Royal College of Emergency Medicine

The State of Emergency Medicine in England

Introduction

Emergency Medicine services in England continued to face significant pressure throughout 2025. Crowding and long waits remain commonplace, raising concerns about patient safety, staff wellbeing, and the ability of the system to provide timely emergency care.

This report outlines the state of Emergency Medicine in 2025, examining the scale of overcrowding in Emergency Departments (EDs) and the impact this is having on patient safety and staff. Drawing on national data, research and frontline evidence from clinicians, it highlights how long waits, high bed occupancy and a lack of patient flow continue to lead to overcrowded departments. This leads to unsustainable conditions in EDs, declining public confidence in emergency care and increasing pressure on staff.

2025 also saw the publication of further evidence linking long waits in EDs to unnecessary patient deaths. There can no longer be any doubt as to the scale of the problem facing emergency medicine, and the need for the government's current approach to be reviewed.

The Royal College of Emergency Medicine (RCEM) is calling for urgent action across the health and care system to ensure that:

- Avoidable deaths linked to long ED waits are eliminated; and that these deaths must be treated with the seriousness they deserve
- The current practice of caring for patients in corridors or other non-designated spaces is ended
- New NHS policies do not add pressure to EDs for the sake of improving high profile metrics, without clear improvements in bed occupancy and/or hospital flow
- A whole-system approach is adopted to address overcrowding across the entire patient pathway
- Meaningful accountability is embedded across NHS organisations and government to improve and eventually eliminate overcrowding in Emergency Departments.

Context

EDs in England remained in a state of distress throughout 2025.

Key figures:

- **In 2025, there were almost 17 million Type 1 Emergency Department (ED) attendances in England, the highest figure ever.**
- **Overcrowding itself has become a routine part of working in many EDs.** Around 90% of respondents to a recent survey of English clinical leads reported that overcrowding occurs at least several days each week.
- **There were an estimated 15,860 excess deaths** associated with long waits in 2025 this represents an almost ten-fold increase in the number of excess deaths over a decade. (1,657 excess deaths in 2015).
- **60.5% of patients were admitted, transferred, or discharged within four hours in 2025;** only marginally improved from 59% in 2024, and still a far cry from the NHS constitutional standard of 95% or the interim target of 78% set in the Urgent and Emergency Care Plan.

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- **1,744,993 patients waited 12 hours or more from their time of arrival in A&E,** a decrease of 43,000 from 2024.
- **However, 489,138 patients waited 24 hours or more in an Emergency Department.** This has increased by around 150,000 patients in just 3 years.
- **Over half a million patients (554,251) waited for 12 hours or more** after the decision to admit them to a hospital ward was made. This is the highest number on record.
- **General and Acute bed occupancy averaged 93.1%, well above level required to maintain operational effectiveness.**[1]
- Hospital occupancy is driven in part by keeping patients in hospital who don't need to be there. **On average 12,906 patients per day were medically fit for discharge but remained in hospital,** restricting bed availability and patient flow.

Impact on patients

Long waits in EDs are associated with patient harm, increased mortality risk, and declining public confidence in emergency care. We know that delays in assessment, treatment and admission can worsen patient outcomes, particularly for those with serious or time-sensitive conditions.

Research has demonstrated a clear link between waiting times before admission and mortality. For every 72 patients who wait between eight and twelve hours in an ED before admission, there is one additional (excess) death.[2] RCEM conservatively estimates that 15,860 deaths in England in 2025 were associated with long waits. These are avoidable deaths which government must act swiftly to address.

