

Health and Social Care Committee

Oral evidence: Corridor Care, HC 1757

Wednesday 11 March 2026

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Alex McIntyre; Joe Robertson; Karin Smyth; Gregory Stafford.

Questions 1-88

Witnesses

[I](#): Dr Rosie Benneyworth, Interim Chief Executive, HSSIB; Dr Ian Higginson, President, Royal College of Emergency Medicine; and Professor Ranger, General Secretary and Chief Executive, Royal College of Nursing.

[II](#): Karin Smyth MP, Minister for Secondary Care, DHSC; Professor Tim Briggs, National Director for Clinical Improvement and Elective Recovery and Chair, Getting It Right First Time (GIRFT) Programme, NHS England; Sarah-Jane Marsh, National Priority Programme Director for Urgent and Emergency Care, NHS England; and Kelly McGovern, Chief Nursing Officer, West Hertfordshire Teaching Hospitals NHS Trust.

Examination of witnesses

Witnesses: Dr Rosie Benneyworth, Dr Ian Higginson and Professor Ranger.

Q1 **Chair:** Welcome to this one-off session of the Health and Social Care Committee on corridor care. There is a lot of public interest, a lot of interest in the sector, and a lot of interest from patients and staff in this important and pressing matter. We have two panels today. May I start by asking the members of the first panel to briefly introduce themselves and their organisations?

Dr Higginson: I am Dr Ian Higginson. I am an emergency physician working in Plymouth in the south-west of England and I am president of the Royal College of Emergency Medicine.

Dr Benneyworth: Good morning, everyone. I am Dr Rosie Benneyworth. I am the interim chief executive of the Health Services Safety Investigations Body. We investigate national patient safety concerns across England and make recommendations to national bodies about what needs to change.

Professor Ranger: Good morning. I am Nicola Ranger. I am the general secretary and chief executive of the Royal College of Nursing, representing over half a million nursing members. Previously, I was a chief nurse in hospitals for 10 years.

Q2 **Chair:** Thank you, all three of you, for being with us. We are grateful to the Royal Colleges, which are very good friends of this Committee. This is the first time that HSSIB has given us public evidence in this Parliament. For people who might not know what HSSIB is, what do you actually do and where do you sit in the landscape of patient safety?

Dr Benneyworth: We are an arm's length body set up under the Health and Care Act 2022. We have been operational since 2023. We undertake national investigations into anything that is causing patient safety concerns. We look at all sectors—the acute sector, community, mental health, primary care—and the transitions between them. Our investigators are skilled, and many have a background in other safety-critical industries, including military, aviation, nuclear and legal. We go out and observe what is happening across multiple sites, working with national stakeholders and local stakeholders. We work extensively with patients and their families who have experienced harm.

When we have undertaken an investigation, we make recommendations to the national bodies about the areas we have had concerns about and the things that we think need to be addressed. Those organisations then have three months to respond to our recommendations, and we publish their response on our website. We have great examples of impact over the past three years, where we have seen lives being saved as a result of our work.

As well as our national investigations, we want to professionalise local investigations. We often hear that local investigations can be done quite poorly; they often do not involve families and patients very well; and they can blame individual staff members, which can be devastating for the staff involved. We therefore have a programme of work looking at how we can improve local investigation quality, support local investigators and professionalise their roles.

Q3 **Chair:** What caused HSSIB to want to look at corridor care?

Dr Benneyworth: We work extensively with patients and families and other organisations. We heard repeatedly about concerns with patient safety in temporary care environments, so we looked at exploring the management of patient safety risks in such environments, and we found widespread use of those environments. When we talk about temporary care environments, we are talking about areas that are not set up for patient care. We found the use of corridors and chairs, and sometimes store cupboards, gyms and all sorts of areas that were not designed for patient care were also being used.

Q4 **Chair:** Thank you. Nicola Ranger, you have been very vocal on this. Do you agree with the findings of HSSIB's inquiry? What extra have your members reported on this issue?



Professor Ranger: We absolutely agreed with the findings of HSSIB, but I think our real concern, more than anything, is that that care is being normalised. We can see standards of care that, post pandemic, have probably been normalised, but would have been seen as totally unacceptable in 2019.

I think there has to be a rebalancing. Our members started really pushing us and saying how shocked they were from 2023 onwards, post pandemic, but the real harrowing bit for us was last year, when we put out a survey over Christmas and new year. If I am honest, we were expecting our members to have things to do in their time off other than filling in our survey, but we received 5,000 testimonies of harrowing experiences—of how they felt, as nurses, looking after people in a way that they felt ashamed about. We felt very strongly that our members' voices had to be the wake-up call to say, "We cannot normalise this. This is not what any of us would want for people in this country." As a college, we got behind this to say, "Enough's enough. We have to sort this out as a country."

Dr Higginson: Our membership absolutely welcomes the report. It demonstrates the need for truly independent investigation bodies working to look at this sort of stuff. It absolutely reflected the reality on the ground for our patients and, importantly, our staff.

We also recognise the tension between trying to mitigate the effects, which is where a lot of the findings in that report were cited, versus normalising the phenomenon. When we wrote our own guidance on crowding, we stuck all the mitigation at the back, to try to get that message and say: "This is guidance we shouldn't be having to write. It's stuff that we shouldn't be having to talk about." We are able to quantify some of the risks that HSSIB was unable to for patients.

From our point of view, corridor care is a visible symptom of overcrowding, which is a national issue, a national crisis and a national scandal. It is caused predominantly by long waits for admission to hospital. There is absolutely no safe or acceptable way to provide care for patients in corridors or other non-designated spaces, whatever we try to do. It just cannot be done. Also, it is not inevitable; this can be fixed. We have been talking about this issue loudly since 2015; we wrote our first guidance on the subject back in 2014-15. It has been progressively getting worse. We have not seen any improvement in reality over all that time. We cannot understand why it has not got the focus it deserves, because it is actively killing patients. As Professor Ranger pointed out, it is actively harming staff.

Q5 **Chair:** I note that you said "truly independent" about that investigation. There is a national conversation happening right now about where HSSIB should sit in the system. The current plan, under the NHS organisation Bill to come, is that it will sit under the CQC. Dr Rosie, could you comment on how important that independence is? What does that mean for your investigations? If the Government insist on this current plan, what will need to happen to make sure that that is not compromised?



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Dr Benneyworth: There are two aspects that we feel are really important. One is around independence and one is around protected disclosure. Independence is vital for us. We need the independence to be able to decide what we investigate—to make sure that nothing is being covered up and that no one is stopping us investigating what is important. We need the independence to be able to investigate the national system as well as the local system. Many of the patient safety risks are related to how the national system works, as well as what is happening on the ground, so we need to be able to look freely at the national system. We need the independence to make recommendations to all parts of the system without people telling us that we can't. That is what we mean by independence.

The other important part of our legislation, which is vital, is around protected disclosure. That means that everything that people talk to us about is protected by law. There are safeguards and caveats to that—if someone tells us something that is criminal in nature, we will escalate it—but it is absolutely vital for us. We so often get staff, members and patients telling us that they tell us things that they would not tell others, including a regulator, because they are fearful. We are still in a culture—the NHS culture, in parts—where there is a fearfulness about speaking freely and speaking up about things. It is vital that people have the safe space that they need to be able to talk about things that go wrong without fear of being blamed or losing their job. It is vital for patients, because sometimes they fear that if they talk freely, that will impact on their ongoing care in a provider. We feel that there definitely needs to be a firewall or some protection in terms of our identity, independence and ability to maintain protected disclosure.

Q6 Chair: Ian, one of the things I noted when reading your report was the concern that the fact that Government did not want to normalise corridor care and therefore did not put out guidance was in itself harming patients. What lessons can we learn for future crises like this that creep up and feel like they get worse every year? It should not have taken the Royal College to release guidance. Would it be right to say that the Government should have grasped that nettle when you were raising the alarm and that putting out guidance does not normalise it?

Dr Higginson: My advice would be to listen to patients, staff and professionals who are walking the walk. Our members and Professor Ranger's members work in emergency departments every day looking after patients, so we know what it is like. Our agendas are based around caring for patients and staff, a deep love for the NHS and a deep desire for the care that we deliver to be of the quality that we would like for ourselves or our families.

Despite the fact that we represent 15,000 doctors and advanced clinical practitioners, we have felt persistently that our voices have not been heard as they perhaps should have been. We have also felt that the patient voice has not been heard as well as it should have been. At times, I have wondered why. For instance, we know that, at a conservative estimate, some 16,000 patients a year are dying in association with long



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waits in emergency departments. That is a lot of patients. If this was any other sector, there would be howling rage. If it was an airline, we would be grounding aircraft. Yet this has been getting progressively worse, year on year. Again, at times it has been difficult to work out why our voices and the voices of other expert bodies have not been in play.

Chair: Thank you. We will no doubt raise that with the second panel.

- Q7 **Paulette Hamilton:** Good morning all. My question is about nurses and the wider staff in the NHS. Nicola, I have read the survey—it is absolutely brilliant—but could you tell me how nurses are feeling at the moment in that environment, with everything that is going on?

Professor Ranger: As Dr Higginson said, A&E nurses in particular have really felt that sense of pressure. There are patients in waiting rooms, corridors and all sorts of places, and they are worried about them. We have seen an increase in violence, aggression and frustration towards nursing staff, and they are often the ones closest to the patient. That has felt very difficult. It has now spilled out to wards. Many of them feel very ashamed about sticking patients on wards when they know that someone is stuck by a nurse's station, needs the toilet, or is dying and needs a quiet space. There is a real sense of anger and shame. The thing that worries me most is that they are losing hope. That is why there has to be a sense of urgency on this. They feel that this is just the way it is.

