

Corridor Care Improvement Plan

Quality Assurance Committee

20th August 2026

Presented for:	Assurance and Information
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Previous Committees:	Quality and Safety Assurance Group 13 th August 2026

Freedom of Information Act (FOIA) Exemption	☐ YES (restricted from the FOIA) ☒ NO (available to the public under the FOIA)
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Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Quality of care
Link to CQC Well-led Statement	Shared Direction and Culture
<u>Regulatory Impact</u>	Regulation 9: Person-centred care

Key points	Purpose
1. To update the Committee on progress with identification, monitoring and prevention of harm to patients in acute and emergency care pathways	Assurance
2. To provide assurance that actions are progressing in line with the agreed plan to eradicate corridor care	Assurance

<u>Risk Appetite Framework</u>			
Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	Workforce Performance Risk - We will deliver safe and effective patient care through having the right systems and processes in place to manage performance of our workforce.	Cautious	Operating outside
Operational Risk	Health& Safety Risk - We will protect the health and wellbeing of our patients and workforce by delivering services in line with or in excess of minimum health & safety laws and guidelines.	Minimal	Operating within
Clinical Risk	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could	Minimal	Operating within

	limit the ability to achieve safe and effective care for our patients.		
Financial Risk	Financial Management & WRP - We will deliver sound financial management and reporting for the Trust whilst seeking to deliver against Waste Reduction targets but always with a focus on maintaining and enhancing patient safety.	Minimal	Operating within
External Risk	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Cautious	Operating outside

1. Summary

In common with other NHS trusts, overcrowding in LTHT Emergency Departments (ED) and inpatient wards has resulted in the use of corridors and other non-clinical spaces to accommodate patients awaiting assessment, treatment or admission. This reflects wider challenges in patient flow, capacity and system coordination, and results in care being delivered in environments that may not meet expected standards of safety, privacy and dignity. An Executive-led improvement programme has been established with the objective of eradicating corridor care in LTHT by or before 2029, in line with NHSE ambitions.

This monthly update paper describes the numbers of patients experiencing corridor care in LTHT during July 2026 (Emergency departments) and June (Inpatient areas), and details progress against the patient flow action plans. It also offers assurance about the safety of patients experiencing corridor care.

2. Patients experiencing corridor care in LTHT – data for July 2026

2.1 Emergency Departments

In line with national guidance, LTHT has reported a daily count of the number of patients who received corridor care in the EDs for more than 45 minutes within the previous 24-hour reporting period (from midnight to midnight), in the same way that attendances are reported.

The total number of patients who experienced corridor care for more than 45 minutes within LTHT Emergency Departments during the period 1–31st July 2026 was 1,227, representing an increase of 37 patients compared with June 2026.

While the marginal increase is disappointing, July 2026 recorded an overall increase of 83 attendances across both sites. Although this change is not statistically significant, the increase was predominantly observed at the SJUH site. Notably, despite this rise in demand, the number of corridor care spaces utilised at SJUH reduced by 28 during the month. This provides assurance that the strengthened focus on minimising corridor care is becoming embedded in operational practice, with corridor care being used only when all other clinical spaces are exhausted. Ongoing monitoring and oversight continue to support compliance with this approach. Continued delivery of the actions outlined in the improvement plan (Appendix 1) is expected to support the sustained reduction of corridor care and drive further improvements over the coming months.

2.2 Progress on actions (July 2026) to mitigate risks and reduce corridor care in the EDs

The LTHT Full Capacity Plan (FCP) continues to reference all identified corridor care areas. Although it was anticipated that a number of these areas could be decommissioned, sustained high patient attendances and ongoing challenges in achieving timely patient flow from the Emergency Department (ED) have limited progress in this regard.

The actions outlined within the improvement plan remain in place and continue to focus on strengthening patient flow throughout the organisation. It is anticipated that the impact of these measures will become increasingly evident over the coming months. Progress will continue to be closely monitored, with a revised ED Full Capacity Plan scheduled for completion by the end of August.

