour de Comptes) noted in 2024 that French emergency services were under pressure following COVID-19, and, in Canada, the Office of the Auditor General of Ontario noted in 2023 that waiting times for emergency care had increased. Denmark has made reforms specifically aimed at improving patient flow, beginning a programme of healthcare reform in 2007 to improve patient flow and reduce overcrowding in hospitals. This programme included plans for a more centralised system of specialised emergency departments, which meant that patients cannot attend an A&E without first talking to a clinician or calling an ambulance.

2.16 The NHS in England is ahead of its home nations' counterparts in terms of A&E performance. In 2024-25, the percentage of patients in England in A&E who were discharged, transferred or admitted within four hours was 73.9%, compared with 68.7% in Scotland, 68.1% in Wales and 45.5% in Northern Ireland. It should be noted that the data for Northern Ireland are not directly comparable as there is no policy in Northern Ireland that explicitly directs patients requiring observation, assessment or recovery to be transferred out of A&E. England also performs better than Australia whose national four-hour performance was 53.4% in 2024-25.

Part Three

Improving performance

3.1 This section of the report examines NHS England's (NHSE's) support to trusts to improve accident and emergency (A&E) performance. This includes the two most recent national plans to improve A&E performance: the two-year *2023 Delivery plan for recovering urgent and emergency care services* (the 2023 plan) and the subsequent *Urgent and emergency care plan 2025-26* (the 2025 plan). We also examine NHSE's targeted support to the worst performing trusts.

Governance and accountability

3.2 In its 2025-26 planning framework, NHSE set out its intention for Integrated Care Boards (ICBs) and trusts to earn greater flexibility and freedom. It described its role as providing support, oversight, and targeted intervention based on the needs of local systems. In addition, NHSE sees its role as establishing central guidance and operational standards. NHS trusts have statutory and regulatory responsibilities to improve performance in their A&Es where they are not meeting constitutional standards. NHSE is clear that its role is providing support, guidance, incentives, oversight of performance and, if necessary, regulatory action. NHSE considers that the shift in responsibility to trusts for performance is important to improving A&E.