- Q8 **Paulette Hamilton:** I was a nurse myself and I took pride in what I was doing, the clothes I wore and how I looked after my patients. Is there a sense of embarrassment with everything that is going on?

Professor Ranger: I think there is. I think people are genuinely trying, but I was talking to a patient literally last week who said that there is a lack of eye contact because the nurses feel embarrassed. Those are symptoms of people almost just putting their heads down because they feel upset with what they are seeing. When patients are struggling to get eye contact from a nurse, that is not a good place to be. Nursing is a profession of safety, vigilance and care, and looking at someone is the best way to get a sense of that. I think that is a real symptom of many nurses not feeling proud of what they are doing. That is why I absolutely agree that this is an emergency. We cannot get to a place where people do not feel proud of what they are doing. We know that there are still pockets of brilliance. We know that. We are not saying this about everything, but it is about consistency. Nurses say that if their loved one was admitted at this moment in time, the first thing they would think is, "Who do I know in that organisation, to make sure my family is okay?" That is not okay. That is why we have to get on and get this sorted out and better.

Dr Benneworth: In our investigation we spoke a lot to staff working. First, we were completely impressed by the dedication and commitment of the staff, who were so motivated to make things as good as possible for patients, despite all the challenges. But we heard from staff at all levels that they were really struggling to care for people in corridors and those

temporary care environments. We heard expressions like, “This isn’t what I trained for.” We feel that causes moral injury for staff. As Professor Ranger said, negative emotions of guilt, shame and anger arise from staff not being able to provide the care that they want to provide. That was leading to fatigue and burnout.

We heard from staff about some of the practical difficulties, such as having difficult conversations with people, when they are in a corridor, about life-changing illnesses, and having to manage that to provide privacy, dignity and respect. We have identified, in our report, all the patient safety risks. Staff are aware of those risks but are often unable to change them. Having said that, we saw staff going above and beyond, and some amazing examples of mitigations that staff were putting in place to make patient care as safe as possible.

Q9 Paulette Hamilton: Dr Higginson, may I go a step further? I am a great believer in the idea that people’s mental health suffers from corridor care. What have doctors and others in your team seen of deteriorating mental health, just from having the light on 24 hours a day and not being able to rest properly?

Dr Higginson: I will start with staff and then move on to patients, if I may?

Paulette Hamilton: No, no. Just stick with staff.

Dr Higginson: Okay. On staff, we recently conducted a survey of our membership to help to inform this hearing. It was a survey of English emergency departments. Some 97% of clinical leads who replied felt that the current situation was unsustainable for working for the long term, and 50% felt it was unsustainable in the short term. Our trainees are the youngest people, just coming into it; they should be bright and absolutely loving everything that they are doing. Some 30% of them show active evidence of burnout on circulated training questionnaires, and 23% of trainers show the same. That is about moral stress and moral injury; both contribute to staff sickness and burnout.

From among the other words submitted in that survey, I will pick the word “disillusionment”. Often our staff feel that they are left to fend for themselves, with poor engagement throughout the system, and they often feel unheard and unsupported because it has been going on for so long, with little apparent mitigation. We agree with the finding of the reported increase in violence and aggression towards staff, which is now being related to corridor care.

Why does that matter? There is a human cost, but staff also reduce their hours, retire early or leave. I will give you some examples. I was round to dinner with a friend of mine the other day; he is a very experienced consultant. We started to talk about retirement and he said, “I love my job. I feel I’ve got so much to offer. I love emergency medicine. I don’t think I can go back and do another shift because I am embarrassed at the care that we are delivering.” Other quotes from our survey include “soul



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destroying”, “working conditions are inhumane”, “increased numbers of nurses crying after their shifts”. I can say, on a personal level, that I have experienced the phenomenon of avoiding eye contact.

A final example is the waiting room announcement. I am often asked to do it in my department. Why? I am a consultant, so it is part of the responsibility that I carry, but also many of the staff find it very difficult to simply go out into the waiting room, face the patients who have been waiting there for so long and explain what has been going on. Those are indicators. We should not have staff feeling like that in our health service.

Q10 Paulette Hamilton: What can we do to better support staff in these environments? I will start by saying that this should not be happening at all, but it is happening, so what can we do to better support staff in these environments?

Dr Higginson: Fix the problem—that is how we help staff do this. Our members simply want to offer brilliant emergency care to our patients. These are amazing clinicians—doctors, practitioners and nurses—and they can do an amazing job. However, they cannot do it in overcrowded departments, and we certainly cannot do it in the corridor. Fix the problem, fix the problem, fix the problem.

Q11 Paulette Hamilton: Give me one example of how the problem can be fixed?

Dr Higginson: The majority of the problem is essentially a result of a lack of availability of beds for our patients. If we had beds to admit our patients to, our departments would not be overcrowded, and they would function.

Q12 Paulette Hamilton: Would you say that, if we sort out social care—so, those blockages of beds—that would help with what is happening in corridor care?

Dr Higginson: There is no single solution. Undoubtedly, discharge from hospital into social care is one part of the problem, but the efficiency with which hospitals work and the number of beds available are also both factors in that. It is a really complicated beast, and there is no uni-solution, but there is a solution if you take the problem in the round.

Dr Benneyworth: On the point about fixing the problem, in 2022—on the back of one of our investigations into harms caused by delays in transferring patients to the right place of care—we made a recommendation to the Department of Health and Social Care to lead an immediate strategic national response to address patient safety issues across health and social care arising from their flow through and out of hospitals. Because of our concerns at that time, it was around ambulance handovers—

Q13 Paulette Hamilton: Sorry, for someone who does not speak that language, can you just clearly say what you are talking about?



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Dr Benneyworth: Sorry about that. We undertook an investigation in 2022, so four years ago, that looked at ambulance handovers, but the same problems were there then that are causing the problems now—it is about how patients flow through a hospital. At that point, we made a recommendation and raised this with the Department of Health and Social Care, and we said that there needs to be an immediate response to these concerns. Unfortunately, we were not satisfied that the response was adequate, and those risks, as we see today, have remained.

On your question about how we support staff, I agree that the first thing is to try to solve the problem. However, in the meantime, we have done some work looking at the impact of fatigue on staff, which is something that we really need to understand. If you work in any other industry, they have an organisational response to fatigue and fatigue risk management, which we do not in the NHS—we expect it to be an individual responsibility.

Q14 **Paulette Hamilton:** So they have no fatigue risk management in the NHS.

Dr Benneyworth: It is very limited, and that is something we have also investigated in the past. We have suggested that this is something that we need to learn from other industries and adopt. We also know that people very often speak up about concerns about what they are seeing, but very often those concerns are not listened to or acted on. We need to create much more of a learning environment in the NHS where people feel freely able to speak up and raise concerns, and where they have confidence that they are being listened to.

Q15 **Paulette Hamilton:** Are you trying to say that staff cannot talk to management about how they are feeling and what is going on?

Dr Benneyworth: We do hear that in some of our investigations, yes. Sometimes they feel that when they raise concerns, nothing happens as a result, so they give up on raising them.

Professor Ranger: There are things that we need to do quite urgently. We respect many of the things that the Government are doing, but they are looking at the medium and long-term. What are we going to do now? The real concern for us is, as you have said, the real impact on staff. We are pleased that there is at least a definition, and there is at least a sense of NHS trusts having to measure and account for the scale of the problem. Sadly, many trust boards—I am ashamed to say—do not even realise how many patients they have sitting in chairs for 72 hours, because it is not measured or recorded.

As the Secretary of the State says, the best disinfectant is sunlight. Well, we need to at least measure it if we want to see—to any degree—whether things are getting better or worse. I am pleased that NHS England is really leaning into those trusts that are struggling. That is right, and we are seeing leadership, but there are also some agile things that cost money that we did during covid, which ensured, regardless of the swabbing—that is a separate issue—that flow of patients out into social care and



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community settings. That includes things like “discharge to assess”. All of those criteria were done in the community and nursing homes, which has much better outcomes for patients. All of that, because of funding arguments, is happening back in hospitals. Some 50% of hospice capacity is currently closed when 42% of people die in beds—

Paulette Hamilton: Nicola, you will be able to bring out all of this, but I have been told my time is up, so I am going to say thank you all and hand back.

Q16 **Joe Robertson:** Do you think the Government’s new definition of corridor care—spending 45 minutes or more in a clinically inappropriate area—is the right one?

Dr Benneyworth: One of the things we raised in our report was that there was no definition, and that was causing, as we talked about, “sunlight”. There was no ability to measure what was happening. We need to have a definition so that we can measure and understand the scale of the problem. We therefore welcome the fact that a definition has been agreed on.

Q17 **Joe Robertson:** When I visited my nearest hospital, St Mary’s on the Isle of Wight, I saw people being cared for in corridors, in reception areas, in a cupboard—not one person, but two people sharing a cupboard— and people still waiting in ambulances. Will those waiting in ambulances count as being cared for in a corridor care setting, because if they are not, then clearly there will be pressure just to leave people in ambulances to keep the figures looking better? Is there any view or comment on that?

Dr Higginson: We do have a view. It is important to say that we are really pleased that the Secretary of State has made a commitment to end corridor care. That was a really welcome and brave commitment. For us, the problem is overcrowding. Corridor care, remember, is a symptom of overcrowding. It is possible to hide patients in all sorts of places that are not corridors.

The argument can be made both ways. If this new measure goes where other measures have not, that is great; we will take anything that makes a difference. We are a little bit concerned about the two aspects of the nature of the measure. First, as you alluded to, when is a corridor not a corridor? Secondly, we believe the 45-minute threshold will potentially lead to what you are describing as gaming, which could otherwise be called cheating on the figures. We are concerned that the definition is a bit complex and that we are going to see the sort of unwelcome behaviours that we have seen in the past with the introduction of new metrics. We think this metric potentially exposes us to that, but, on the other hand, if it makes a difference, we will take it, and we will work with it positively and hope that it does make a positive difference.