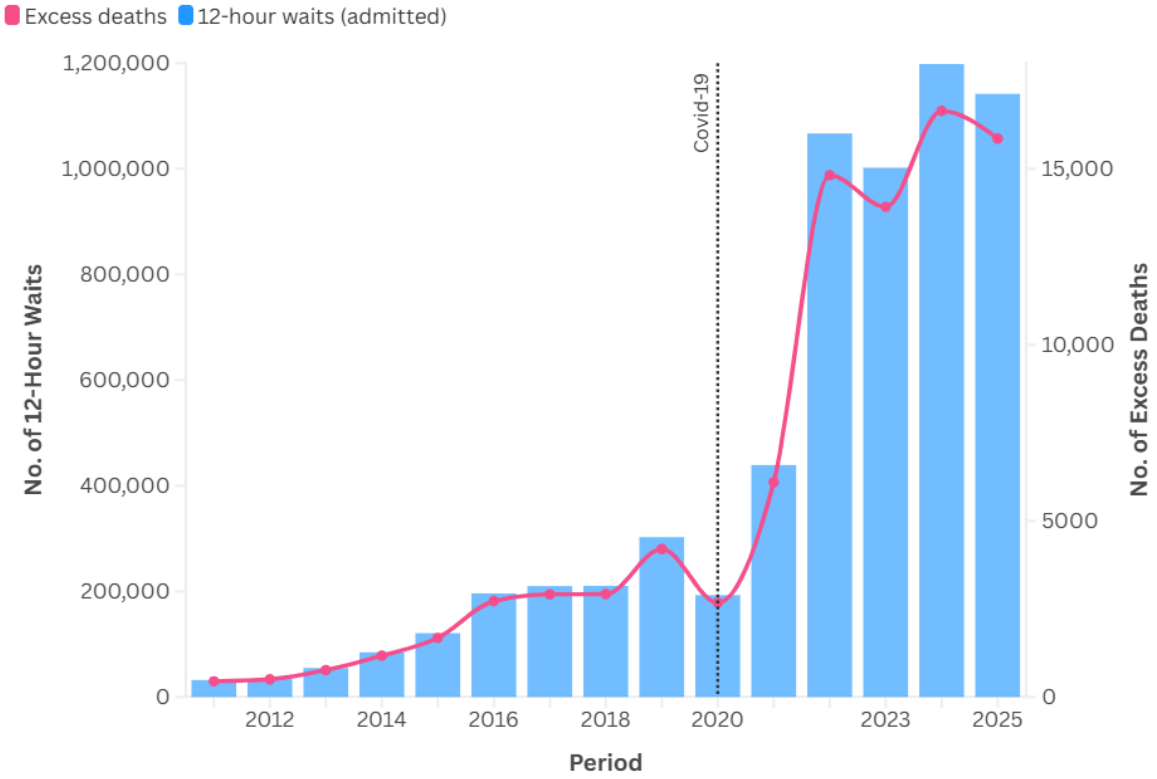


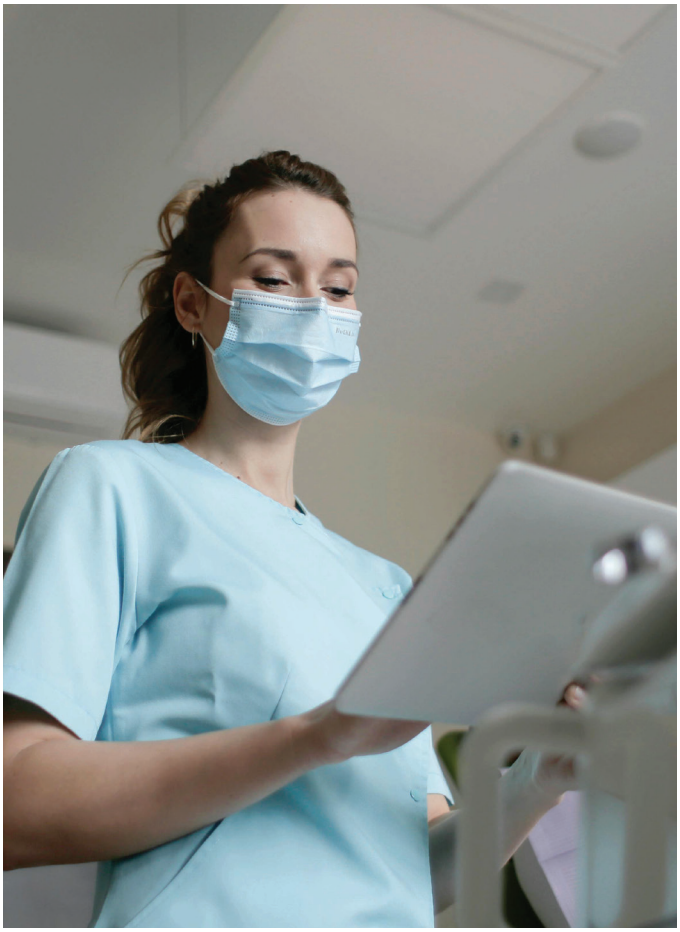
Figure 1: Excess deaths and 12-hour waits in English EDs, 2011 - 2025

