

To: • Trust chief executive officers and chairs

cc. • Trust medical directors and directors of nursing

• Regional directors

NHS England
Wellington House
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4 March 2026

Dear colleagues

Additional actions to virtually eliminate corridor care

We all know that corridor care is unacceptable; it creates an exceptionally poor experience for patients – particularly older patients – and their loved ones, generates low morale for our staff, and undermines the public's confidence in the ability of the NHS to provide safe care when they need it most.

This year, a number of colleagues have gone to great lengths to eradicate or significantly reduce the incidence of corridor care, and to mitigate its effects where needed. It is evidence that with the right leadership ambition and focus we can do much more to prevent corridor care in the future.

Over the last few weeks, we have worked constructively with the Corridor Care Coalition – representing patients, staff and the public – on this issue, and want to thank them for their leadership and challenge on behalf of both patients and staff.

Responding to their collective constructive challenge, we write to inform you of the following actions we are now taking, in addition to existing work led by GIRFT.

Increasing visibility and transparency

We agree with the Corridor Care Coalition central ask that the starting point needs to be consistent transparency on the extent to which patients are experiencing – and staff are having to deliver – care in non-designated areas.

To that end we have engaged with clinical and professional groups on a single definition of 'corridor care' to be shared across the NHS.

In summary, a patient has experienced corridor care if they have spent at least 45 minutes in a clinically inappropriate area of an emergency department or general and acute ward.

Ambulance handover delays should continue to be reported separately and monitored alongside corridor care to ensure efforts to reduce corridor care do not lead to longer waits in ambulances outside the hospital.

The 45-minute threshold for corridor care aligns with the W45 protocol for ambulances. We aim to revise both down to 30 minutes in 2027/28 once demonstrable progress has been made.

The full definition and worked examples accompany this letter [and are on our website](#). These should be used consistently from now on, both internally to your organisation and in discussions with system, and regional and national colleagues.

Based on this definition, we will begin collecting data on corridor care and will publish it, subject to data quality, each month from May 2026 on NHS England's website.

The newly defined corridor care measures will need to be submitted in the UEC Daily Sitrep collection. New fields to collect these data will be available for completion from 6 March. At the same time, the current fields used to collect Temporary Escalation Spaces will be stood down.

If you have any questions about the definitions, please email england.DailySitRep@nhs.net.

For questions about beds, please email england.bedsanddischarges@nhs.net.

For technical questions about the submission of your data, please email nhsi.SITREPSupportTeam@nhs.net.

Additional national-level actions

In addition to increasing consistency and transparency of what we measure, we will be taking forward the following national actions over the coming months.

1. **Supporting operational and clinical improvement** – we will shortly publish a **Getting It Right First Time improvement guide** on corridor care based on learning from the team's work on the ground with the most challenged organisations. The GIRFT programme's intensive on-the-ground work with the most challenged trusts will also continue.
2. **Increasing public awareness of ED alternatives and preventative actions** – we will review national communications' campaigns and resources for local use on community-based alternatives to Emergency Departments and avoiding hospital admissions, to ensure they are effective.
3. **Clarifying escalation and incident reporting** – our recent [Principles for providing patient care in corridors](#) guidance reminds trusts of the importance of internal oversight, escalation and incident reporting. We will refine these further to make it clearer that trust boards should take formal ownership of corridor care as an organisational risk, that any proposed use of corridor care should be approved at executive-level, and that all individual cases meeting the criteria in the definition should be reported as an incident.
4. **Supporting trusts and systems to implement existing guidance on improving urgent and emergency and acute care** – including the [Model Emergency Department](#), [Extended emergency medicine ambulatory care operating principles](#), [Model Acute Pathway](#) and the [FRAIL strategy](#), to embed important measures which can make a difference to the timeliness and efficiency of care, including timely assessment by senior doctors, particularly for older people with frailty.

5. **Prioritising the eradication of corridor care as part of wider ongoing work on new care delivery standards** – we are currently developing a new **Urgent and Emergency Care Strategy** through which we will set out priority work to improve the whole pathway. Additionally, as part of other ongoing work across NHS England, we will:
 - a) **set expectations of the role of senior clinicians.** As part of the **National Care Delivery Standards** – within the **Quality Strategy** workstream – we will set further expectations on access to consultants and other key professionals to support clinical decision making
 - b) **review the Section 136 pathway, including the role of places of safety, and ensuring clear alignment with the development of Mental Health Emergency Departments.** This work aims to improve the experience and care of people in mental health crisis and reduce the need for prolonged stays in Emergency Departments, as part of the wider programme to strengthen the national mental health crisis care model
6. **Supporting the workforce** – as part of ongoing work on the **10 Year Workforce Plan**, we will consider UEC and acute staffing models, and further support for staff who may be required to provide care outside of their normal environment.
7. **Co-produce further actions local leaders can take to reduce corridor care and improve support for staff and patients** – working initially with the 30 trusts facing the biggest challenges, as set out in the following section.

Co-producing further trust-level actions

On 26 February we convened CEOs, chairs, chief operating officers, medical directors, chief nurses and directors of communication from 30 trusts assessed as facing the biggest challenges on corridor care.

The purpose of this summit was to discuss and develop additional actions to support the eradication of corridor care which are more amenable to local ownership rather than national direction.

I want to thank those colleagues who attended for the positive and proactive approach to owning and solving these challenges displayed in the room.

There was a clear consensus in the room on the importance of:

- trust boards owning and treating corridor care as an organisational risk, including making reviews of corridor care and incidence data a standing item at trust board meetings
- trust executives regularly walking the corridors and wards, including out of hours, to speak with patients who have been waiting more than 12 hours, and to staff
- trust chief executives, medical directors and chief nurses regularly chairing hospital discharge meetings to better understand actual system blockages and ensure effective discharge planning

- trusts taking steps to improve the capture of near real-time patient and staff experiences of corridor care to inform action and board oversight – which we will develop a support offer on
- trusts setting and enforcing clear professional standards and expectations on senior clinicians to lead organisational responses to situations where corridor care is being used or is at risk of being used

Each of the 30 trusts is now rapidly developing their own set of commitments for action over the coming months. To support further improvement, we will assess the real-world impact of these actions to inform future guidance for all trusts.

I said at the beginning of this letter that we all know that corridor care is unacceptable. Where colleagues have made the biggest difference this year leadership teams have adopted this as an organisational policy, and acted accordingly.

So while there are many factors at play in corridor care which are beyond the direct control of individual trusts, let's all emulate those colleagues who are showing the way on this, and ensure we are doing everything within our control to eradicate corridor care, and give all our patients the quality, safety and dignity of care they deserve.

Yours sincerely



Sarah-Jane Marsh CBE

National Director of Urgent and Emergency Care and Operations

NHS England