Q18 **Joe Robertson:** Is there not an issue here that we all know what inappropriate care looks like? We all know what an inappropriate waiting time is, and we all know what an inappropriate area for someone to wait from a clinical perspective is. If we just start measuring it now, does it not



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just become the benchmark on which to measure any improvement, or the opposite, from March 2026, despite it having already gone well beyond what is acceptable? How can we use the existing data to show whether there has been any improvement or not and avoid March 2026 being the benchmark to measure the future against?

Dr Higginson: On one level, we already have a well-established, validated metric for overcrowding, and that is the four-hour standard or indeed 12-hour waits. You could argue, if you want to look now at what is happening, look at the four-hour standard, the 12-hour standard or patient feedback and staff surveys. All those are metrics that measure the quality of emergency care.

The four-hour standard in particular will give you a measure. If we were seeing all our patients through the department in four hours, we would not have patients in corridors, cupboards, waiting rooms, ambulances or wherever else we hide them, because the vast majority of our departments would not be overcrowded. That is one side of the coin.

The other side of the coin is that this is shining light on a particular problem that has caught media, public and political attention, so it is welcome in that regard. As I said, however we do it, if it makes a difference, we will take it, but if it is just another measure that is not underpinned by effective action, as we have seen in the past, it will limit its value, just as the four-hour standard has proved not to be as valuable as it should have been.

Professor Ranger: I think that's right. As Dr Higginson said, we have already had the four-hour standard and the 12-hour standard, but I hope this measure will start to change things. There are many areas in a hospital where data on waiting times is not collected. I hope it will start to capture those people in cupboards, and those people who are stuck by the nurses' station and have been there for 24 hours. As I keep going on about, I met a patient who had sat in a chair for 72 hours; that was completely unrecorded experience and safety data. This measure will have to capture that.

But data is only going to be part of it. As has been said, A&E performance has been going down since 2010. The only thing that will truly make a difference is a genuine culture change that says "This is unacceptable. How are we going to start to make it better?" But we are pleased that at least this will start to capture the hidden examples that are often outside the emergency department. There is heartbreaking care both in the emergency department and certainly outside it.

Q19 Joe Robertson: Will someone waiting in an ambulance count as waiting in a corridor care setting? If they do not, a hospital or a Government that is looking to improve the corridor care figures will simply leave people in ambulances, thereby creating another massive problem.

Professor Ranger: The handover ambulance delay is captured separately, so it will still be captured. It will not necessarily be captured in the extra patient data, but data on people waiting in ambulances is



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captured now, so you will not be able to game it, because your ambulance handovers will not go up.

- Q20 **Joe Robertson:** But you could still improve your corridor care data by leaving people in ambulances. It may make the ambulance data worse, but it would improve your corridor care data. That is my issue: keeping someone in an ambulance rather than a cupboard is not a solution.

Professor Ranger: It is not the solution. People can game it now. I have been to a hospital where they told me that on the 45-minute handover delay for ambulance it was brilliant, but what they did not tell me was that five extra patients were stuck on the ward in order to achieve that. You can play all parts of the system off each other, which is why it will come down to culture. This is about people: it will take the commitment of trust boards, leaders and politicians. The data can be played off to say whatever you want, but we have got to make this about people and patients, and that requires culture and leadership.

Dr Benneworth: This is why it is vital that we do not see it as an ED problem. It needs to be seen as a whole-system problem. We need to look at risk right across the whole urgent and emergency care pathway, rather than just in one section of it.

- Q21 **Jen Craft:** I would like to move on to the standards of care and patient safety in the current situation. Dr Benneworth, you found that concerns around normalising corridor care present a barrier to trusts putting in place all the possible patient safety mitigations. Do we have to accept that corridor care is part and parcel of the system for the foreseeable future?

Dr Benneworth: There is a real tension here, because we do not want to see corridor care. In our investigation we saw that in those organisations that had accepted that it was happening and had put in place mitigations to deal with it, the environment was calmer and they were identifying patient safety risks. While we have corridor care and people being looked after in unsuitable environments, it is vital that hospitals put in place the protocols and adaptations needed to make sure that patient safety risks are identified. For example, if someone is in a corridor, it is very difficult to pick it up if they suddenly deteriorate, so it is really important that processes are in place and the hospital has really thought through how to pick up the early deterioration of patients.

Some of the equipment was not there; the oxygen supply and the emergency drugs and equipment were not easily to hand for people in these situations. While this is happening, and recognising that it is not acceptable and not what we want to happen, people need to think very carefully about how we make sure that patients are safe in the meantime.

- Q22 **Jen Craft:** Is it fair to describe corridor care as a way of spreading risk across the hospital and the wider health and social care system? And is it effective as a tool for managing that kind of risk? I can see Professor Ranger shaking her head quite firmly at that. Feel free to come in.



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Professor Ranger: I think that is how we have got into this mess—this whole normalisation. If you talk to nurses, they will say, “Well, we’ve got to spread the risk”. Risk is not something you spread; it is something where you sort out the problem and you get to it.

I think this is because, inch by inch by inch, we have compromised and normalised this and mitigated. Who is paying the price for that now? The staff and the patients. If we had stopped that slippery slope and put in those actions to mitigate right from the beginning, maybe we would not have got into this mess.

There are 14,500 people in England every day who are in hospital when they do not need to be. That is enough for 20 district general hospitals of patients every day in England who do not need to be there. Where is the focus on that? There is capacity in the system. There are nursing homes and there is availability for patients in other settings. I think that is where we have got to put some energy and focus, because my worry is this constant culture of mitigation. I totally understand it, but there has got to be a date and a time when we say, “This is going to stop.”

This constant idea that you just spread the risk is totally normalising this, and I think that is why we are having real difficulty turning this around, because we have mitigated so much, with plugs in corridors and corridor-care nurses. I went to a hospital that had put in extra patients in every single bay. They had put in nearly 80 extra beds in one hospital—five extra patients per ward. That is just squashed in bays, and it is totally normalised. It is for really good, understandable reasons—because people want to keep people safe and want to do the best they can—but, in the long term, that desire to do that has made this situation far worse.

Dr Higginson: What has happened over time is that the risk was all concentrated in emergency departments, so emergency departments became, rather than the safety net, the safety valve. It just got piled in and piled in to emergency departments until they could take no more patients and the apparently elastic walls stopped expanding.

Then, back in the late 2000s, something called the full capacity protocol came in. That was the idea that it would be safer to have one patient in a corridor on every ward than 30 patients concentrated in an emergency department. That is where the idea of risk sharing came from, as part of these so-called full capacity protocols.

Where they were introduced—they were not in every hospital—they then created problems on the wards for patients who were still in corridors, and for nurses who were there. But what invariably happened is that patients just kept coming into the emergency departments, so they filled up. So then we started stacking patients in ambulances, and, in some cases, that actually reduced the risk in the emergency departments.

I think what has happened, and what still happens, is that the risk is maximally managed in the ED. When the ED is absolutely full and everyone is crying out, “I’ve got a resuscitation coming in; I need a bed



now”, the risk gets spread a little bit. But we acutely feel in emergency medicine that this problem is not completely owned throughout the system, and indeed throughout organisations. The corridor care on wards is a tentative step towards risk sharing and ownership, but it is just a mitigation and the whole problem is not actually owned throughout organisations.

I occasionally have to step out of the ED to keep my skills up, so I go down to theatres for a day to practise my airway skills, and, my word, it is lovely down there! There is one patient at a time; there are loads of staff; there is coffee. It is a beautiful environment. That is exactly how I would want it to be if I had an operation—I would not want it any other way—so I try not to be angry; I try to be envious.

I then go back up to my department and I see our poor staff looking after patients in corridors, and our poor patients like that. It is like two different worlds in the same organisation, and that is one example of how risk is concentrated in very specific parts of organisations.

Dr Benneyworth: I want to talk about risk management. For some time, one of the things we have been calling for as an organisation is much better, much more effective safety management systems across the whole health and care system, learning from other industries. Other industries have much better ways of managing risk than we do, and we need to learn from them. A couple of years ago, we did a report on safety management systems and accountability across the system. There is lack of clear accountability across the health and care system. For example, no one is accountable for a patient’s safety as they cross between health and social care. We do not have effective risk management in ICBs—we found that in our report—to allow that balance of where we keep the risk across the urgent and emergency care system. As a result, everyone ends up in A&E—in the ED, as we have talked about. I think we need a fundamentally new approach to managing patient flow and patient safety across the system, looking at learning from other industries.

Q23 **Jen Craft:** Thank you; that was a helpful segue to my next question. NHSE is clarifying its current guidance with respect to escalation and incident reporting to make it clearer that trust boards should take formal ownership of corridor care, perhaps baking more of that accountability into the system. What do you think requires clarification in the current guidance on corridor care? Do you welcome trust boards taking ownership of that to provide a more holistic overview?

Professor Ranger: I do. I think that many organisations have got very large. As a result, some are not always seeing the reality, and hiding a little from it, if I am honest. It is one thing to read something on paper, but it is another thing to see it and listen to staff. Some organisations are incredible in how they listen and see what the reality is for their staff; there are others I speak to, such as nurses, who say that they have not seen their executive team at 10 o’clock at night ever, and that is not okay actually. There is something about real accountability and leadership, and that is what I think needs to happen. So much of what needs to get



better—which will be leaving hospital—is not always seen as interesting and new, but it is the vital thing. Trust boards need to really think about how they look at their data. There has to be that real sense of, “We have to get this better”, and the blaming has to stop. The system is an issue—we absolutely get that, especially thinking about social care—but there are always things that each organisation can do better. There is something about taking accountability for the bit that you can do and doing it well and leading it. I think that that could be stronger at the moment.