1 National Institute for Health and Care Excellence (NICE). *Emergency and acute medical care in over 16s: service delivery and organisation: Evidence review 39 – Bed occupancy.* NICE guideline NG94. London: NICE; 2018. Available at: NICE Guideline Template

2 Jones S, Moulton C, Swift S, et al. *Association between delays to patient admission from the emergency department and all-cause 30-day mortality.* Emergency Medicine Journal. 2022;39(3):168–173. Available at: https://emj.bmj.com/content/39/3/168

Figure 1 shows the number of 12 hour waits in ED and associated excess deaths over time. It is striking how much this problem has increased since 2021 as the frequency of long waits has skyrocketed.

12-hour waits are one of the measurable effects of overcrowding within an ED which affects the environment in which patients receive care. Many factors can contribute to overcrowding, but the primary driver of long waits is 'exit block'. This is where patients in the ED cannot be transferred to in-patient wards or other specialist facilities due to a lack of capacity in those areas, often because of a lack of bed availability.



When EDs are full, they will usually still accept patients, and those patients end up being "double bunked" in cubicles or being treated in non-designated clinical areas, including corridors and cupboards. Alternatively, they may be asked to wait in chairs in waiting rooms. Privacy, dignity and clinical safety are impossible to maintain in these spaces.

Once EDs can no longer physically fit in more patients, it becomes challenging to take in patients arriving in ambulances, which means that ambulance crews are kept waiting to "offload" rather than being out on the road responding to emergencies. We know that in some cases, delays in ambulance response times can lead to poor patient experience (for instance lying on a cold street with a broken hip), or death.

The impact of these conditions undermines patient confidence. A recent Ipsos poll produced for RCEM found that 42% of patients said they would hesitate to attend A&E due to concerns about long waits. This raises concerns about public confidence in emergency care and the risk that some patients may delay seeking urgent medical attention, possibly leading to deterioration in health. These concerns are shared by staff.

Evidence from the 2025 UNCORKED study highlights the scale of these pressures. The study found that almost one-in-five patients in UK EDs were being cared for in escalation spaces, including repurposed clinical areas and non-clinical areas not designed for patient care.[3]

The study also found that between around 10% and 26% of respondent departments had no immediate resuscitation cubicle capacity available at certain points. This is a fundamental failure to provide a basic resource for the sickest patients, the primary role of an emergency department.

Patient testimony published by the All-Party Parliamentary Group on Emergency Care in 2025 highlight the dreadful experience associated of corridor care:[4]

'Corridor care has affected my confidence. I would think twice about going to A&E again unless it was absolutely unavoidable. The experience of being left on a corridor made me feel forgotten and vulnerable.'

'While I know staff are doing their best, the environment didn't feel like the right place to receive care, and that has shaken my trust.'

Overcrowding affects patient dignity, safety and trust in the healthcare system.

[3] Roberts T, Trainee Emergency Research Network (TERN), et al. *Understanding corridor and escalation area care in UK emergency departments: a multicentre cross-sectional snapshot study.* Emergency Medicine Journal. 2025. Available at: https://emj.bmj.com/content/43/2/72-0

[4] APPG on Emergency Care: Corridor Care (2025), https://rcem.ac.uk/wp-content/uploads/2025/11/APPG-report-final-2.pdf

Impact on staff

ED staff also experience the consequences of overcrowding and long waits. When departments are operating beyond safe capacity, clinicians must care for large numbers of patients while managing delays in admission and limited space. Staff report that this can make it difficult to assess and treat patients safely, particularly in non-designated areas such as corridors or other temporary spaces.

Clinicians report that these conditions can affect their ability to deliver the standard of care they want to provide to patients. This leads to moral distress and moral injury. Managing high patient volumes, long waits and limited space can contribute to stress, fatigue and burnout.

Staff told us...

