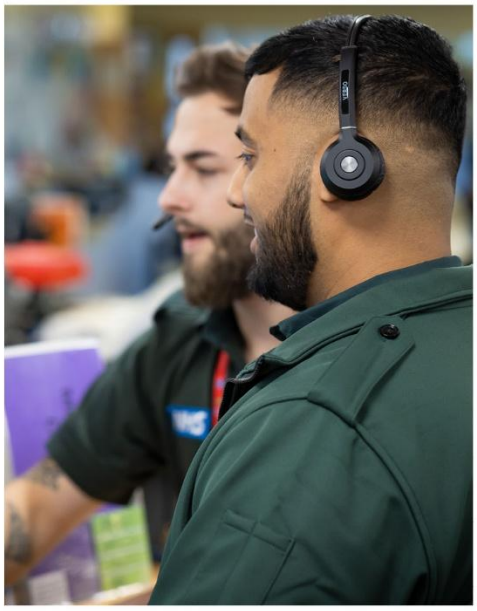
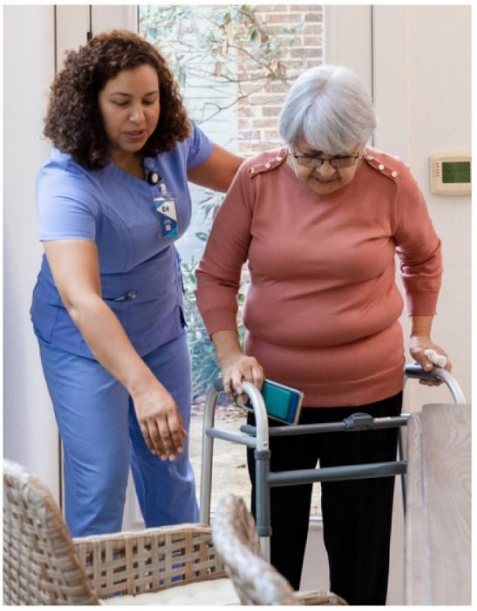
Department of Health & Social Care

NHS England

Urgent and emergency care plan 2025/26

June 2025





Contents

Summary of priority actions and their impact

Actions	**Impact for patients and carers**
Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter	By the year-end, with improvement over winter, we expect to: • reduce ambulance wait times for Category 2 patients – such as those with a stroke, heart attack, sepsis or major trauma – by over 14% (from 35 to 30 minutes) • eradicate last winter's lengthy ambulance handover delays by meeting the maximum 45-minute ambulance handover time standard, helping get 550,000 more ambulances back on the road for patients • ensure a minimum of 78% of patients who attend A&E (up from the current 75%) are admitted, transferred or discharged within 4 hours, meaning over 800,000 people a year will receive more timely care • reduce the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so this occurs less than 10% of the time. This will improve patient safety for the 1.7 million attendances a year that currently exceed this timeframe • reduce the number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month • tackle the delays in patients waiting to be discharged – starting with the nearly 30,000 patients a year staying 21 days over their discharge-ready-date, saving up to half a million bed days annually • increase the number of children seen within 4 hours, resulting in thousands of children every month receiving more timely care than in 2024/25
Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter	• improve vaccination rates for frontline staff towards the pre-pandemic uptake level of 2018/19. This means that in 2025/26, we aim to improve uptake by at least 5 percentage points • increase the number of patients receiving urgent care in primary, community and mental health settings, including the number of people seen by Urgent Community Response teams and cared for in virtual wards

	• meet the maximum 45-minute ambulance handover time standard • improve flow through hospitals, with a particular focus on reducing patients waiting over 12 hours and making progress on eliminating corridor care • set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings • reduce length of stay for patients who need an overnight emergency admission. This is currently nearly a day longer than in 2019 (0.9 days) and needs to be reduced by at least 0.4 days
National improvement resource and additional capital investment is simplified and aligned to supporting systems where it can make the biggest difference	Allocating over £370 million of capital investment to support: • around 40 new same day emergency care centres and urgent treatment centres • mental health crisis assessment centres and additional mental health inpatient capacity to reduce the number of mental health patients having to seek treatment in emergency departments • expansion of the Connected Care Records for ambulance services, giving paramedics access to the patient summary (including recent treatment history) from different NHS services, enabling better patient care and avoiding unnecessary admissions

Introduction

1. This summer will mark a turning point for the NHS: the 10 Year Health Plan will set the most transformative agenda we have seen in over 2 generations.

2. But we cannot wait for the publication of the plan to fix those things we can change now.

3. Working across whole systems to improve urgent and emergency care (UEC) won't just deliver a better winter for our patients and staff, it will start to free up leadership headroom. Improving this important UEC pathway will help financially challenged systems become more productive and cost-effective.

4. But most of all, this plan is about being accountable to our communities. It's about committing to working around the clock this summer to prepare for winter 2025/26. Ultimately, this is about improving patient outcomes.

The imperative for change

5. The current performance of UEC services does not meet the standards our patients need or our frontline staff want to deliver.