Q24 Jen Craft: Has anyone anything else to add?

Dr Higginson: Briefly. We can put all the effort we like into reporting systems, recording problems, documenting problems, and seeking reassurance and assurance, but that must translate into ownership of a problem at a board level and then throughout an organisation—ownership and leadership. There are dashboards—the red and green things; you are all very experienced people, so you know—but there are patients and staff at the end of them, so it has to become reality. That means going down to departments, looking yourself in the eye, talking with patients, and then feeling a sense of ownership of this as a problem. As Professor Ranger has pointed out, that has been variably present in organisations. Leadership does matter in this, but it also has to be linked to the right solutions and to absolutely dedicated, persistent action.

Dr Benneworth: Trust boards have a huge role to play, and the visibility of data will certainly help, but this is about culture and how you actually create that learning environment. How do you have that constant willingness to improve, to use data for improvement and not just for performance management? How do you tie together the decision making on quality and safety, financial delivery and operational delivery? At the moment, there is a huge focus on financial and operational delivery, yet we know that 13% of all healthcare costs are on safety failure. We need to make sure that those decisions are brought much closer together and that quality and safety is not seen as an add-on or something separate.

Jen Craft: My local hospital, Basildon, has corridor care, and I have seen it happen. It is really important to say that when I speak to patients being treated in the corridor, they are full of nothing but praise for the staff. They see the effort that the staff are putting in despite having to work under extremely trying circumstances. For your members, it is important that they hear that patients are very grateful for what they do.

Q25 Alex McIntyre: Dr Benneworth, I am keen to come back to one of your answers from a moment ago. You said that there are other sectors that manage risk much better. Can you give some examples of where you have seen positive experiences? What sectors could we be learning from? Where is that best learning that we can take?

Dr Benneworth: I spent some time with some of the aviation industry, and I know that there is a lot of debate. Healthcare is very complex, and we cannot compare it directly with aviation, but we can compare the way that they underpin everything that they do with effective safety science.



That drives all their decision making. They also have safety management systems and quality management systems that go through every level—internationally as well as nationally—of decision making. What that does is allow the proactive management of risk: risks are escalated and very much tied into the decision making about investment and prioritisation. They also have much clearer lines of accountability, so it is clear who is accountable for someone's safety at every level of the organisation. They have worked very hard on culture as well, so it is expected that people raise concerns about near misses and things that have gone wrong. That is encouraged and supported. Then they have very clear feedback mechanisms about what happens as a result of that.

Although we cannot directly compare industries, there is a huge amount of learning through all the other industries—the safety-critical industry. Fatigue risk management is another example. There are a lot of examples in other industries about how organisations recognise and manage risk. You cannot stop someone being tired or fatigued, but you can put in place things to support people so that they do not get to that state to start off with, and so that there is organisational responsibility for managing fatigue to make sure it does not lead to safety concerns.

Q26 Alex McIntyre: Thank you; that was a very thorough answer. I want to come back to the points that Dr Higginson and Professor Ranger made about culture and how we can drive cultural change across the organisation. On 4 March, NHS England wrote to NHS trusts about the additional action needed to eliminate corridor care. I have noticed that the Minister has come into the room. Cultural change is quite a big thing. It is difficult to do, and it requires a lot of buy-in. If you had one real action point that you would like to see from the leadership in NHS trusts to change the culture, what would it be? If you could issue a directive that the Minister could send out to NHS trusts to say, "Do this tomorrow", what would it be?

Professor Ranger: One thing I would like them to do tomorrow is exactly what we have said: go and see and speak to their departments, wards and patients at 10 o'clock at night and out of hours. The patient pressure is 24/7 and often people feel pretty alone at nights and weekends, when it is really difficult and there are fewer people around to support. They could at least listen, understand and then think, "What am I going to do tomorrow that is different, given what I have heard today?" It may even be something simple like getting some coffee for the staff. It is something tangible the next day that shows, "I have listened, and I have heard. I cannot sort it all out straight away, but I promise you that you matter, and we are going to sort it." That would not take that much.

Dr Benneyworth: There are a couple of things I would suggest. One is curiosity. Boards of trusts need to have their ears and eyes open to things that just do not seem right. The data might not show it, but they could be getting a sense that something is not right. It is about having the professional curiosity to dig into issues and to go and talk to people and listen to patients—particularly to patient complaints and incidents, making sure that those are leading to demonstrable change and action.



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The second thing is moving away from a blame culture. We still very much work by saying, when something goes wrong, “Who’s to blame for this?”, rather than thinking, “Actually, what are the systemic reasons for this happening? Why has this happened? How do we support the staff member where something has gone wrong, and how do we really learn from it?” It is about developing that culture of learning.

Dr Higginson: I asked my members this question in a survey, and 99% of them feel that the Government are not on to the right solutions at the moment. The feeling is that many of the national and local initiatives aimed at reducing overcrowding are pointing at the wrong part of the system.

Their message for MPs and our ministerial colleagues is that they would welcome a change to the “inaccurate political messaging” and a focus on admission avoidance. It would be welcome if that changed and we started looking at what we call the “backdoor” of emergency departments—getting beds for our patients. That is a complex issue, and there is not one solution. It is also about looking at primary care, in particular, and what that can offer, as well as social care and the way in which hospitals work. They also called for MPs—who perhaps do not feel able to—to simply go to local EDs and talk to staff who feel underestimated and undervalued, and to encourage hospital executive teams in particular to take ownership of this problem. That is the message from our 15,000 specialists.

Q27 **Chair:** Is this survey already in the public domain, or would you be willing to share it with us?

Dr Higginson: We undertook this survey last week and published it today. We could not get it to you in advance, and we spoke about that with the Clerk, but it is available to you now.

Q28 **Ben Coleman:** Thank you all for coming. I think we all agree that the fact that corridor care has become the norm is wholly unacceptable, and we have to repair the damage. One thing you talked about that struck me is the efficiency of hospitals, the role that boards see that they should playing and the effectiveness of boards. From what you are saying, by and large, hospitals are not efficient enough and boards are not doing their job well enough. This is not something that has happened overnight; it has developed over time. Dr Higginson, why do you think things have gone so wrong?

Dr Higginson: This problem has been a mixture of culture, history, resourcing and all sorts of things. When it comes down to it, from our perspective, my department is open 24/7, so the services that we require to deal with absolute emergencies—I am very lucky that I am in a major hospital—are on tap, 24/7. However, a lot of the hospital is not working into extended hours, and a lot of the hospital, and the system surrounding it, does not work at weekends. We see the effect of that over Christmas.

Q29 **Ben Coleman:** When I asked why things have gone so wrong, is it because there has not been pressure put on hospitals to do intelligent things like that?



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Dr Higginson: Thank you for refocusing me. There has not been ownership of or engagement with this evolving problem. There has been a reliance on doing the same thing over and over again—perhaps more of it—and expecting different results, rather than taking a step back and saying, “How can we redesign this system around the patients and their needs?”

Q30 **Ben Coleman:** Dr Benneyworth, if you agree with that, what role does the Government then play in ensuring that the system does the sort of thing that Dr Higginson described?

Dr Benneyworth: In our investigations, we see the direct link between productivity, quality and safety in virtually all our investigations, so it is vital that at every level we put quality and safety of care at the centre of all decision making.

Q31 **Ben Coleman:** Are you saying it is not at the centre at the moment?

Dr Benneyworth: Sometimes there is the potential for operational delivery, performance or financial performance to be divorced from the discussions.

Q32 **Ben Coleman:** How do we put them at the centre? You have said that several times, but the question I think we are all very interested in is: how?

Dr Benneyworth: We start with what is important for patients, and we listen to patients. We extensively engage with people to articulate what is important to them.

Q33 **Ben Coleman:** So you are saying we are not engaging sufficiently with patients at the moment?

Dr Benneyworth: I think it is probably mixed. I suspect there is good engagement in some parts.

Q34 **Ben Coleman:** You are all making a lot of very helpful statements, but it would be really interesting for us to understand, when you say, “These things should happen”, whether they are happening. When you say that something should happen, tell us how much it is happening and what could be done to make it happen if it is not.

Dr Benneyworth: I will use an example. There is a real opportunity in looking at effective quality and safety management systems across the system, as I said. That would bring together the decision making around quality, performance and financial delivery. The new quality strategy that is being developed is a huge opportunity to do that. I think there are opportunities that we could use to progress this—

Q35 **Ben Coleman:** As a former management consultant, I have used the word “opportunities” a lot. When I say there is an opportunity to do something, it means it should be done. Is that what you are saying?

Dr Benneyworth: Our opinion as an organisation is that we should be looking at effective quality and safety management across the NHS.

- Q36 **Ben Coleman:** Thank you; you have been very clear. Dr Higginson, can I ask about staffing, because I struggle with that? We talk a lot about staffing, just in numbers. You have said, in terms, “We’ve put more senior doctors into the system, but corridor care hasn’t eased.” Where do you think the extra capacity that you put in has actually gone?

Dr Higginson: Staffing is complex. Overall, our emergency departments are currently understaffed to do the job that they are doing, but so are hospitals and other organisations to work at their most effective. How we would be if we were not overcrowded is a completely different question, and I am sure that our learned colleagues in GIRFT will be looking at that as part of their efforts too.

- Q37 **Ben Coleman:** On staffing, just increasing consultant numbers is not the solution.

Dr Higginson: Increasing senior doctors will definitely help. We are down on senior doctors, but if we were not overcrowded, overall we would probably actually have enough doctors and nurses in our department. Most emergency departments are running an extra ward in addition to their department, in their corridors, and that soaks up resources and makes them very inefficient.

- Q38 **Ben Coleman:** Professor Ranger, does that ring true from a nursing point of view? Does corridor care feel like a staffing-level problem, or are staff having to plug gaps elsewhere—other problems in the system?