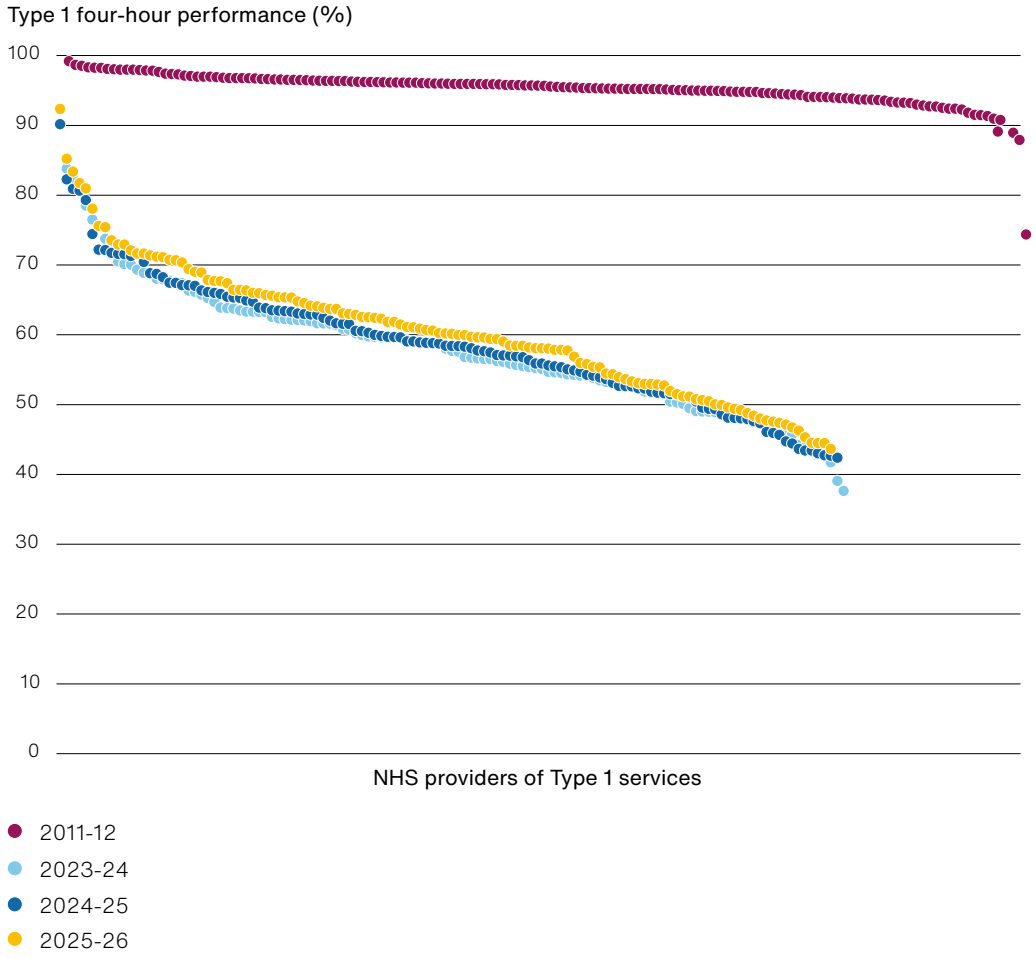
Variation in A&E performance

3.3 There is a large variation in performance on the four-hour metric in Type 1 A&Es in England, with performance ranging from 44% to 92% in 2025-26 (**Figure 10**). Variation between Type 1 A&Es has increased 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 and was from 44% to 92%. Even if NHSE and trusts are able to reduce the variation, there will still be some way to go to get the majority of Type 1 A&Es close to 2011-12 levels.

Figure 10

Variation in Type 1 accident and emergency (A&E) performance, 2011-12 and 2023-24 to 2025-26

Compared with 2011-12, the four-hour performance of Type 1 A&Es from 2023-24 to 2025-26 varies greatly and is much lower



Notes

1 Annual performance is aggregated from quarterly statistics of NHS providers' A&E performance.

2 2011-12 has been chosen by the National Audit Office as a benchmark to display variation against 2023-24 to 2025-26 because it was the earliest year available in the same publication series.

3 There were 150 NHS providers reporting Type 1 A&E performance in 2011-12, 123 in 2023-24, 122 in 2024-25 and 121 in 2025-26.

Source: National Audit Office analysis of published NHS performance statistics

NHSE's efforts to improve performance

3.4 NHSE has used several ways to improve performance and reduce the variation in performance across trusts: at strategic level through improvement plans; by publishing national guidance for trusts to implement; and by providing support to individual trusts through 'tiering' and improvement teams such as Getting It Right First Time.

Strategic improvement efforts

3.5 In January 2023, NHSE published the *Delivery plan for recovering urgent and emergency care services* (the 2023 plan). In this two year plan, NHSE prioritised efforts to reduce or divert demand, and increasing resources in A&E to improve waiting times. The main objective of the 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 set out several ambitions and targets, including targets of 76% of A&E patients being admitted, transferred or discharged within four hours of arrival by March 2024, and an average ambulance response time of 30 minutes to category 2 incidents (emergency calls).

3.6 The 2023 plan laid out five areas that would require sustained focus to achieve improvement, which were:

- increasing capacity;
- growing the workforce;
- improving discharge;
- expanding and better joining up care outside of hospital; and
- making it easier to access the right care.

3.7 Supporting these areas, NHSE developed 10 "high impact interventions". NHSE asked trusts to implement four of these interventions, with NHSE offering support in the form of good practice sharing and guidance. NHSE allocated some trusts capital funding from the Additional Capacity Targeted Investment Fund to help them build facilities such as same day emergency care spaces.

3.8 Alongside improvements in the A&E, the 2023 plan emphasised the importance of managing demand for emergency services. These efforts focus on diverting people who do not need urgent care to more appropriate services, such as virtual wards and community healthcare. **Figure 11** outlines the key aims and achievements of the 2023 plan. The aims are focused on inputs, such as increasing bed numbers or providing same day emergency care services, rather than on outcomes.

Figure 11

Progress made in delivering the aims of the *Delivery plan for recovering urgent and emergency care services* (the two-year 2023 plan) up to April 2025

NHS England (NHSE) and NHS trusts have taken actions to achieve many of the aims of the 2023 plan