6. It has been over 5 years since the 18-minute response to Category 2 ambulance calls standard was met, and over a decade since the service delivered the standard for 95% of patients waiting 4 hours or less in A&E.

7. The public continue to feel the impact of poor UEC delivery. The British Social Attitudes Survey into the NHS and social care, published in April this year, showed that satisfaction with the NHS and, in particular, A&E services – already at a record low last year – has deteriorated even further and is declining at a faster rate than before.

8. In short, we've normalised asking our staff to deliver sub-optimal care, and our patients have all but given up hope of expecting a reliable service in urgent care.

9. The burnout our frontline staff feel – particularly in the acute sector who feel the brunt of the consequence of poor system-wide urgent care delivery – has been clear in the conversations we've had with staff as part of the Change NHS process. The stories our patients have told us through the same process – sometimes heartbreaking descriptions of truly terrible experiences – underpin the urgency we now expect NHS leaders to have to meet essential constitutional standards.

10. We must do everything we can to significantly improve UEC services this winter compared to what our patients and staff have experienced in recent years, and this plan sets out clear expectations about what each part of the NHS needs to do – starting from today – to make this happen.

11. Every day, over 140,000 people access UEC services across the country, including more than 11,000 who are so unwell they need to be admitted to hospital for a day or more, and 20,700 people who are seen by the ambulance service. Since 2010/11, the number accessing UEC services has risen by 90%, and the number seen by the ambulance service has risen by 61%.

12. This huge increase in reliance on UEC services has only in part been fuelled by an ageing population and an increase in multiple long-term conditions and mental health needs. In truth, it is largely a consequence of services being organised in a confusing and

disparate way by multiple providers. We do not always work together to deliver services in a way our communities would expect and NHS staff would like.

13. Our inability – and, in some exceptional circumstances, unwillingness – to work more coherently across different service providers in the NHS and social care has led to a deterioration in performance that would have been unimaginable a decade ago.

14. When patients feel they have no choice but to go to emergency departments or call an ambulance just to access care, the system has failed them.

15. There are some exceptionally effective UEC services – however, this isn't consistently the case, with wide variation across the country. A significant and tangible step change is needed from all boards and chief executives to fully optimise all available services to improve UEC. Successful systems have reformed their approach to improving UEC; they have a shared focus on maximising the use of primary care and community diagnostics, as well as working closely with acute providers to improve internal flow.

16. While the 10 Year Health Plan will set a new course for how we deliver health and care services in the future, there are things we can and must do now to ensure our patients receive a better service this coming winter.

17. To make that commitment more than just a set of words in another publication, there are 3 things we need to change at different levels of the health and care system.

18. First, we all need to focus as a whole system on the 7 priorities that will have the biggest impact on UEC improvement this coming winter. As a minimum, these are:

- patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes
- eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes
- a minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours
- reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time
- reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month

- tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000 patients staying 21 days over their discharge-ready-date
- seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25

19. Second, leaders will need to commit to developing and testing collective winter plans, which will be signed off by every board and chief executive within each system by summer 2025. Regions will work with systems and providers on an exercise to stress-test and refine their plans in September 2025 and will continue to oversee improvement support to the most challenged organisations in the run up to and throughout this winter. As a minimum, each plan should show how, by this winter, systems will:

- improve vaccination rates
- increase the number of patients receiving care in primary, community and mental health settings
- meet the maximum 45-minute ambulance handover time standard
- improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care
- set local performance targets by pathway to improve patient discharge times, and eliminate internal discharge delays of more than 48 hours in all settings

20. Each part of the system has responsibility for improving UEC performance. However, blame shunting has become a feature in some poorly performing systems and can no longer be tolerated. Each part of the system has responsibility for improving UEC performance, so systems' winter plans should evidence how:

- **integrated care boards (ICBs) and primary care** are demonstrably improving access to primary and community care and driving stretching system-wide improvement to prevent avoidable admissions and discharge rates
- **community providers** are quantifying demonstrable improvement in admission avoidance, making more effective use of community beds and care home facilities, and using technology to support people to stay well at home
- **trusts** are using all available tools to improve patient flow, including: optimising triage and appointment systems to direct less urgent cases to same day emergency care (SDEC); optimising the use of urgent treatment centres (UTCs) and Hot Clinics; ensuring medical directors and chief nurses are applying clinical operational standards to ensure all specialties – not just UEC – lead UEC improvement; and training and empowering medical staff to use the clock to drive performance improvements

- **ambulance trusts** are rapidly adapting best practice to maximise improvement opportunities this winter and nominating an executive director to work with every ICB to develop the system winter plan

21. To support providers and systems to accelerate improvement, we will significantly increase the amount of data available to the NHS and the public. We will undertake an urgent review of UEC data by the end of June 2025 (Q1), with improvements rapidly implemented as part of the NHS Federated Data Platform Operational Dashboard work. We will also explore how to improve the transparency of individual site-level improvement plans, enabling patients to understand the actions being taken to improve services and address their concerns.