Professor Ranger: We still have 24,000 nursing vacancies in England in hospitals, and a significantly higher number in social care. There will be reports that say, “We’ve put more staff in,” but it is about where we put them in. We have probably spent money on extra teams—falls teams, pressure ulcer teams, urinary continence teams—but those closest to the patient, those people that are the lifeblood to keep things flowing, have not increased in number and probably still feel understaffed.

- Q39 **Ben Coleman:** If they are the lifeblood, why would hospitals be taking the decision to place new staff elsewhere?

Professor Ranger: I think it is a mitigation, with good intentions—and also because many people closest to the patient feel a bit trapped. They are at the most junior level and they earn the least. It is a way to progress. That is why there has to be reform for progression.

You asked earlier what we need to do around efficiency. It is many years ago that I was there, but the American system is so efficient. There is a 24-hour pharmacy—far too much happens late in the day in the UK—and a 24-hour ward clerk. We should be investing in those closest to the patient so there is no novice factor—so people can progress their pay but stay in the same job and so you have the most expertise closest to the patient. All that reform needs to happen.

There is another thing that we need to sort out: many of our patients waiting the longest are elderly patients, yet we have done very little to reform nursing homes and how we do things like that.



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Q40 Ben Coleman: I would like you to give us examples of where it is happening well. I can give you one: we had a very interesting corridor care meeting the other day, and I was talking to the Walsall Healthcare NHS trust, which is doing things like virtual wards led by specialist consultants, a discharge lounge, with pharmacists there, expanding day case surgery, and a discharge escalation pathway—I know that sounds rather jargony, but it is shorthand. You must be aware of other places. Can each of you give me the name of one place in the country that you think is getting it right, please?

Professor Ranger: You are going to hear from one of the chief nurses in this organisation, and that is Watford—West Hertfordshire. What you will hear from the chief nurse is that she owns it, the board owns it, and the chief executive owns it, and it makes a huge difference.

Dr Benneyworth: I do not have one organisation, and we do not name organisations as part of our work.

Q41 Ben Coleman: Are you aware of any individual organisations?

Dr Benneyworth: We are aware of lots of different pockets of good practice across the country. The difficulty is how we share that learning and scale it right across the country.

Q42 Ben Coleman: So you do have places that you know of; you would just rather not name them.

Dr Benneyworth: Because of our protected disclosure legislation, we do not talk about what we have heard or seen in our investigations in terms of individual places.

Dr Higginson: I am not going to name individual departments, but I think Rosie's answer encapsulates it. We hear about pockets, or good practice. Every department does something well. It is very unusual to find a hospital that is doing everything right. When I go to look at departments, I see bits of exceptional practice and bits where they are struggling, along with the rest of us. In that regard, it is hard to pick an example. I can tell you that, as of last week, 88% of departments in our survey reported being overcrowded either every day or every other day.

Ben Coleman: We know there is a problem.

Dr Higginson: That meant 12% were not overcrowded, which is great news.

Q43 Ben Coleman: We talked about the American system and the way things are funded here. On the incentives, you talked about the use of block contracts not being appropriate. Will you explain how the way we pay for care at the moment makes corridor care more, rather than less, likely?

Dr Higginson: Under a block contract, as I am sure you are all aware, the money does not follow the patients. Services are essentially getting paid to shuffle patients around rather than sort them out. Theresa May described it as patient "pinball" back in 2018. Meanwhile, the bits of the



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system that do sort patients out are not being adequately funded to do it, because they are under a block contract. Does it incentivise corridor care? It probably does. If you want to do something for the same price—if you want to put an extra 30 patients somewhere and not pay any extra for it—if you put them in an ED, you are going to achieve that, at least temporarily.

Q44 **Ben Coleman:** What would you like to test that might get a better result?

Dr Higginson: I would like to return to a system that rewards services for sorting patients out, and particularly one that incentivises high-quality care over activity. The funding models have to follow the patients; they have to follow services that do stuff for patients, and not just direct them to other parts of the system.

Q45 **Ben Coleman:** Do you think that would reduce corridor care?

Dr Higginson: I think it would, because if you start to value emergency care for instance, either within emergency departments or indeed within hospitals, the incentives will be there. At the moment, we tend to value elective care and other forms of care over emergency care. That has led to under-investment in the urgent and emergency care part of the system. The sad thing is that when the urgent and emergency care part of the system falls over, the rest of the system also struggles. If a surgeon needs to do an urgent operation on a patient and he cannot get them into a bed, he cannot do that operation.

Ben Coleman: Thank you very much.

Q46 **Chair:** As the Minister is in the room, this is my very last question: if you were to ask her to go away with one thought only, what would it be?

Professor Ranger: I would love us to do some things that we did during covid, such as discharge to assess and other things that will actually get some hope back for the staff and the patients. They are not always long-term solutions, but the real concern is that we are normalising abnormal care, and we need to pull some levers that make it easier for patients to get where they need to be, and quickly.

Dr Benneyworth: I would like us to transform the way we manage quality and safety across the country by looking at effective learning from other industries and at effective safety management systems with clear accountability and much better risk management.

Dr Higginson: I would say that overcrowding and the resulting corridor care are primarily the result of a lack of available beds for patients, so I would like to see the focus on that, rather than on looking for solutions around other parts of the system. Focus on where the problem actually is.

Chair: Thank you very much. That is a great place to stop our first panel. Thank you for your time; you are very welcome to stay.

Examination of witnesses

Witnesses: Karin Smyth MP, Sarah-Jane Marsh, Professor Tim Briggs and Kelly McGovern.

Q47 **Chair:** Welcome. Can you please introduce yourselves and what you do? Kelly McGovern, can you start, please?

Kelly McGovern: I am Kelly McGovern, the chief nurse of West Hertfordshire teaching hospital.

Karin Smyth: I am Karin Smyth, the Minister of State.

Sarah-Jane Marsh: I am Sarah-Jane Marsh, the national director of urgent and emergency care and operations in NHS England.

Professor Briggs: I am Tim Briggs, the national director of clinical improvement, elective and UEC recovery, and also the founder and leader of the GIRFT programme.

Q48 **Chair:** Thank you all for being here. I think that first panel really brought to life the awful experiences of both staff and patients. I was really struck by the testimony about the avoidance of eye contact because staff are so ashamed. I do not know if you were in the room for some of that testimony, but it was incredibly powerful and really worrying.

Obviously, there is huge interest in this issue because the human stories are horrific; I will just tell you a couple of quick ones—these are courtesy of ITV News, who have done various investigations and secret filming. Peter spent his 60th birthday in the Royal Liverpool university hospital. He described the experience as, “mental cruelty”. He said, “It has got to be the worst experience of my life. It just makes you feel inhuman. It makes you feel like you don’t matter and as if they can just do what they like with you.” That was one experience. Another was a woman called Catherine at Queen’s hospital in Romford. She described it as, “a warzone.” She said, “There was no dignity. I was crying all the time. It was traumatising.”

Minister of State, I think everyone welcomes the commitment we have had from this Government that they want to end corridor care. When can we expect that to happen by?

Q49 **Karin Smyth:** Thank you, Chair. I was in the room for the last moments of the panel. We are very clear that this is unacceptable and that the word “normalised” should not be normalised. That is why the Secretary of State committed to seeing the end of this practice by the end of the current Parliament. The urgent and emergency care improvement plan that we released in the summer, which I know colleagues will want to talk about today, is part of reducing that demand, improving flow—critically—and getting it right the first time. We heard examples in the last panel of how that can work when the whole hospital owns the issue and, indeed, owns the entire pathway, so we are keen to explore that.

The definition and the collection and publication of data are also a key part of demonstrating that commitment and making sure that we get that right. This practice is unacceptable for patients and, as we have heard, it



is completely awful for staff. No one wants to come into work at any time of their shift and see it. That is why it is unacceptable.

- Q50 **Chair:** That is very welcome, but in the context of the NHS, between now and the end of the Parliament is not necessarily that long. We would love for this to disappear next year. What are the milestones and metrics by which the Committee could measure the progress of Government and the system to reach that aim?

Karin Smyth: The commitment is to get that right by the end of the Parliament. I know that people in the outside world find it hard to define what “this” is, and we will get Sarah-Jane to go through that. That is why we are collecting and validating the data, and the aim is to have that publicly available by May. That is an important point, and I am keen to discuss with the Committee what that looks like, so we get it right.

I appreciate that at the moment—again, Sarah-Jane can go into this in more detail—data is collected, and there is an indication of where this is more of a problem. To your last panel, it does not happen everywhere, and I accept the points from RCEM that hospitals get some things right in some places, but it is hard to get everything right everywhere.

The collection of the data is an indicator of system pressure that staff are working under and that patients are well aware of. We as MPs are also well aware of it from our inboxes. Collecting that data and having it publicly available means you will absolutely be able to hold us to account on this and see where the issues are. I am very keen to sort that through.

- Q51 **Chair:** But you have not really answered my question. Just so that I am clear, on this 45-minute “waiting in an inappropriate setting” metric that we are now going to start measuring, by the time we get to the election, whenever that may be—by the end of this Parliament—that will be zero. However, does that take into account all the other bits of the system? My colleague Joe Robertson made the point that one way to get to zero is by shunting patients into other parts of the system and spreading that risk. Is the Government’s view that zero does not mean just that metric, but all the metrics? When are we going to get halfway? Are we modelling the changes that you have put in place? Will there be a year or two while the system sorts itself out and then this drops off a cliff, or are we expecting linear change over time? Has the modelling been done? How will we know that you are on track? There is no point in us coming back in three years’ time and saying, “Oh, you missed it. Oh, well.” When do we know that you are struggling and we need to help?