NHSE area of focus	Aims	Achieved as at March 2025
Increasing capacity in accident and emergency (A&E)	Increase and sustain the total number of core (overnight) beds by 5,000 to 99,500 total beds.	Partially – achieved in January 2024 (99,529 beds) but was not sustained. As at March 2025, the number of core General & Acute beds was above target (99,817 beds) but by April 2026 there were 97,883 core beds across all trusts.
	All Type 1 A&Es to provide a same day emergency care service for 12 hours a day.	Partially – all Type 1 A&Es provided same day emergency care services, but only 79% operated 12 hours a day, seven days per week.
Increasing the workforce in A&E	Increase the size of the NHS emergency medicine workforce.	No targets. However, there were 2,402 emergency medicine consultants in March 2023 and 2,733 in March 2025.
	Increase the number of clinicians available for NHS 111 online.	No – as at April 2024, 12 clinicians had entered recruitment into NHS 111 (compared with a shortfall of 170 clinicians). No data available for March 2025.
Improving discharge	£1.6 billion of additional social care discharge funding over 2023-24 and 2024-25.	Yes – £600 million in 2023-24 and £1 billion in 2024-25 was distributed. Impact on improving discharge is less clear. In September 2023, 13.5% of discharges were delayed. In March 2025, this figure was 13.7%.
	All hospitals to have a transfer care hub by winter 2023.	Unable to quantify as no publicly available data for winter 2023. However, NHSE reported that all hospitals had a hub by March 2025.
	Expand intermediate care capacity to support discharge.	Yes – 10,460 NHS or jointly commissioned intermediate care beds as at March 2025, compared to 8,983 beds as at September 2024, which is the first month that data are available.
	Increase capacity of community bed-based services and reduce average length of stay by two days.	Unable to quantify as no publicly available data. Yes – community bed average length of stay reduced by 2.3 days between March 2023 and March 2025.
Expanding out of hospital care	The provision of an additional 3,000 virtual ward beds, while increasing the occupancy of virtual wards to 80%.	Yes – capacity increased by over 3,000 by March 2025, occupancy reached the target of 80% in January 2025, but was not maintained.
	All Type 1 A&Es to provide acute frailty services for 10 hours a day, every day.	No – only 54% of services were open for the minimum acceptable hours.
	70% of referrals for urgent community response being filled within two hours.	Yes – 85% of urgent community response referrals met the two-hour target.
Making it easier to access the right care	Mental health support to be available via NHS 111 from April 2024.	Partially – NHS 111 mental health support offered from August 2024.
	All systems to meet the minimum required structures and processes of single point of access by winter 2024.	No – as of February 2025, only seven of 100 single point of access fully met requirements.

Notes

1 We have assessed progress as at March 2025 when the 2023 plan ended, unless the plan specified a different target date.

2 Type 1 A&Es are 24-hour emergency departments intended to treat the most urgent cases of the three main A&E types including resuscitation.

3 Same day emergency care services refer to medical services.

Source: National Audit Office analysis of evidence provided by the Department of Health & Social Care and NHS England

Trust level support

3.9 Since 2022, NHSE has placed lower-performing trusts into two tiers, offering these trusts additional support to improve performance. Trusts in tier one receive on-site support and regular performance monitoring from the national NHSE team. Trusts in tier two get less intensive support and monitoring from regional teams. NHSE intends to replace the tiering system and make regional teams responsible for managing and overseeing the performance of providers. Metrics measuring the performance of urgent and emergency care are a subset of the NHS Oversight Framework.

3.10 NHSE supports trusts who are struggling with A&E performance through the NHSE programme Getting It Right First Time which aims to share best practice and reduce variation across the NHS. This programme has worked with several NHS trusts to help to improve A&E performance and hospital flow, such as through its Further Faster programme which provides direct support to trusts, or by publishing guidance and operational standards that aim to improve performance.

Outcomes

3.11 Despite achieving many of the aims set out in the 2023 plan, this has only translated to marginal 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 fell short of the plan's interim target to reach 76% by March 2024. In March 2025, the four-hour target was 78% and overall performance was 75%.

3.12 There was also little improvement in 12-hour performance, with 10.4% of patients waiting for 12 or more hours in A&E for care in March 2023, only falling slightly to 10.1% in March 2024. The 2023 plan did not set a specific numerical target for 12-hour performance. The lack of marked improvement suggests a need for more systematic change. In March 2026, an evaluation by the National Institute for Health and Care Research of the impact of the discharge fund found it only had small impacts because of uncertainty about future funding, its narrow focus on discharge from hospital, and the quality of data. The evaluation found that 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.[17]

3.13 While NHSE considers that it and trusts were able to achieve most of the actions in the 2023 plan, the intended improvements in outcomes did not fully materialise. By March 2025, at the end of the 2023 plan's timeline, NHSE rated its confidence that the 2023 plan would be successfully delivered as 'red', as opposed to 'amber' or 'green', meaning it was not successful in achieving the improvements that NHSE had intended.

17 National Institute for Health and Care Research, *The impact of hospital discharge funding on health and social care outcomes,* March 2026.