22. Finally, we will simplify and align the numerous national improvement resources and additional capital investment to support the systems where those resources can make the biggest difference. There are currently multiple resources, teams and funding sources aligned with various elements of UEC improvement, all of which add value but are confusing. We have started work to bring together these resources and deliver them through a one-team approach to support local leaders, trusts and systems in driving UEC improvement faster this year than ever before. This will be achieved through a redesigned improvement function to ensure we target resources to those systems that need them most.

23. Leadership is the single most crucial factor that will determine our success this winter**.** Every leader must ensure that both within their organisation and across their system everything possible is being done to improve care. Where this was most effective last winter, chief executives, chief nursing officers and medical directors regularly worked from the emergency department to support staff on the frontline. This now needs to be the norm.

Delivering the asks for 2025/26

From treatment to prevention: taking steps now to reduce demand for urgent care later this year

24. To protect the most vulnerable and keep vital health and care services running when respiratory viruses surge, there is more we can do to reduce the effects of the flu.

25. Last winter, we heard your feedback that the restrictions on the National Booking Service and the lack of information on clinic times were suboptimal. That is why, this year, we will commit to:

- expanding the use of the National Booking Service for flu vaccination to make more appointments available, including keeping it open until the end of the flu campaign in March
- developing the “flu walk-in finder” so that, from October 2025, patients can easily look up when they can walk into a community pharmacy to get a vaccination

26. Regions will work with ICBs to develop a plan by the end of Q1 on how they will strengthen the childhood vaccination offer. Increasing vaccine uptake among children is one of the most impactful interventions, with every thousand childhood vaccinations saving around 4 hospital admissions. As a minimum, these plans should set out how:

- GPs and school-aged immunisation providers will increase vaccination rates, working with local directors of public health
- local campaigns will target those in clinical risk groups

27. To support this, we will ask some systems to test the use of health visitors to administer childhood flu vaccinations and other routine immunisations for eligible children. These systems will test the feasibility and value for money of different approaches and provide evidence to inform national roll-out from 2026/27.

28. Plans should also set out the delivery approach to the year-round RSV vaccination programme for older adults and pregnant women (for infant protection), ensuring all those in the older adult catch-up cohort (aged 75 to 79) have been offered a vaccination by 31 August 2025. The aim is to achieve 70% for the catch-up cohorts and 60% in the routine cohort during 2025/26. RSV vaccination provides multi-year protection, so those vaccinated now will have protection this coming winter. The UK Health Security Agency continues to analyse and evaluate these new programmes, with early assessment of the RSV vaccination programme in older adults showing it led to a 30% reduction in the confirmed RSV hospital admission rate among eligible 75 to 79-year-olds.

29. While some trusts have a strong offer, we know that many staff still find it difficult to access a flu vaccination. We will therefore ask all trusts to have an accessible occupational health vaccination offer to staff throughout the entire flu campaign, including onsite bookable and walk-in appointments. All trusts will be asked to have a fully developed plan for improving flu vaccine uptake for NHS staff by the end of Q1, incorporating a stretching target percentage increase on last year’s uptake. This plan should include:

- improved communications and engagement with staff to increase their vaccination rates and to support the promotion of vaccination to eligible patients, better highlighting the link with winter pressures

- work with sector partners to proactively promote available vaccination offers to those who provide and draw on care
- a requirement for NHS hospitals to offer vaccination on discharge to any patients going into a care home

30. We will work with NHS communication teams to share details of the most effective staff vaccination programmes from 2024/25. We will support this with national materials where this is deemed effective. We will also work with professional bodies, patient representative groups and charities to support consistent clinical advice about the benefits of flu jabs for patients in clinically vulnerable groups.

31. In 2024/25, there were patients ready to be admitted but, in some cases, trusts did not have an actionable infection prevention and control (IPC) strategy. Therefore, all systems should test their winter virus resilience plans against the IPC mechanisms available both in and out of hospital. This includes making sure they have identified cohorting spaces ready to be actioned, explored the direct admission of flu patients into community bedded capacity and followed appropriate policies and procedures.

From hospital to community: increasing the number of patients receiving care in community settings

32. At least 1 in 5 people who attend the emergency department don't need urgent or emergency care. An even larger number of attendees could be more efficiently managed by growing community capacity.

33. The Neighbourhood health guidelines published in January 2025 set out the 6 core components of neighbourhood health that all local health and care systems will start to implement systematically this year. This will help people stay independent for as long as possible, reduce avoidable exacerbations of ill health and minimise the time people need to spend in hospital or in long-term residential or nursing home care. This includes neighbourhood multidisciplinary teams (MDTs) co-ordinating proactive care for population cohorts with complex health and social care needs, integrated intermediate care with a "Home First" approach, and scaled and standardised urgent neighbourhood services for people with an escalating or acute health need.