Escalation and Governance Arrangements

To strengthen oversight and ensure corridor care is utilised only as a last resort, a revised escalation framework will be implemented from 17 August. This framework requires a robust review by both the ED team and the Operations Centre prior to the initiation of any corridor care arrangements.

The new process will provide greater assurance through the collection of data on the frequency of corridor care use, confirmation that all available alternatives have been exhausted, and evidence that a full trust operational response has been enacted. This will include, during normal working hours, review by the Urgent Care Tri Team and, out of hours, oversight by Clinical Site Managers and the on-call team.

The enhanced governance arrangements are intended to reduce reliance on corridor care, improve organisational responsiveness during periods of operational pressure, and provide valuable intelligence on the actions most effective in supporting ED performance and patient flow.

2.3 Patients experiencing corridor care on LTHT inpatient wards

Standard corridor care audits have been undertaken across inpatient corridor care areas by the Corporate Nursing Team (see Appendix 2 for summary findings). The data and themes presented relate to inpatient areas only and cover the reporting period of June 2026.

June 2026 saw a reduction in the utilisation of inpatient corridor care spaces compared with May 2026. Encouragingly, there were no reported incidents of moderate harm or above associated with corridor care during the reporting period.

Audit findings demonstrated a slight reduction in the number of Datix reports submitted, alongside an improvement in patient experience measures, with only one negative patient comment recorded. While continued vigilance is required, these findings indicate a positive trajectory in both patient experience and the safe management of corridor care areas.

The revised compliance monitoring process, which has included enhanced oversight and challenge from the Director of Nursing, has demonstrated a positive impact on adherence to expected standards. As a result, this approach will be maintained to support ongoing quality assurance, governance, and continuous improvement.

2.4 Assurance regarding the safety of patients in corridor care spaces in ED

Urgent Care services operate under an agreed Standard Operating Procedure (SOP) for safety rounding for all patients cared for within the EDs. Oversight is provided by the nurse in charge on each shift, and data is recorded locally using Symphony and CEM Books.

From 1 June 2026, the senior leadership team have implemented additional 2-hourly safety and dignity checks for all patients experiencing corridor care. The audits demonstrate improving governance and oversight arrangements, with evidence of strengthened compliance with several safety standards and enhanced documentation of corridor care escalation processes. The reviews have identified persistent challenges in completing assurance audits consistently, particularly within LGI, limiting the ability to provide comprehensive assurance. Actions remain focused on improving audit completion rates, strengthening staff compliance with safety checks and patient communication requirements, and increasing operational oversight to ensure corridor care is delivered in line with agreed standards while reducing associated patient safety risks.

2.2 Progress on workstreams to eradicate corridor care

An Executive-led Task and Finish Group has been established to provide strategic leadership, oversight and assurance of the improvement programme required to eliminate corridor care within LTHT at the earliest possible opportunity. The Group meets weekly to review progress, monitor delivery against agreed milestones, address risks and barriers, and ensure organisational alignment across the key workstreams.

Appendix 1 sets out the improvement plan, including the agreed objectives, milestones, timescales and performance measures. The appendix also provides an update on progress to date and details the actions currently underway to support delivery of the programme.

In addition to the improvement plan, a focused 30-day improvement event was undertaken from on 23 June 2026. The event was being led by Directors, with daily involvement from tri-team leadership to ensure a coordinated and system-wide approach. The 30 day event

highlighted that while bed capacity pressures remain a significant contributor to corridor care, 12-hour waits and delayed admissions, operational processes across the patient pathway are also driving avoidable delays. Analysis of incident reports identified recurring themes including delayed discharges, late ward rounds, bed-board communication issues, delays in transfer and transport arrangements, and prolonged periods where beds remained unoccupied despite high demand. The review demonstrated that patients frequently waited for extended periods after a bed had been allocated because beds were not ready or supporting processes had not been completed. Positive engagement through the event has improved organisational understanding of flow challenges and reinforced the need for greater accountability across bed-holding specialties

The 30-day flow event concluded with four priority actions: implementation of a 45-minute bed turnaround standard across all bed-holding CSUs; development of specialty-specific plans to eliminate avoidable 12-hour breaches; strengthening of governance and assurance arrangements for corridor care; and regular reporting of patient flow improvement activity through site Patient Flow Groups. These actions are intended to improve bed utilisation, reduce delays in patient admission and discharge, strengthen accountability for flow performance, and support delivery of safer patient care ahead of winter pressures. An update will be provided in September paper.