3.14 The Getting It Right First Time programme and other forms of NHSE support can have a positive impact on trusts' A&E performance. However, it is unclear how well this support can translate into sustainable change and how much best practice can be embedded to become business-as-usual, because support offers are generally time-limited and only provided to a limited number of trusts. The Further Faster programme, for example, only includes a limited number of trusts. NHSE does not have means to enforce its recommendations to trusts. It can be challenging for trusts to prioritise recommendations if they require a significant and difficult level of change.

Other opportunities for improvement

3.15 Performance improvements are better enabled with whole-of-hospital systems, end-to-end approaches and strong leadership. We have seen examples of all these on our case study visits and when talking to stakeholders, but we cannot quantify their prevalence.

Whole-of-hospital systems and end-to-end approaches

3.16 Hospitals have their own specific challenges and varying access to resources; however, some examples of good practice we found on our visits included the following.

- Departments and wards had dedicated flow coordinators who could stream patients efficiently into beds.
- 'Red lines' on avoiding corridor care and unnecessary patient moves, which aimed to improve safety as patients were only transferred when there was space.
- Good communication between departments helped flow, as moving a patient into and out of a ward needs coordination.
- Care transfer hubs to help deal with the logistical and administrative challenges in discharging some patients (not all trusts have the resources to staff a care transfer hub).
- Multidisciplinary teams on wards to deal quickly with complex barriers to flow.
- Standardised and accelerated discharge processes (e.g. pre-packed medications, early 'to take away' preparation).
- Run flow/operational meetings, and safety briefings throughout the day to review capacity, demand, and barriers.

3.17 Shared digital systems and data can help to create visibility and future forecasts of demand and capacity. A higher-performing hospital we visited had a good patient records system that detailed and followed the patient's journey from admission to discharge; showed the status of resources and bed availability; and gave visibility to everyone across the hospital of what was happening and where, to inform decisions about what to prioritise or reassign to facilitate flow. Some hospitals use electronic patient record systems which allow them to track patients as they move through the hospital. The roll out of the electronic patient record is not yet complete and not all trusts who have them, are using electronic patient record systems to measure patient flow.

3.18 In Scotland, a poorer performing hospital saw 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. It also moved accountability away from the Emergency Department and shared it with the wider hospital. 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.

Strong leadership

3.19 NHSE has highlighted the importance of leadership and culture. The impact and quality of leadership and culture is difficult to audit systematically, however, during our visits to A&Es, NHS staff told us of the importance of leaders seeing the state of emergency care and hospital flow for themselves and committing to improving performance. One hospital which had seen recent improvements in performance, stated that having visible leaders who created a culture of improvement, collaboration and partnership across the system was one of the key reasons behind that improvement.

3.20 Stakeholders we have spoken to have noted that changes to ways of working could bring real benefits. The Royal College of Emergency Medicine has argued for hospitals to be more of a seven day service. It noted that a lack of weekend working in other parts of the hospital can create delays and backlogs in A&E that last throughout Monday and Tuesday. The Society for Acute Medicine advocated for more use of Acute Medical Units which are constantly monitored, intensive, consultant-led areas open 24/7. These units act as a gateway for patients leaving A&E to the rest of the hospital and quickly assess and treat patients before they are admitted to a general ward, thus helping the flow of patients out of A&E. While many hospitals have Acute Medical Units, patients do not always pass through them. The Royal College of Pharmacy has suggested allowing community pharmacists to supply some discharge prescriptions written in hospital, for example a dose increase or reduction to a non-specialised regular medicine, so patients can be discharged without having to wait for the hospital pharmacy to deal with the prescription.

Bed management and capacity

3.21 Higher-performing and improving hospitals we visited ensured flexible use of beds and physical capacity to match demand and maintain flow. Some examples we found included:

- distribution of surge capacity (for example, winter beds) across all wards to flex capacity up or down efficiently - this avoids having to open and staff an entirely new ward during peak demand;
- flexing of elective and emergency beds to respond to fluctuations in demand;
- use of discharge lounges to free inpatient beds earlier for incoming demand; and
- use of Acute Medical Units and assessment units as step down/step through areas to maintain flow.

The Royal College of Emergency Medicine told us that increasing capacity was important in fixing overcrowding within hospitals and improving flow.

Cooperation with other healthcare organisations

3.22 One of the biggest challenges when it comes to freeing up beds in a hospital is that, often, discharge is reliant upon an external organisation such as other hospitals and social care. Hospitals that effectively collaborate with these organisations can better facilitate flow. On our visits we saw some examples of this.