34. We can see the benefit of this approach in examples across the country. In Washwood Heath in Birmingham, social care, primary care, mental health, community nursing teams and secondary care respiratory services are all working together to improve discharge, reduce admissions and provide SDEC for respiratory and cardiovascular disease patients. Over the last year, they have seen A&E attendances fall by over 30% among targeted patients, length of stay in hospital fall by over 14% and Category 3 ambulances are now conveyancing patients to the health centre instead of the emergency department.

35. Similarly for patients living with frailty or complex needs, neighbourhood multidisciplinary teams have been shown to reduce demand on hospital-based unplanned care. In Northamptonshire, local integrated teams involving a range of health and care providers are delivering responsive interventions, such as extended GP reviews, peer support groups, clinical-supported decision-making and remote monitoring. In the 18 months to March 2023, this approach resulted in a 9% reduction in hospital attendances for over 65s and a 20% reduction in falls-related acute attendance due to improved rapid response.

36. Achieving this shift is everyone's responsibility and requires everyone's full participation. As part of their system winter plan submission, ICBs will need to evidence how NHS providers and local authorities (through health and wellbeing boards) will improve discharge and admissions avoidance. System winter plans should build on the Better Care Fund (BCF) plans agreed between ICBs and local authorities in March 2025, which include local goals for performance on emergency admissions for over 65s and timely discharge. Where ICBs and local authorities are facing challenges in achieving these goals, the newly formed Discharge and Admissions Group will agree improvement plans with them, as set out in paragraph 76 below.

37. System winter plans should clearly set out how local partners – NHS acute trusts and primary care – are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for them. They should also detail how they plan to expand access to SDEC and enable direct ambulance off-loading at specialty facilities, such as SDECs.

38. Plans should set out how systems intend to expand access to urgent care services at home and in the community, so patients don't need to attend hospitals unnecessarily. This includes understanding the actual volume and optimising the use of urgent community response and virtual ward capacity in each integrated care system (ICS) as well as planning with the ambulance service and 111 how to use this capacity most effectively.

39. This will mean more 999 callers receive timely, clinically appropriate care without requiring hospital conveyance. Currently, half of ambulance incidents convey patients to an emergency department – a reduction on previous years, but there is still significant regional variation (45 to 54%). This new approach will enable ambulance services to prioritise the most critical cases while providing alternative pathways for those with less urgent needs. To achieve this, we will:

    - undertake and implement the findings of an evidence-based clinical review of categorisation, increasing clinical triage of 999 calls to identify patients who can be safely assessed and managed remotely, directing them to appropriate urgent care pathways such as virtual wards or urgent community response teams

- enhance paramedic-led care in the community to ensure more patients receive effective treatment at the scene or in their own homes, reducing avoidable hospital conveyance. This will be delivered through ambulance crews operating a call before convey principle and enabling “see and treat”, supported by additional clinicians in emergency operating centres (EOCs) and single points of access (SPoAs)
- expand overnight support for 999 call handlers and clinicians to provide urgent in-home care for clinically assessed patients, with follow-up services available the next day
- reduce the variation in rates of hear and treat (currently 8.1% to 20.7%) and see and treat (currently 25.6% to 36.7%), building on the progress we have already made. Progress will be reviewed monthly and research undertaken to understand what types of community capacity are most effective in preventing an avoidable conveyance

40. This model is already demonstrating success. For example, Hampshire’s call before convey initiative reduced emergency department attendances or admissions for 32 to 38% of cases, with 24% avoiding hospital entirely. This saved up to 87 hours over 3 weeks. Similarly, urgent community response services in Dorset and Kirklees have successfully managed approximately 80% of eligible patients without hospital attendance.

41. To support these initiatives, we have published ambulance commissioning guidance for systems – including ambulance trusts, acute trusts, and community providers – to enhance capacity and capability across urgent and emergency care pathways. Priorities in the guidance include:

- increasing the number of multidisciplinary clinicians in EOCs and enhancing their skills to improve patient management
- building on the EOC capacity by developing SPoA that accept calls directly from care homes and GPs, avoiding the need for clinicians to ring 999
- expanding capacity in the community sector, broadening access criteria and extending service availability beyond core hours
- strengthening ambulance trust access to SDEC and UTCs, supported by trusted assessor principles

42. The guidance also reinforces the “call before convey” principle, ensuring paramedics can access senior multidisciplinary decision-making support at the scene. This will help identify safe and appropriate alternatives to emergency department conveyance when this is not the most suitable option. By prioritising the right care in the right setting, we can optimise emergency resources for those with the greatest need.

43. We will publish and implement the recommendations from the 111 review to make the service quicker and simpler to navigate. This includes using natural language processing technology to improve call streaming from October 2025. We will also work with GPs and other healthcare providers to improve the patient referral process to primary care. Additionally, we will work with stakeholders to develop new measures that reflect the quality of care provided by 111 (including disposition outcomes) not just how quickly calls are answered, with the aim of implementing these in April 2026.

High-quality emergency care: meeting the maximum 45-minute ambulance handover

44. Putting a greater leadership focus on increasing and improving UEC services outside hospital will help colleagues to be more ambitious about improving ambulance handovers. The only way we are going to consign 8 and 12-hour ambulance handover times to history is by ripping the plaster off and ambulance services and trusts collectively signing up to a stretching but deliverable standard.