Karin Smyth: I will bring Sarah-Jane in on the details of the modelling, the process and the variation across the country. Just so that everyone is very clear, from the Government’s point of view, we take this very seriously and are committed to the targets and people’s rights in the NHS constitution. We might come back to that issue.

It is absolutely right to get the clinical pathways, safety and quality correct. However, we think the four-hour target, for example, is an important indicator for public confidence in the system. I think it is



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unacceptable that our constituents, who may not have that care at neighbourhood or primary care level, are trying to find somewhere to go for their condition. We do not think that patients go to the wrong place. It is up to the system and to us to demonstrate our support for people, which is why the neighbourhood level is so important.

To your point, Chair, we are absolutely committed to delivering on those commitments. That is why I am—and was in my previous life—a supporter of targets. I know they sometimes drive behaviour, and we must watch that. However, our commitment to the British public is to deliver on those targets and watch the pathway through.

We now see this pressure particularly in corridors. That is unacceptable, and it is where the pressure is showing. That is why this is important. Absolutely to your point, we do not want that pressure coming up somewhere else and to miss it. I think Sarah-Jane can explain the trajectory across the country.

Sarah-Jane Marsh: As Dr Higginson said, the big problem is overcrowding in emergency departments, which is spilling out and resulting in corridor care. We need to get to the heart of that overcrowding. This is really about getting back to delivering the four-hour standard. That is the key commitment, and we continue to track progress against that target.

On corridor care, as we start working with the organisations with the biggest challenges, doing a trajectory or saying, “We will try this and we will try that,” has not been as effective as a cultural leadership response that says, “We’re not having this in our organisation. It is not acceptable for staff or patients. Therefore, we will put in place a two or three-month plan to turn this around, and we are committing to make that work.”

That is not to say that when people make that commitment and make advances—Tim will be able to talk through some of those examples—there will not be days when there is a blip, things fall over and we get into difficulty. But the key is that we go back and put it right.

On the 2029 ambition, we do not want to say that we will go 90%, 80% or 10%. We want to be really ambitious on corridor care and get ahead of 2029. That is what our leaders want to see. Getting to the heart of the root cause—overcrowding—and getting back to the delivery of the four hours will take longer. That is not something that we can immediately address; there are lots of different causes. So that is a more realistic timeline for returning to where we need to be, around the four hours. On corridor care, this can be done with the right culture, leadership, systems and processes, and we are starting to see that happen in various places around the country.

Q52 **Chair:** So we do not have specific interim targets, but the message is clear: as soon as possible. I am slightly concerned. I do not understand why having a strong interim target would not help the system to move. Is the experience that it just is not as effective?



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Sarah-Jane Marsh: What is effective at present—and maybe I can turn to Tim—is Tim and his team spending time with the trust to assess what they think the root and the scale of the issue are in that particular instance, and then saying, “Right, we think you can do x, y and z by July, and we will be back to see what has happened.”

Q53 **Chair:** So you are talking about trust-by-trust interim targets, not a system target. I understand that better now.

Sarah-Jane Marsh: It is trust by trust. I would not rule out getting to a place, once we have the data quality and we can see. What we do not want is a tale of patients being left behind as we go around trust by trust. But right now it is that—

Q54 **Chair:** So collect the data, make a trust-by-trust plan, and maybe at some point we will be able to aggregate the data. Is that right?

Professor Briggs: The GIRFT programme is clinically led using data to drive real change. I was asked to get involved with the corridor care conversation by Sarah-Jane and Sir Jim in September last year. Over the winter, we have been working with 30 of the most challenged organisations with corridor issues. What is clear, and this builds on what Ian Higginson just said, is that in these challenged organisations the problem is not the ED; it is the flow of patients throughout the hospital.

You mentioned our document that came out yesterday about reducing corridor care. I think it will have a major impact. It starts with the ambulance, the ED, avoidant admission, how you are admitted and how you are pulled through. The big thing that is going to be required is culture and leadership change. In these trusts, we as the medical profession must step up to the plate. In many of these organisations, the ED department is seen as isolated from elsewhere, but this is actually everybody’s problem. Unless we all act and solve this problem, it will continue.

The good news is that I am now seeing some good data from some of these really challenged organisations. I will give you some examples. BHRUT, which includes Queen’s in Ilford, was in the press in November regarding corridor care. It now has no corridor care. In February 2026, compared to February 2025, it has saved 10,444 hours of temporary nursing corridor care. That has saved the organisation £156,000. Its ambulance handovers are right, and it is not storing all these patients on the ward. So the flow is correct.

Another example is the big trust in Hull, where this has, again, been a real problem for a long time. It has now gone live with its GIRFT clinical operational standards. I was at a meeting with the HUTH trust, and I said that this is not optional; and we are mandating that we need you to do this. After the first six weeks, it has seen a 27% reduction in delayed ambulance handovers and a 47% drop in patients waiting in the ED for over 12 hours.

There are other hospitals that have already cleared the corridor by everybody owning the problem and putting the patients through, starting



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at the front and going right through to the back end and on to discharge, with virtual wards, hot clinics and so on.

So we know that it can be done. Over the next six months, with our document, we have set three red lines: ambulance handovers of 45 minutes, 24-hour waits in ED are totally unacceptable, and corridor care. We will hold trusts to account for that, to ensure we have some real impact over the next six or seven months, as we get ready for the winter of 2026-27.

- Q55 **Chair:** That is really helpful. It is also helpful to know that there are already green shoots. The Committee received that guidance at 4.53 pm yesterday. Perhaps it was a coincidence that it arrived ahead of this session, or perhaps not, but it is helpful to have seen some of it. I have a few questions on it. At first glance, it strikes us that not much in it is new in terms of guidance. It seems to be more of a consolidation of guidance in one place, with case studies. Is that fair? What is new in this?

Professor Briggs: I think it is the first time that we are joining it right up. If you look at the document, the front end starts with the ambulance, then ED and how we avoid admission with SDEC and what have you. Then, when patients come in, what are we doing about that to get the flow right? The end of it is then about culture and education. At the top, that is all embedded and overseen by the GIRFT clinical operational standards. For the first time, those are now setting standards not just in the ED department, but throughout the rest of the hospital. When do we expect acute physicians to see the patient? When do we expect specialist physicians or surgeons to see the patient? That is going to be a game changer in terms of us all owning the problem. Throughout all the trusts we are working with, that has not been the case. I think it will have quite an impact. We have asked for this to be embedded by the end of July.

- Q56 **Chair:** Okay. You mentioned that, in the challenged trusts you have been working with, you have mandated this.

Professor Briggs: Yes.

- Q57 **Chair:** Will this be mandated in challenged trusts across the board?

Professor Briggs: Yes.

- Q58 **Chair:** Brilliant. I will ask this quickly, and then I will need to move on. Dr Higginson spoke about the number of beds being an issue elsewhere in the hospital. Is that a part of this plan as well? How much do you see that as the problem?

Professor Briggs: As Ian said, it is a multifactorial problem. We know that we have over 13,000 beds occupied by patients who are ready to be discharged, but there is still a lot that we can do with the existing beds. If you are one of the patients in a corridor, most of whom are elderly and frail, and you are there for 24 hours, if you did not go in with delirium, you will have delirium by the end, and that will increase your length of stay. What we have to do is pull the patients through, get them seen by the right experts at the right time, get the early diagnostics and get them



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mobile. The back end is about discharge to home. It is about hot clinics and virtual wards, and we can make a real impact getting that flow right.

The other thing that we have seen, in the trusts we have been working with that are already moving the dial, is that morale has changed among the staff because they can now see the wood from the trees and they can now start to see the art of the possible. We are quite excited about that, and we will be working very closely with Sarah-Jane to encompass this and embed this over the next six to eight months.

Q59 Danny Beales: The 4 March letter set out the 30 trusts that are being focused on. What are the common characteristics that those trusts share? Why is it those 30 trusts? Are there common factors among them?

Sarah-Jane Marsh: It is a combination of everything that we have discussed here. It is culture and leadership, clinical engagement and then system and process. What we often see is a narrative that is built up in the organisations that the solutions sit outside the walls of the hospital: "Other people need to do things in primary care, social care or whatever it is, and that would help us." We do not necessarily see the ownership of the problem.

Building on that, sometimes the ownership grows and is there, but then people are struggling for the actual solutions, which is one of the reasons why we have tried to bring everything together in this single guide. I think you are absolutely right that it does not necessarily have lots of new content. That is one thing about this: we know the solutions, but we need consistent application of the things that work. It is those things together that we need to see to be able to move forward.

Conversely, if you go to the ones that do not have corridor care and get really good four-hour and 12-hour performance, you see the absolute reverse. You see the execs really owning it. They understand the data. They have the systems and processes. They use the data really well and have the governance and everything else. You do not even need to go and visit the trusts now to know what the issues will be, because there is such consistency in the group.

Q60 Danny Beales: So is that how you selected the 30? Those are the characteristics you saw after selecting them, based on the data that you had seen.

Sarah-Jane Marsh: The 30 trusts are based on lots of different data points that we have available, including those on how many patients are in the hospital but not in a bed when they need to be, and our 12-hour data. As colleagues have said, that is a really good indication of overcrowding. That is how we formed the group. That is not to say that there are no other trusts that use corridor care, but those are the 30 that all of our data suggested was where the problem is the most serious.

Q61 Danny Beales: Some of the characteristics that you were defining concern blame or fatalism in the system. Some of the actions that were identified in the meeting of those 30 trusts in February—that trust



executives should walk the corridors and that there should be senior leadership in discharge meetings—seem quite basic actions, so is corridor care a bit of a canary in the coalmine? If these things are not happening—if senior leaders are not there in the evenings and are not talking to staff—that is quite a worrying sign for a trust more generally.