"The heavy burden of mental health work affects their own mental health."

"The working conditions are i nhumane...morale is non-existent."

The strain which overcrowding places on the emergency medicine workforce is unsustainable. In a recent survey of clinical leads in England, 97% of clinical leads described the situation as unsustainable in the long term, with 44% also describing it as unsustainable in the short term.

This is exacerbated by workforce shortages. A March 2026 survey by RCEM showed that around 60% of clinical leads described their department as moderately understaffed, while just over one-in-five said their department was severely understaffed. The survey evidenced that in some areas, financial pressures have led to delays or freezes in the recruitment of much needed senior clinical staff.

NHS and government response

Crowding and long waits are no longer isolated incidents but a persistent feature of the ED, affecting both patients and the staff who care for them.

However, 99% of clinical leads in England felt that whether or not the government understood the problems facing Emergency Medicine services, the government was not taking the right steps to fix them.

There has also been a tendency to chase one target at the expense of another, or to pursue short-term solutions. The drive to reduce ambulance response times by introducing "rapid release" protocols is undoubtedly increasing overcrowding in EDs where there is no organisation-wide response to free up space. More recently there has been a push to admit patients to "Same Day Emergency Care" units. Whilst this may be the right thing to do for some patients, emergency clinicians frequently report that they are under pressure to transfer patients to such facilities simply because they will be off the clock, and their long waits will not be measured. Finally, the repeated introduction of short-term capital incentives is a testament to the centrally driven desire to chase short-term improvements in data at the expense of long-term improvements in care.

RCEM has argued that there has been undue focus on isolated parts of the problem, at the expense of focusing on the problem in the round. "Demand management" (trying to direct patients to the most appropriate service) and "alternatives to admission" is the right thing to do but will only go so far.

- "Demand management" strategies need to be focused on the patient cohort who end up in emergency department corridors: the sickest patients Whilst attempts to "decongest" emergency departments using such facilities as Urgent Treatment Centres, badging these as an answer to corridor care shows a lack of understanding of the fundamental problem.
- Admission avoidance strategies are valid. However, there is inconsistency in models adopted both in the community and in hospitals, and many services do not have the capacity or capability required. Opening hours do not extend into evenings or weekends, they often declare themselves full, and both criteria and appetite for risk may be overly restrictive, preventing optimal use.

There needs to be equal focus on organisational culture, leadership, and ownership of the problem, as well as on ensuring that when patients need access to either a specialist service or admission to a hospital bed, one is available for them. The latter needs attention to how systems operate over the whole week, not just Mondays to Fridays, and into the evenings. Hospitals can operate very inefficiently, which means patients stay longer than they need to because they are waiting for tests, specialist input, or for things like prescriptions and transport. Thousands of precious beds are taken up by patients who don't need to be there. And finally, we know that many beds are occupied for longer than necessary simply because patients have been admitted through overcrowded departments. In this regard, we are victims of our own failure and simply adding to the problem.

Recommendations

The Royal College of Emergency Medicine is calling on the government to make a national commitment to end overcrowding in Emergency Departments across England.

The government must:

Eradicate mortality associated with long waits in emergency departments by the end of the decade and ensure that these deaths are treated with the same seriousness and equivalency as deaths in any other part of the NHS or walk of life. Government should do this by meeting the 4-hour constitutional standard.

Follow through on its commitment to end the current practice of caring for patients in corridors or other non-designated spaces by the end of this parliament.

Ensure no new NHS policies increase pressure on EDs without demonstrable improvements first having been made in hospital flow metrics (long waits, bed occupancy).

Prioritise the adoption of a whole-system approach with responsibility for performance spread across the entire patient pathway.

- Encourage senior leaders within organisations to drive ownership of the problem both by themselves, and by their whole organisation. Overcrowding in an ED reflects failure in an organisation and system.
- Ensure that there is genuine accountability for ending overcrowding across the system and that trusts/health boards, the NHS in (country) and national government play their role in ending overcrowding.
- Introduce 7-day extended hours working across the health system so that emergency departments have the supporting services they need to operate and that other specialities are resourced adequately to provide this.

Ensure that hospital bed occupancy is used as a system-wide metric so that adequate attention is given to improving flow.