45. Most trusts are already implementing the Release to Rescue standard, and it should now be delivered without exception, including in the winter months.

46. This will be triggered once a handover reaches 30 minutes, meaning that all ambulances will complete their handover and leave the hospital site at 45 minutes. This allows ambulances to be cleared and available for the next call. To achieve this, ambulance services will do everything they can to avoid conveyance, and no 111 dispositions should occur without going through validation, even if that means holding risk out-of-hours and overnight. All acute trusts will be required to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target. This will significantly reduce ambulance response times across the country, with evidence from 2024/25 demonstrating that Release to Rescue implementation across London reduced the average length of ambulance handovers by 11%. The benefits of this approach can be seen in increased capacity to respond to those in need within the community, improved 4-hour performance, and reduced congestion in emergency departments.

Improving flow through hospitals

47. We will provide clear pathways and the right waiting environment when people do need to come to a hospital site with an urgent need. We will take a significant step to separate urgent from emergency care, so that people are treated in the most appropriate setting.

48. The evidence shows that co-located UTCs reduce both the number of people who spend time in emergency departments and overcrowding. Without this separation, everyone can often wait much longer. In UTCs, over 95% of people are treated and discharged within 4 hours.

49. For people who require treatment that can be completed within a day, we are expanding SDEC services across the country. The evidence shows that patients treated in an SDEC wait less on average for a clinical review, spend less time in an emergency department and in hospital overall, and are more likely to go home to their usual place of residence.

50. We know co-located UTCs and SDECs improve the patient experience and hospital flow, which is why we want to accelerate their implementation across England. We are allocating £250 million of capital budget to continue this expansion, the equivalent of 40 new SDECs or UTCs. We will prioritise supporting those systems that can best evidence how early investment will impact service improvement this winter.

51. Every patient living with frailty should be identified early in their journey and a comprehensive geriatric assessment initiated or amended. This assessment and early involvement of a frailty team is proven to reduce admissions and length of stay and improve the patient's chance of maintaining independent living.

52. We should be seeing more children within 4 hours based on the occupancy levels of most of the country; Lord Darzi's independent investigation identified more than 10,000 infants, some of the most vulnerable members of our society, have been left waiting for over 6 hours in A&E departments. We need to use UTCs effectively, as well as children and young people's specific services, and standards need to be refined. ICBs should also consider commissioning means of local advice and guidance (such as Healthier Together) so parents can navigate their local systems and care provisions more effectively.

Ending 12-hour waits in corridors for a bed

53. Last year, we saw too many patients cared for in corridors, waiting over 12 hours for a bed. This should never happen. We're asking our patients to accept care that falls below the standards they deserve while also asking our staff to do things we've no right to ask them. This is why this spring we have committed to publish the collected data on the prevalence of corridor care for the first time. In 2025/26, we will seek to publish site-level performance data on total attendances, admitted attendances and long waits.

54. We also know that when some patients arrive at an emergency department they require immediate treatment to avoid unnecessary deterioration. In some cases this is obvious, while for others, this may be more subtle. According to the UK Sepsis Trust, 245,000 people are affected each year by sepsis, with 48,000 deaths every year determined as sepsis-related. We know that early identification and accurate diagnosis, allowing appropriate management, can save lives. Everyone should be using the National Early Warning Score (NEWS2) to help identify symptoms early, and we will continue to work

with the Royal Colleges and Societies on updating and sharing sepsis guidance and learning from best practice.

55. As soon as possible, and set out in the system winter plans, we need to ensure that people see the right clinician and don't stay longer in the emergency department than necessary.

56. System winter plans need to set out how their clinical model will be configured and adapted to make sure the most appropriate clinician is consistently available to provide continuity of care, proactively identify deteriorating conditions, support rapid assessments into the most appropriate pathways, and join up more effectively with primary and community teams. While safety is always the priority, we also need to work to time-bound standards. This will speed up the decision-making process, with rapid specialty opinions and diagnosis and with only the patients who genuinely meet the "criteria to admit" standards (as published on FutureNHS – password required) being admitted.

57. We will work with the Royal Colleges and Societies to consult, publish and audit trusts against new clinical operational standards for the first 72 hours of care. These will set the minimum expectations in areas such as time to review following referral, availability for advice, and what happens to patients when multiple specialist teams need to input into care. We will publish these standards by late summer 2025, allowing them to be implemented by winter.

Mental health teams leading from the front

58. Mental health provision is critical to improving UEC services, and mental health trust chief executives and boards need to play a full and active role in the development of their system winter plan.

59. An emergency department is seldom the most appropriate setting for people experiencing a mental health crisis, yet too often, service users find themselves with no local alternative. As a result, too many patients wait for 24 hours or more in emergency departments. This is not acceptable. Those systems that invested in crisis assessment centres or specialist alternatives to emergency departments are able to evidence both a positive impact for service users in crisis and a broader impact on improving UEC provision in their areas. Those systems that haven't yet been able to invest in crisis assessment centres have seen benefits from ensuring community assertive outreach and crisis intervention teams are working with acute providers to support patients who attend an emergency department with mental health-related issues.