Sarah-Jane Marsh: Yes. When I say “blame”, I think that what we do not see is the right ownership of the problems. I am not necessarily saying that leadership teams are blaming others; they are just not owning that they are part of it.

I agree with lots of points that the panel made at the beginning. We have some very large organisations now—multi-sites, multi-A&E departments and so on—and there are definite issues with people being in amongst the problem, standing in the problem, talking to patients, talking to staff and so on.

- Q62 **Danny Beales:** The RCN talked about accountability and leadership being key, and you have touched on that as well. This issue is vital, but can I take you back to whether it is a wider systemic issue with trusts, management and leadership performance? On leadership and accountability, it should not take a strategy or the GIRFT programme coming in to say, “Don’t do corridor care.” That would not happen if people were not walking the halls and this were not happening. Why is this not being dealt with more systemically? Who should be dealing with these problems?

Sarah-Jane Marsh: As an overall leadership team in NHS England, we feel very strongly about the professional leadership standards of the community, and ensuring that our chief execs, our medical directors, our nurse directors and our chief operating officers see connectivity with the frontline as a key part of their job.

Over the past 12 months, we have done a lot of work in bringing chief execs, chief nurses, chief operating officers and medical directors together to talk about these challenges and issues and highlight their importance. The event that we held was partly about reconnecting people with the power of that. Sometimes they may not see the difference that it makes to staff, but when they come together and we show them the difference that it can make, it reinspires them to go back out and do that.

I sat with many of the board. There were chairs as well as executives at that board, and they were like, “We’re going to go again on this. We were doing this and we were doing that, but we’re going to go harder. We’re going to put a rota in that says that someone will always be there on a Friday night, or whatever it is.” I am confident that our leadership teams are owning it, but it is part of our responsibility nationally to set the expectations and standards for our leaders.

- Q63 **Danny Beales:** What will the support for the 30 trusts look like in practice? Professor Briggs, you may want to elaborate on this. Is it purely about giving advice and sharing knowledge? If the identification of resourcing-based issues, capital investment issues or wider systemic



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interrelationships with parts of the system come up, what does the practical support look like?

Professor Briggs: First, the problem that I have seen from the 30 trusts we have worked with over the winter is about engagement, getting all the clinical buy-in and getting everybody owning the problem—I go back to that. If we can get everybody owning the problem, pulling through from the ED, we will make a really big impact. I have visited these trusts, had the conversations with the chief medical officers, and the CN or the team, and asked them what help they needed. The programme can offer support to those trusts to help them to embed the changes they need to make from the front to the back end.

To get this sorted completely, we have to go right to the front end, to GPs and primary care. We have to make sure that the ambulance services are all doing the same thing, and we have conversations with them. Mental health has been brought up; we are already looking at that piece. We are looking at the patients who are deteriorating in the community and need an emergency response, and at what happens to them when they come to the ED—

- Q64 **Danny Beales:** Sorry to interject, but in answer to previous questions you have spoken about the plans being very much focused on and owned by the trust. You are now talking about the identification, the broader systemic issues, the relationships with primary care and mental health, which we heard about from the previous panel, and how we need to fix the back door to social care and primary care. How can both be true? How can these things be trust-specific and owned by the trust, but also interrelated with other parts of the system? Is that not a challenge?

Professor Briggs: I believe that if we get the flow right, as per our document and our work with trusts, we will make a big impact. But if we are to make it sustainable in the medium to long term, we have to involve the ambulance trusts. We are already having conversations on behalf of or with the trusts. We have to go into primary care. For instance, with care homes—

- Q65 **Danny Beales:** Do the 30 areas need system-wide plans for their area, based on all the partners rather than just the trust?

Professor Briggs: Yes, they will, but you have to start somewhere. Corridor care, to me, is—

- Q66 **Danny Beales:** So you see this as the first stage?

Professor Briggs: Yes. We will make a big impact, but to make it sustainable we have to look at what we do with our ambulance service and primary care, and then at the back end and what we do with community services. This is the first part, but—

- Q67 **Danny Beales:** How long do you envisage the support package for those 30 areas being in place for, in the evolution from trust to system?



Professor Briggs: The support package that we offer to the trust varies depending on what its issue is. It is focused on the acute trusts at the moment, but this year we are going to broaden that conversation to the ambulance trust community services and into primary care.

I have been working very closely with Claire Fuller. We have been doing about 24 PCNs over five regions, where we have had the conversation about how we bring primary and secondary care much closer together. That conversation is happening. We have to embed that in the community to make this sustainable for the long term, but what we are doing now will make a significant difference.

Q68 **Danny Beales:** That is very helpful. Finally—I am running over time—the letter also mentions the development of a new urgent and emergency care strategy. Sarah-Jane, this might be a question for you. Why is that strategy needed? How will it be different from, or add something to, the existing strategies or, for instance, the A&E model guidance?

Sarah-Jane Marsh: The model ED essentially codifies for everybody what the higher-performing emergency departments already do. It tries to set that out in a really clear way so that we can make sure that we standardise.

The UEC strategy that you referred to is being worked on as part of the medium term for the 10-year plan. We have not made a significant change in the way we deliver UEC services over the last couple of decades. There has been a lot of incremental change and different ways of working. This strategy looks at much more fundamental change. It is being worked up at the moment; it is not even at the initial draft stage, so it will not be out for a while. It will look at some of the broader issues that we heard in the first panel about how patients access UEC services, how we can look after frail, elderly people in a different way, our discharge models, working with social care, and so on.

To go back to Tim's point, we own today's problem of corridor care now, and we do not think we need a new medium-term strategy to resolve that. We do need one to get back to the delivery of 95% in four hours. If we could achieve that, we would not be having this conversation. It would be a very different, much more exciting one for patients.

Karin Smyth: May I respond to Mr Beales's good point that it seems quite basic? One thing that surprised me last winter when I came into post as a new Minister, having worked previously in the system, was why certain things happened. We must not underestimate what is sometimes called muscle memory loss about how to do things right. I have been impressed with Sarah-Jane, the leadership, Julian Redhead and Tim going around to trusts to see what happens. It is an issue of clinical leadership and managerial leadership. I am a strong supporter of managers being able to do that. It is about recognising what should be pretty basic and is known, but does not happen. Covid has a lot to do with that, as does turnover. We should support the system to do that, hold it accountable and hold managers accountable.



Of course, good management leadership walks the floor. As Nicola Ranger rightly said, it understands what is going on at 10 o'clock at night, and it gives hope to staff. A fundamental part of the managerial framework is supporting managers with what good looks like and being able to demonstrate clinically that this is not normal. It can be done. It is done very well in different places, which is why we need to go in and challenge that clinically, give hope and support and say, "This is what we are trying to do overall." As you say, it looks pretty basic. The fact that it needs to be said demonstrates where we have been.

Andrew George: That is a good segue into my first question. Dr Higginson referred to the impact of the stresses and pressures on staff in previous panel. He said that 90% of senior doctors are saying that the system is unsustainable in the long term. Professor Ranger talked about the impact on nurses. If we are looking at culture and managerial leadership—I think that was the expression you used, Minister—we are not talking enough to staff, are we? To what extent is the managerial leadership actually consulting staff, hearing what is happening on the frontline and seeking advice from them rather than bringing wisdom down from on high?

Karin Smyth: This might be a good point to bring in what we do there.

Andrew George: I was hoping that we could shift to that.

Karin Smyth: From my point of view, I think that is right. The framework is to support managers and bring forward, as we have done, a commitment to the leadership college around that. But the here and now is what the team at NHS England is doing, which is having clinical leaders talk to other clinical leaders about what can be done and owning the problem at a board level. That is true across the piece, in terms of bringing the waiting lists down, looking at the financial balance and getting that accountability back to board level to do the job, particularly across chief executive officers, chief operating officers, the chief medical officer and the chief nursing officer, to get that quality and the safety right, as we heard in the last session, and own that at board level. That is very much what we are trying to do, but the example of when it is being done is a good opportunity to hear about that.

Q69 **Andrew George:** You are obviously doing it right. How are you doing it?

Kelly McGovern: Our journey started about three years ago, so this was not a quick fix. When I started two and a half years ago, we had been in the media for our 28-bedded corridor, we were 120th in the country for our four-hour performance and we had 120 surge beds, with patients in gyms, as described—everything that has been described was us. We had a disempowered workforce who had normalised that behaviour, and I do not think that they could see how to get out of it. One of the things they are great at is working in a crisis, and that is what a corridor is: managing a crisis.

What we did—my deputy medical director and I, because it needs to be both together—was work in our ED every day for a month. We worked



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alongside all our clinicians, and we shared the risk. That is one thing that has happened since covid: we have become almost paralysed by risk. We have become paralysed by how we order an MRI scan and what blood test is needed, and we have lost our ability to assess patients from head to toe and think about their journey and where the best place is for them. What we saw quite quickly, in four weeks, was an empowered workforce who knew that we were all in it together. We had to make it a whole-hospital programme, which meant that medicine and surgery—everybody—was coming into that ED and owning it. I have about 650 beds, and on any one day I could have 50 patients who are waiting and delayed, but I have 600 patients I can get out of that hospital. That is what we focused on: the other 600 patients.

We made flow our priority, but actually we made values our priority. Culture and leadership, and standing in that environment on their worst days, were what helped us to change the direction for the organisation. Yes, data is really important, but data on its own did not help us. We had to do the culture and leadership thing first. Then came the data and the operational excellence, and an exec team who do not accept corridor care as a standard in our organisation.

Q70 Andrew George: You are talking about sharing the risk across the hospital, which is certainly something that we learned from the first panel. Are you saying that admission into the hospital is now much smoother because beds are now available as a result of that sense of shared risk? Does that mean that the corridor patient is now in a corridor on the ward, or does it mean that you are managing the discharge from the hospital and there are beds available?