3. Quality and Performance Implications

Eliminating corridor care will improve patient safety, privacy, dignity, and overall quality of care by ensuring patients are treated in appropriate clinical environments. It will reduce risks associated with delayed patient placement, availability of bed headed services, limited observation, and compromised infection prevention and control.

The proposal is expected to have a positive impact on patient and staff experience, supporting safer clinical practice, improved multidisciplinary working, and staff wellbeing.

There may be short-term operational pressures during implementation, including impacts on patient flow and waiting times if capacity is constrained. These risks will be mitigated through strengthened patient flow, discharge planning, and ongoing performance monitoring.

Overall, the proposal is expected to deliver a positive quality impact while supporting compliance with national standards and improving patient outcomes.

4. Financial Implications

The elimination of corridor care may require investment in workforce, capacity and patient flow initiatives, funded through existing approved resources and/or identified system funding. Any additional expenditure will be subject to the Trust's standard approval processes.

The proposal is expected to deliver significant quality and safety benefits, including improved patient privacy, dignity and clinical outcomes, alongside reduced clinical risk and enhanced staff and patient experience. A Quality Impact Assessment (QIA) has been undertaken and identifies an overall positive impact on quality of care.

There are no material VAT implications associated with this proposal. Any VAT incurred will be managed in accordance with NHS VAT regulations and recovered where applicable.

No actual or potential conflicts of interest have been identified in relation to this proposal. Any procurement activity arising from implementation will be undertaken in accordance with Trust procurement requirements and relevant legislation, including the Bribery Act 2010.

5. Risk

The proposal supports the Trust's low risk appetite for patient safety, quality and regulatory compliance by reducing the risks associated with providing care in non-designated clinical areas. Eliminating corridor care is intended to reduce risks relating to patient safety, privacy, dignity, infection prevention and staff wellbeing.

Implementation may create short-term operational and financial pressures, including impacts on patient flow, bed capacity and elective activity. These risks will be managed through existing operational governance, escalation processes and system-wide working with partners. The external environment remains challenging due to sustained demand and wider health and care system pressures; however, the proposal is aligned with national policy and regulatory expectations.

The key risks relate to patient safety, operational performance, workforce capacity, financial impact and regulatory compliance. These risks are reflected within the Trust's Corporate Risk Register (CRR10) and will continue to be monitored through established governance arrangements.

The proposal supports the Trust's statutory duties to provide safe, effective care and is not considered to represent a material change to the Trust's overall risk appetite.

6. Communication and Involvement

The programme to eliminate corridor care has been developed through engagement with clinical and operational leaders and will continue to be supported through established governance arrangements.

Implementation will be accompanied by a communication and engagement plan to ensure staff, patients, partners and the public are appropriately informed and involved. Progress will be communicated through existing internal and system forums, with feedback used to

inform ongoing improvement. Regular updates will be provided to the Board through established reporting mechanisms.

7. Impact on Equality & Health Inequalities

An Equality and Health Inequality Impact Assessment (E&HIIA) has not yet been completed, as this paper sets out the strategic approach to eliminating corridor care rather than specific service changes. An E&HIIA will be undertaken where required as individual workstreams are developed and implemented to ensure any equality or health inequality impacts are identified and appropriately mitigated.

8. Recommendation

This paper is for information and assurance of the mitigating actions in place to maintain quality and safety across pathways and eradicate corridor care in LTHT.

9. Supporting Information

Restricted from the Public Domain