60. We will provide an additional £26 million of capital to support those systems that can demonstrate they can invest in crisis assessment centres in-year, ahead of this winter. They should be able to demonstrate they can offer rapid assessment and short-term

support in a therapeutic environment to ensure people in mental health crisis have timely access to specialist support and are directed to the right care pathway. All areas will have an opportunity to apply for this funding.

61. Too many mental health patients are still admitted to mental health hospitals far away from their home and family. We know this risks higher rates of suicide, depression and anxiety for patients following discharge due to being far away from their normal support network. This is why we are providing £75 million to eliminate inappropriate out-of-area placements by delivering additional capacity to improve local mental health inpatient provision. The new capacity will be available by the end of this financial year. We expect this to lead to a reduction of around 150 to 160 patients in inappropriate out-of-area placements at any one time.

62. System winter plans will need to demonstrate how local mental health providers can evidence that mental health inpatient stays will be as short as possible. Plans should set out:

- how the number of patients in out-of-area placements (OAPs) will be reduced as part of a broader commitment to eliminate all ICB commissioned OAPs by March 2027
- how mental health providers will proactively identify and reduce the re-admissions of high intensity users of crisis pathways. They will also be required to produce their own percentage reduction target of re-admissions for their highest intensity users
- how they will ensure fewer patients who need a mental health admission wait over 24 hours. This will include the consistent and systematic use of the mental health UEC Action Cards in all relevant settings (acutes) and delivery of the 10 high-impact actions for mental health discharges to support flow through all mental health (including child and adolescent mental health) and learning disability and autism pathways

A whole-system approach to improving patient discharge

63. In some trusts, 1 in 4 bed days are lost due to delayed discharges. This is unacceptable.

64. Acute trusts need to set stretching local performance targets for daily pathway 0 discharges and profile them through the week to ensure they are met, so we don't create problems we can't solve at the weekend. Acute trusts and local authorities should set local performance targets for pathway 1, 2 and 3 patients, ensuring patients are discharged as soon as possible to appropriate rehabilitation, reablement or recovery support, based on the "Home First" principle. ICBs should work with local authorities to ensure that BCF capacity plans include appropriate capacity for surges over winter, both for step-up and step-down care, making effective use of the 3.9% increase in the NHS

minimum contribution to adult social care announced in the 2025/26 BCF policy framework. As part of local plans, acute trusts, local authorities and ICBs should progressively eliminate the longest and most unacceptable discharge delays, starting with the 0.7% of patients who wait more than 21 days beyond their discharge ready date. All settings should eliminate any internal delays to discharge of more than 48 hours. These actions must combine to ensure that ICBs and local authorities achieve their local goals for reducing discharge delays, 1 of the 3 goals in the new BCF policy framework.

65. System winter plans must demonstrate effective use of capacity across the full system. The discharge rates of people who are ready to leave community beds are markedly low, with 1 in 5 beds occupied by people with no criteria to reside in the service. Reviewing bed usage and returning people to home-based care where possible will reduce long stays and increase capacity for those who need it. As well as providing surge capacity, additional beds have the potential to support acute admissions avoidance for respiratory and flu cases, alongside IPC cohorting where it is effective and appropriate to do so.

66. Focusing community bedded capacity on higher levels of dependency can have a profound impact. In Leicester, Leicestershire and Rutland, a joint health and care initiative relocated 25 beds in over 3 locations to a single 15-bed high dependency unit. Patients who do not meet the criteria to reside within the high dependency unit are managed within home-based services. The service is provided in 3 wings of an independent care home, with an onsite therapy and nursing MDT and in-reach mental health and other more specialised services as required. Funding is provided via the BCF and is not significantly higher than previous costs. 6 months in, the system has already seen a reduction in acute delays from 12 days to 1.45 days, saving 777 bed days (equating to around £0.5 million within the system) and a 50% reduction in one-to-one care on discharge.

67. We are seeing the impact of where trusts, local authorities and ICBs are collaborating to drive down discharge delays through early discharge planning, efficient in-hospital processes, streamlining complex discharge processes and matching intermediate care capacity to people’s needs. The key to improvement in these systems is actively using data about discharge-ready dates and proactively reviewing the reasons for delays to tackle variations in performance.

68. Systems that are struggling to improve discharge can use the additional guidance and best practice we have produced, including:

- care transfer hubs best practice, which sets out the 9 essential features of effective discharge arrangements for people with more complex needs
- Community rehabilitation and reablement model, which sets out best practice for commissioners and providers of intermediate care

- Neighbourhood health guidelines 2025/26, which support acute and community trusts, ICBs and local authorities to determine how neighbourhood MDTs will work with hospital wards and care transfer hubs, helping people with more complex needs return home with the right community support for their ongoing recovery

From analogue to digital: using data and digital investment to improve flow

69. 2025/26 is about getting the digital basics right for urgent and emergency care. We will use technology to speed up and improve patient care, allowing clinicians to view records and make referrals more efficiently – and to reduce the administrative burden on staff.