- Embedded social workers, local authority staff, and community services within hospital teams to accelerate discharge.
- Sharing patient information across organisations to improve coordination and reduce duplication.
- System-wide communication channels allowing hospitals within the same area to talk to one another.

NHSE's recent efforts to improve performance

3.23 Following the conclusion of the two year 2023 plan, NHSE published the *Urgent and emergency care plan 2025-26* (the 2025 plan) in June 2025. While the 2023 plan was more holistic, covering various aspects of the health system, including primary and community care, the 2025 plan was more focused on operational improvements within A&Es with a greater focus on local accountability. Following publication of the 2025 plan, NHSE published several pieces of national guidance highlighting best practice to improve the management of A&Es and reduce corridor care, for example, *The Model Emergency Department: high performing urgent and emergency care pathways* in February 2026.

3.24 NHSE is relying on trusts to implement and embed this guidance throughout their hospitals as part of their overall urgent and emergency care performance and the NHS funding framework, rather than with specific programme funding. The lack of additional funding could be particularly challenging when trying to create or expand services such as same day emergency care which may require physical changes to the hospital building. The Royal College of Emergency Medicine stated that it believes *The Model Emergency Department* guidance is unlikely to have a meaningful impact on reducing overcrowding in hospitals, as the guidance is not particularly different to what was already being practised and small in scope. The Society for Acute Medicine was positive about the contents of some guidance but noted that they have been issued without impetus or additional funding.

3.25 NHSE's medium-term planning framework 2026-27 to 2027-28 sets out the need for whole-of-system approach to problems such as discharge delays. NHSE's guidance and operational standards to address the problems in A&E may not be implemented as part of the wider hospital system. NHSE focuses on individual aspects of care or services, such as guidance to eliminate corridor care and *The Model Emergency Department*. The Royal College of Emergency Medicine has noted this shortfall, emphasising the need to take a whole-system approach and that guidance such as *The Model Emergency Department* is only 'one piece of the puzzle'.

3.26 In 2024, a literature review looked at 39 academic articles on international challenges and efforts to improve patient flow in A&Es. The study found that there was a wide range of interventions used to address patient flow, but the effectiveness of these interventions varied, and most interventions were focused on A&E itself, neglecting the rest of the patient journey. It concluded that further research was needed to investigate and enhance the effectiveness of interventions outside A&E in improving patient flow and it noted that it was essential to develop interventions that relate to all three phases of patient flow: before, within and after A&E. The study made five suggestions for improvement.[18]

3.27 We have assessed NHSE's and trusts' actions against those suggestions in **Figure 12**. While they have implemented many of these, our analysis of flow in Part Two shows that, based on performance against the four-hour target, flow has not improved markedly as a result.

18 M Samadbeik et al, 'Patient flow in emergency departments: a comprehensive umbrella review of solutions and challenges across the health system', *BMC Health Services Research,* 24, 274 (2024).

Figure 12
NHS England's (NHSE's) actions to improve hospital flow

Some of NHSE's actions since 2023 align with suggested ways to improve how patients flow through accident and emergency (A&E) and the wider hospital

Suggestion	NHSE's and trusts' actions
Develop ways of improving patient flow from before patients arrive at A&E and after they leave A&E. This includes smooth care transitions; effective discharge management; improved access to primary care; diversion of frail older individuals from A&Es; and efficient transition for patients after leaving hospital.	Introduced services such as urgent community response and virtual wards which aim to divert demand from A&E. Tried to improve discharge in the *Delivery plan for recovering urgent and emergency care services* (the 2023 plan). Published an intermediate care framework for rehabilitation, reablement and recovery following hospital discharge in September 2023.
Embrace community based care that can help reduce the length of time people stay in hospitals.	Tried to improve community based care through the 2023 plan.
Strengthen technology and innovation interventions that focus on flow before, within, and after A&E, particularly the latter.	Improved technology with some hospitals using electronic patient record systems that allow them to track patients as they move through the hospital.
Have standard measures to measure outcomes other than time. These should encompass proportion-related outcomes, cost-related outcomes, process-related outcomes, and patient- or provider-related outcomes.	Developed a standard measure for corridor care. Does not have a standard measure for patient flow.
Address the root causes of patient flow challenges and conduct rigorous research and evaluation. Health systems should focus on implementing interventions that address factors such as population changes, capacity challenges and process related issues.	Developed guidance and operational standards based on clinical consensus and experience. 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 does not require trusts to collect data to understand flow in their individual hospitals.

