The “new normal” in the National Health Service: sacrificing safety from A&E to discharge

Notes from a Resident Doctor

A resident doctor
1 November 2026

Below is the latest diary entry by a resident doctor at a National Health Service (NHS) hospital trust in England. The diary, written for NHS FightBack, exposes conditions in frontline healthcare and has been followed by thousands of NHS workers on Facebook and X.

I dread walking into A&E. Patients line the corridors, lie on the floor, and are crammed into a single room while acutely unwell. I am one of a small, burnt-out team trying to care for them all.

This is the “new normal”—and it is unsafe at every point, from A&E to discharge home. Patient and staff safety are being sacrificed to save money. The NHS is stumbling from one crisis to another, and winter will make it far worse.

The front door: triage abandoned

At my hospital, management are now diverting GP-referred patients straight to assessment units, bypassing ED [Emergency Department] triage entirely — all in the name of cutting waiting times and costs. Without thorough triage and holistic assessment by the specialist emergency team, serious diagnoses will be missed. A patient referred straight to the surgical assessment unit with abdominal pain, without triage, could be having a heart attack and need urgent cardiology instead. Patients are also being moved straight from ED to the wards without a senior review. These are deliberate policies that sacrifice safety for savings, and they kill.

The department behind that door is hollowed out. We see over 100,000 patients a year in our A&E with only half the recommended minimum of 25 consultants. When we demanded more staff, a senior manager replied that the trust is in a difficult financial position, so the only way they can increase posts is to take them from elsewhere in the organisation.

Every day last month across England, an average of over 3,300 patients received treatment in the hallways of an A&E department or in a ward without a bed. A total of 100,000 instances in one month.

Patients go hours without critical antibiotics, pain relief, or even basic observations. One patient with a perforated appendix waited over 12 hours for emergency surgery and ended up in intensive care because of the delay. Another described their admission to me: observations taken once, no blood tests, no food, for over 10 hours. An intimate breast examination had to be conducted in a corridor. Another patient lay exposed in the corridor, with no curtain and no dignity.

The Royal College of Emergency Medicine’s (RCEM) report confirms the scale of what we see every shift: 15,860 preventable deaths in England in 2025 as a result of delayed treatment—one additional death for every 72 patients forced to wait 8–12 hours. This is not an accident of a “tough winter.” It is a ten-fold increase from 1,657 preventable deaths in 2015.

The RCEM report notes that staff are being broken alongside patients. Ninety-seven percent of clinical leads say the overcrowding is unsustainable. One healthcare worker put it plainly: “The working conditions are inhumane… morale is non-existent.”

The ward: beds before patients

Once past the front door, patients enter a system that cannot find them a bed. Our hospital has been running at Operational Pressures Escalation Level (OPEL) 3 since August, with scattered days at OPEL 4—the highest level, meaning the system faces extreme pressure and cannot deliver comprehensive care.

The RCEM report identifies that general and acute bed occupancy averaged 93.1 percent in England, well above the maximum level at which a hospital can operate safely (85 percent).

Consultants and registrars—whose job should be purely clinical—have to spend a large proportion of their day organising beds rather than focusing on unwell patients. This creates a conflict of interest, as they are pressured to discharge patients early

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to bring in more.

The ward itself is unsafe. One of my patients was hypothermic overnight because of the cold weather and the hospital's failure to maintain heating, despite maintenance issues being raised months ago. There are sometimes not enough side rooms to isolate patients with infections such as COVID, flu or E.coli diarrhoea, spreading disease across the whole ward. Patients are denied side rooms even at the end of life.

Discharge: nowhere safe to send them

When patients are ready to discharge, the options are limited. On an average day in England, 12,906 patients were medically fit for discharge but remained in a bed, largely because safe discharge is impossible due to the collapse of social care. Many forced to stay end up catching hospital-acquired infections, which delay their discharge further. One of our patients who was medically fit and waiting for a package of care subsequently contracted hospital-acquired pneumonia and died in hospital.

Others are discharged too early and unsafely because of bed pressures and return to A&E within days to repeat the cycle.

Winter will escalate the crisis

This is the state of the NHS weeks before winter has even begun. Viruses like flu and COVID are spreading rapidly. NHS England's medical director says, "The number of admissions for flu are the highest that I can remember seeing at this time of year, and it's coincided with just the start of the expected increase in COVID cases in our hospitals."

Trusts are already declaring critical incidents. Nottingham's two major hospitals did so after A&E departments saw three of their highest attendances on record in two weeks. York and Scarborough hospitals face a shortfall of dozens of beds.

But as leading emergency care doctors have warned, the NHS has reached the point where, "we can't tell where one crisis ends, and the next begins." Dr. Vicky Price, president of the Society for Acute Medicine, put it sharply, hospitals are not heading into a winter crisis, they are "carrying an existing healthcare crisis into winter." She added, "The reality is that these problems have been building for years."

The causes are systemic: bed shortages, staffing collapse, gutting of social care—all the result of decades of underfunding by Tory and Labour governments alike.

Had funding risen in line with 2010–11 levels over the past 15 years, the NHS would have received roughly £54 billion more each year! Instead, Health Secretary Yvette Cooper's recent pledge of £140 million to "boost" urgent care is a drop in the ocean compared with the scale of the crisis they've helped create.

The government pursues a cost-cutting programme disguised as "efficiency savings"—£17 billion in savings over three years as the result of productivity increases and up to 100,000 job losses by 2028—while channelling resources to private profiteers and the military.

The fate of the NHS rests with us

Our union, the BMA [British Medical Association], has responded with absolute silence. Their refusal to address our working conditions, and their cancellation of our strikes for pay restoration and specialty training jobs, paint a clear picture that they will not fight for us, our patients, or the NHS.

The Starmer government, which refused to respond to the RCEM's appeal for "urgent action", has been replaced by Andy Burnham, who pledged £8.4 billion for the nuclear-armed submarine programme, to be paid for by welfare cuts. The trajectory is unchanged: austerity and war, while the NHS is starved.

We cannot entrust the defence of the NHS to the Labour government or the BMA leadership. We on the frontline know the real conditions: unsafe wards, unpaid overtime, burnout. We must now take responsibility for conducting the fight ourselves.

As 1.4 million NHS workers, we have the strength to unite and organise independently to defend the NHS—for all who work in it and rely on it.

I urge my colleagues to contact NHS FightBack and report on conditions at your own A&E and hospital trust. We need to break the wall of silence and build a network of rank-and-file workplace committees to organise the opposition!

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