70. We have already seen the impact this can have, which is why we are providing an additional investment of £20 million in the Connected Care Records programme for all systems. This will establish the interoperability necessary for paramedics to see the patient summary from all different NHS services, including the patient's most recent treatment. All ambulance trusts will have sight of the summary by the end of 2025/26, up from 50% who currently have access. This in turn will enable them to provide better care to patients and avoid unnecessary admissions. For example, One London Shared Care Record provides a single, secure view of patient information, helping to speed up communication between care professionals across London.

71. We will continue to drive adoption of the NHS Federated Data Platform (FDP). The FDP will have been rolled out to 85% of acute trusts by the end of March 2026, with 77% of acute trusts having access by the end of Q2 this year, allowing for adoption ahead of winter. By expanding the use of the FDP, systems and trusts can consolidate multiple frontline operational systems into a single view, facilitating more effective and efficient clinical and operational decisions.

72. Rolling out the FDP is one thing: ensuring it is used effectively is another. System winter plans will need to evidence how teams will use FDP real-time data and forecasting tools to better manage demand, for example, by detailing how:

- the A&E Forecasting Tool is providing intelligence to support local operational decision-makers with resource and capacity management
- the Timely Care Hub is providing task tracking, monitoring and reporting of key metrics for quality
- the Optimised Patient Tracking and Intelligent Choices Application (OPTICA) system is providing clear visibility of all tasks required within the discharge process, supporting patients to return home or into step-down care

73. Finally, falls place a significant burden on UEC services, costing the NHS more than £2.3 billion a year. Falls in social care, home and community settings make up around 75% of this cost. Care technology in these settings can support people to live independently and avoid falling; for example, remote monitoring technology in care homes has been found to halve falls and prevent “long lies”, strongly associated with hospital admissions. To increase providers' confidence to adopt suitable, safe and future-proof technologies, we will set new national standards for initial priority care technologies by March 2026 and publish guidance to support providers to implement technology effectively.

Giving urgent care improvement the system-wide focus it deserves

74. None of the expectations set out in this plan will happen by accident: they require every leader in health and care to be purposeful and focused on getting the best out of their own teams and organisation and working across systems to create the most stretching ambitions for winter improvement we have seen in recent years. At its heart, this challenge is all about leadership.

75. We are combining the various elements of improvement support that have been developed – sometimes in silos – and using these resources to create a meaningful offer to systems to support them to realise their ambitions. We will also use the new NHS Performance Assessment Framework, which incorporates a range of metrics across all sectors, including primary care, hospitals, and ambulance, community and mental health trusts. This will drive the required focus and subsequent improvement that will support UEC recovery. We will also commit to publishing league tables on performance to drive improved transparency and public accountability and also to encourage less effective systems to work more closely with high performing systems to accelerate improvement.

76. Every system can access:

- **the model health system data** – available for all systems and providers to support UEC improvement. It includes a range of benchmarking data designed to help trusts review their practices and reduce unwarranted variation, which in turn delivers improvements, efficiencies and unlocks savings
- **UEC operational data dashboard** – this will be updated daily to provide a single version of the truth on key UEC performance metrics
- **improvement guides** – available to provide guidance on best practice in the areas that will drive maximum impact against the data points identified in their benchmarking data
- **learning and improvement networks** – led by a high-performing chief executive in each region with the responsibility to focus on reducing variation through the

application of best practice. The Learning and Improvement Networks will bring together clinical and operational leaders to identify opportunities for improvement and explore ways to deliver the improvement and share best practice. They will focus on the reduction of the percentage of patients in hospital over 7 days, supporting flow and reducing corridor care

- **training for on the ground clinical and operational leaders** – covering the fundamentals of operational management, leadership and improvement, including how to use improvement tools like LEAN. We have resourced this to ensure it can be accessed by 25,000 NHS staff this year and will be available from June 2025

77. **For those systems requiring additional support,** regional teams will provide this, including reviewing benchmarking data, improvement plans and associated resourcing, such as buddying teams, so that high-performing systems can support those who are struggling through peer-review.

78. **For those most challenged systems that demonstrate limited progress**, we will use a one-team approach to provide a joined-up intervention and support package. Where capacity allows, every site will have experienced clinical and operational improvers from the national teams assigned to them. These specialists will help identify the root cause of the issues, using the available data sources and implementing solutions, before winter, based on the improvement guides. This package will be for a 6-month period and will have personal oversight from the national director, national clinical director, chief nurse and NHS medical directors, delivering a plan that is owned at board and clinician level.