Source: M Samadbeik et al, 'Patient flow in emergency departments: a comprehensive umbrella review of solutions and challenges across the health system', *BMC Health Services Research*, 24, 274 (2024), and National Audit Office analysis of NHS England documents and data

Next steps for A&E

3.28 NHSE's strategic aim is to accelerate improvement so that 85% of patients are admitted, transferred or discharged within four hours by 2028-29 and to challenge hospital leaders to rapidly implement key service developments. It 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. The new pieces of national guidance emphasise practices such as 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. Digital aside, we see a risk that the response focuses on what is measurable and visible, and makes incremental gains, rather than big leaps. There remains scope for NHSE to target the root causes of poor flow spanning the system and to develop strategies and measures for each of these.

Appendix One

Our audit approach

Our scope

1 Our report examines NHS England's (NHSE's) and the Department of Health & Social Care's (DHSC's) response to the decline in accident and emergency (A&E) performance across England. While we are aware of the important role admission avoidance plays in improving A&E flow, this report focuses mainly on flow within NHS hospitals themselves.

Our evidence base

2 We reached our independent conclusions on whether NHSE and DHSC have made effective interventions on improving hospital flow and A&E performance following our analysis of evidence collected between January and June 2026.

3 We conducted interviews with relevant stakeholder groups and organisations during scoping and fieldwork to inform our findings and conclusions:

- Government bodies: officials from NHSE and DHSC responsible for overseeing A&E services, supporting trusts (including Getting It Right First Time) and implementing the *Delivery plan for recovering urgent and emergency care services*, 2023 (the 2023 plan) and the 2025 *Urgent and emergency care plan 2025/26* (the 2025 plan). We also spoke to NHSE regional teams and data analysts.
- Sector bodies: the Royal College of Emergency Medicine, the Society for Acute Medicine, the Royal College of Surgeons, the Royal College of Pharmacy, the NHS Alliance (formerly NHS Providers and NHS Confederation), the Association of Directors of Adult Social Services, and Age UK.

4 We conducted case study visits to hospital trusts with Type 1 A&E departments to gain insight into how initiatives to improve A&E performance are working on the ground. These trusts were selected from the top and bottom 22 performers (in order to gain a better understanding of the different pressures faced by higher and lower performing trusts) in two metrics: performance against the overall four-hour target (the proportion of patients who must wait four hours to be admitted, transferred or discharged from arrival at A&E), and four-hour waits from decision to admit (the proportion of patients who must wait four hours to be admitted into the hospital once it has been decided they need to be admitted). For each trust, we observed how work is done at the different steps of that end-to-end process, spoke to hospital staff and watched real examples of work as it happened. We also met with hospital staff who support process flow, for example team managers and data analysts, to discuss their views and concerns. Our case studies were: University College Hospital (London), Wye Valley Hospital (Hereford), Northern General Hospital (Sheffield), and Whittington Hospital (London). We also visited Chelsea and Westminster Hospital (London) when scoping the study and we have used findings from that visit alongside our case studies.

5 We reviewed 90 published and unpublished documents, including those provided by NHSE, DHSC and third-party organisations. Documents included board papers from the Urgent Emergency Care Recovery Plan Delivery Board, monthly progress reports, national guidance, examples of Getting It Right First Time work, information on support available for poorly performing trusts, updates on the rollout of supporting services, financial information and related reports from our international counterparts.

6 We analysed several datasets, including:

- A&E performance towards the four-hour target and the number of patients who waited 12 hours or more from arrival to admission/transfer/discharge, and comparing this to the overall number of patients being seen in A&E.
- 24-hour waits in A&E. 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.
- Total bed levels across trusts and their occupancy rates.
- Trust staff levels – The number of professionally qualified staff in trusts and the number of emergency medicine consultants.
- The flow of patients through A&E – including attendance source, how urgent their assessment was, and whether they were admitted, discharged or transferred.

- Impact of delayed discharge – the number of bed days lost to patients who are ready to be discharged but are not, the proportion of discharges that are delayed and delayed discharges that last seven or more days.
- Impact on the average length of stay – average length of stay data, the number of beds occupied by patients with a length of stay of more than 21 days.

7 We used cost information from the National Cost Collection in which NHSE collects data on how much trusts spend on emergency care, which aggregates data from NHS trusts on how much they spent on specific NHS services. The National Cost Collection dataset is available to all NHS trusts via an online tool which allows data on spending to be compared between different trusts and regions, as well as breaking down data by different factors such as deprivation level.

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