79. Finally, as set out in the Better Care Fund policy framework for 2025/26, the Department of Health and Social Care (DHSC), NHS England and the Ministry of Housing, Communities and Local Government (MHCLG) are adopting a more targeted approach to oversight and support for local authorities and ICBs in their development and implementation of BCF plans. The newly formed Discharge and Admissions Group will work with challenged systems to help drive improvements in discharge and foster effective collaboration between the NHS, local authorities and social care providers to help prevent avoidable admissions. Where there are significant performance challenges with the 3 BCF headline metrics (emergency admissions for over 65s, delayed discharges, care home admissions for over 65s), DHSC, NHS England and MHCLG will work with local areas to agree improvement plans or, where necessary, revised BCF plans.

Detailed actions: roles and responsibilities

NHS England and DHSC	• Undertake an urgent review of UEC data by the end of June 2025. • Simplify the national improvement and capital investment offers to align to the systems where those resources can make the biggest difference. • Expand the use of the National Booking Service for flu so more flu vaccination appointments are available. • Develop the “flu walk-in finder” so that, from October 2025, patients can look up when they can walk into a community pharmacy to get a vaccination. • Communications teams to share details of the most effective staff vaccination programmes from 2024/25. • Work with professional bodies, patient representative groups and charities to support consistent clinical advice about the benefits of flu jabs for patients in clinically vulnerable groups. • Undertake and implement the findings of an evidence-based clinical review of categorisation, with the aim of improving the clinical triage of 999 calls. • Publish and implement the key recommendations from the 111 review to make the 111 service quicker and simpler to navigate. • Allocate £250 million of capital budget to continue the expansion of co-located urgent treatment centres and same day emergency care. • Publish site-level performance data on total A&E attendances, admitted attendances, long waits and prevalence of corridor care. • Continue to work with the Royal Colleges and Societies on updating and sharing sepsis guidance and best practice. • Work with Royal Colleges and Societies to consult, publish and audit trusts against new internal clinical operational standards for the first 72 hours of care. • Allocate £26 million of capital budget to support systems to invest in crisis assessment centres. • Allocate £75 million of capital budget to eliminate out-of-area placements by delivering additional capacity to improve local mental health inpatient provision. • Invest an additional £20 million in the Connected Care Records programme for all systems. • Continue to drive adoption of the NHS Federated Data Platform (FDP).

	• Set national standards for initial priority care technologies and publish guidance to support providers in implementing technology effectively. • Use the new NHS Performance Assessment Framework to drive the required focus and improvement that will support UEC recovery. • Identify which systems require the most support and intervention.
System winter plans should include	• Delivery approach to strengthening the childhood vaccination offer. • Delivery approach to the year-round RSV vaccination programme for older adults and pregnant women, ensuring all those in the older adult catch up cohort (75 to 79) have been offered a vaccination by 31 August 2025. • Stretching plan for flu vaccine uptake by NHS staff with a target percentage increase on last year's uptake. • Winter virus resilience plans against the infection protection and control (IPC) mechanisms available both in and out of hospital, including appropriate policies and procedures, appropriate cohorting spaces and exploring the direct admission of flu patients into community bedded capacity. • How NHS providers and local authorities (through health and wellbeing boards) will improve discharge and admissions avoidance. • How local partners are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for these individuals. • How systems intend to expand access to urgent care services at home and in the community, so patients don't need to attend hospitals unnecessarily. • How their clinical model will be configured and adapted to make sure that the most appropriate clinician is consistently available to provide continuity of care, proactively identify deteriorating conditions, support rapid assessments and join up more effectively with primary and community teams. • How local mental health providers can evidence that, when mental health patients are admitted to an inpatient setting, their stay will be as short as possible. This should include producing their own % reduction target of re-admissions for their highest intensity users, how the number of patients in out-of-areas placements will be reduced, and how to reduce the number of patients who need a mental health admission waiting over 24 hours

	• Evidence how teams will use FDP real-time data and forecasting tools to better manage demand.
NHS trusts	• Demonstrate plans to improve vaccination rates in health and care workers. • Have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments. • Acute trusts to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target. • To achieve the target of more children being seen within 4 hours, deliver effective utilisation of UTCs, children and young people's specific services and standards. • Acute trusts to set stretching local performance targets for daily pathway 0 discharges and profile them through the week. • Acute trusts and local authorities to set local performance targets for pathway 1, 2 and 3 patients. • Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC cohorting where it is effective and appropriate to do so.
Systems	• Some systems to test the use of health visitors to administer childhood flu vaccinations and other routine immunisations for eligible children. • Implement the "Release to Rescue" standard without exception, including in the winter months.
Integrated care boards	• Consider commissioning means of local advice and guidance (such as Healthier Together) so parents can navigate local systems and care provisions effectively. • Work with local authorities to ensure that BCF capacity plans include appropriate capacity for surges over winter, both for step-up and step-down care.
Ambulance trusts	• Operate a call before convey principle and enable "see and treat", supported by additional clinicians in emergency operating centres and single point of access. • Expand overnight support for 999 call handlers and clinicians to provide urgent in-home care for clinically assessed patients, with follow-up services available the next day. • Reduce the variation in rates of "hear and treat" and "see and treat".