Kelly McGovern: Both. If you had visited our ED on Friday, you would have seen a half-empty department, and we were at 95%. We are managing outside, we are doing neighbourhood health and virtual hospitals—I could tell you 100 things that we are doing. We work as a system, and our community partners and mental health partners worth with us. We are owning it as one risk together, and we have to fix everything; you have to do weekend discharges, and you have to do the back door and the front door.

Q71 Andrew George: Dr Higginson also mentioned that his one aim is to ensure that there are sufficient beds within the hospital—that is the block that creates the stress of corridor care and so on. I recollect having big arguments in this place some 20 years ago on the NHS Confederation publishing a document called “Why we need fewer hospital beds”. I do not know whether any of you remember that, but it was not titled, “How we can arrange the NHS so we need fewer hospital beds”, which would have been an entirely different dynamic. The culture within the NHS after that meant that there was a pressurised cut in beds without necessarily a concomitant improvement in primary care.

I think this is a question for you, Minister: to what extent does that question of bed management and bed capacity need to be looked at again? The majority of hospitals are operating with north of 95% bed



occupancy, with a system under extreme stress. Emergency departments cannot operate in those circumstances, can they?

Karin Smyth: That is a lovely question for me; thank you for that. This is a subject of much academic, clinical and managerial discussion, and I am going to lean into some of my colleagues—it is worthy of the time itself right now.

I do remember that time. I was on a board of a primary care trust in Bristol during the noughties. The Bristol system famously moved to the Frenchay hospital and the new hospital at Southmead, and there has been a long-standing issue around the beds that moved at that time—that is politically contentious as well, so thank you for that—and whether the right number of beds are in the Bristol system.

That was 20 years ago, and, through that time, NHS England, as an independent body, has also had its assessment about whether we have the right number. Generally, 95% is always felt not to be a good level, and it has been at 95% since about 2016-17. This is therefore worthy of more discussion as you look at the future modelling towards neighbourhood health, different clinical pathways and virtual hospitals. All of that does need to be taken into account.

Without making us do more new things, as a Minister, I would want to be assured about that over time, to make sure that we have the right evidence. It is a changing picture, because the situation now, even in my own health economy, is that if we did do things differently—when I quietly visited my local hospital in January, as I know many Members of Parliament do, to see what was happening, to talk to staff and to see those patients, the patients were mainly very elderly, very frail women. My mother is 91; she is in that category, and I do not want her there either. They should be getting support in care homes or at home. We do not really want to be moving lots of these people into beds; we want to be supporting them somewhere else.

I am very happy for the Committee to talk about that more widely. Shining a light on some of that now is a helpful thing to do, and it will be different in different systems.

Chair: Indeed. Our very first report was on social care and on some of these issues, as you well know. I am keen that we do not go down that philosophical rabbit hole now, because we have some quite specific questions that we need to get to.

Q72 Josh Fenton-Glynn: Just quickly to clear up some stuff that came out of the last panel, Dr Rosie Benneyworth said that they are coming across quite common cases where concerns are raised but not acted on, to the point where people will then just stop raising concerns. Minister Smyth, I know the basic answer—that this is unacceptable—but, as a former NHS manager, how are you going to make sure that concerns are listened to and acted on?



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Karin Smyth: Yes, it is unacceptable. A lot of that, as we know, is around culture and making sure that people can and do do that, but it is also about then bringing in the solutions and making the staff a part of that. Again, that is a leadership issue locally—bringing those key clinical staff into solving the problem. As Professor Ranger said in the last panel, we want to give them hope. That is pretty basic, isn't it? But we know that morale is very low.

Q73 Josh Fenton-Glynn: We talk about bringing them hope; she also talked about a failure to measure and act on burnout. My background is in the GMC, and we used to do the national training survey, which gave us burnout stats by specialty. Obviously, emergency medicine was always really high. Is that something that this Government are going to act on?

Karin Smyth: Yes. Again, without leading us down other paths, although I am very happy to come back and talk about that, things like staff standards or things like, as I was this morning, developing the workforce plan—recognising that getting the right people in the right place—and GIRFT are so important. That does help with that.

Coming in as a Government, we were very clear about maintaining morale and about staff. That the feeling of being broken, and working under that pressure, is bad for patients and bad for staff. We are very keen to work, as I said earlier, on things like the leadership college and the framework for supporting staff to get it right—to get that memory back into the system. I don't know if colleagues want to add anything to that.

Q74 Josh Fenton-Glynn: I will bring us back to corridor care, because I only have 10 minutes. It is a particularly higher risk for older and frail patients and those with mental health issues. What alternative provision can be made for the patients outside of emergency departments? Are we able to provide adequate care for those groups in emergency settings?

Sarah-Jane Marsh: I think that is the fundamental question to this whole thing, as well as the one about whether we have enough beds. It depends on how we want to look after our frail, older people. I do not think we want to look after them by sending a 999 ambulance, having them in an emergency department and so on. We are in the foothills of making a transition into a different model for frailty, and that is one of the things we need to accelerate if we are going to get this right.

Q75 Josh Fenton-Glynn: Is that virtual wards?

Sarah-Jane Marsh: It is lots of things. It is, first of all, identifying who those patients are, so they can be looked after in primary care—essentially, case manage. People have a frailty score; we know the people who need that care. They can then have a multidisciplinary team of people looking after them, making sure that we stay ahead of issues and problems, medication reviews and all those things. If they deteriorate and become unwell in the community, the first response should be from people who know them and know their care: the people who can keep them at home or in the nursing home, with an additional level of support—virtual ward, as Kelly alluded to. If they do need to come to hospital, they come



into a frailty unit that has expertise in frailty, which just treats the thing that is the matter with them in the here and now, and gets them turned around and out as soon as we possibly can.

If frail, older patients get admitted, the length of stay starts creeping and creeping. They are then frequently the ones who are subject to a discharge delay. Some of the patients who are most delayed for discharge should never really have been admitted in the first place. This is the group of patients that we do not serve well. They are driving a lot of the issues, and they are not getting a huge medical benefit from the stay in hospital. That is where the resource, which could go on building 10,000 beds to look after them, would be much better deployed in community and social care.

- Q76 Josh Fenton-Glynn:** Fundamentally, we are going to have to come back to a conversation about social care if we are going to properly solve corridor care. I have recently been doing my own research into clinical negligence, which, as you will know, is the second-highest liability across Government. Based on NHS Resolution figures, the number of claims has risen 150% since 2006-07—so in the past two decades. Do you think overcrowding and corridor care are driving that?

Professor Briggs: From my experience—we have been doing a lot with litigation and NHS Resolution—the total bill is £60 billion, on the Government's books. The biggest driver of that is maternity. That is the No. 1. We have seen a reduction in litigation claims in a number of surgical specialties that we have been working with.

- Q77 Josh Fenton-Glynn:** I am talking more specifically about emergency medicine, where there has been a 150% rise in claims.

Professor Briggs: Right. I cannot tell you what that breakdown is today.

Chair: Is that something you could write to us with?

Professor Briggs: Yes.

- Q78 Josh Fenton-Glynn:** NHS England guidance wants to see us avoiding corridor care for those groups. With the current resources that we have, placed where they are, are we able to reduce corridor care or eliminate it for the higher-risk groups?

Sarah-Jane Marsh: I am happy to go, and then maybe Kelly can support. The guidance is very clear that we should not be putting the most vulnerable people in corridors and, however overcrowded we are, choices can always be made about who goes where. Some of the very worst things I see on visits is when some of those choices have not been made appropriately. While we go on the path to total eradication, we need to be absolutely focused, every day, on making sure that vulnerable people are not placed in that position. That is what the principles and the guidance are getting at: "This is not okay, and it is the personal responsibility of those leading organisations to make sure that this does not happen." I know the chief nurse community focus a lot of their energy on this.



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Kelly McGovern: That is a real focus for Duncan, and it something that we talk about in our groups. Corridor care costs more money. When I had a full corridor, I had to have six extra nurses. We have reduced our bank and agency bill dramatically over the last two years. It costs more money to have patients on wards and in corridors, and it is less efficient. You can't deny that corridor care is less efficient and that we need to fix it, but we need to fix it with all the things that people have said. My chief strategy officer says, "You've got to stand at the front door and on the other side of it," because you have to fix every part of it to make it more efficient.

Q79 Josh Fenton-Glynn: I will never forget my brother being in a corridor in an A&E department when he was in the later stages of his cancer treatment, and having to lean over the legs of another patient in order to talk to him and ask him what he needed. We have to remember, and it is fundamental to this whole conversation, that there are patients and their families who find these things deeply traumatic.

Sarah-Jane Marsh: That should never happen, and I am very sorry that that was your experience. We are very clear that patients with cancer, or patients at the end of life, should never be put in a corridor. That is very unacceptable, and I am very sorry.

Q80 Gregory Stafford: Before I get to my questions, I draw attention to my entry in the Register of Members' Financial Interests as I used to work for the Getting It Right First Time programme. Ms McGovern, putting leadership aside—there are some questions about what action on sanction the NHS leadership is taking with trusts whose leaders seem to not even do the basics—what practical steps did your department take to ensure the outcomes you have?

Kelly McGovern: On practical steps, as I said, we made it a whole-hospital programme. We started with, "Why is the four-hour standard such an important standard?" If anyone stays in the emergency department after four hours, their life expectancy, mortality and length of stay change. We brought it back to, "This is your mother, father, brother or sister in that corridor, and you wouldn't want that to happen." Once you start talking to clinicians about the real patient in front of them and not the performance number, and you change your language, that really starts to change the way that people see things. Nobody wants to come in and do a bad job and, actually, if you can show people a different way of doing something and a different hope, they will go with you.

Practically, we did a lot of things. We changed our assessment areas. We changed our criteria. We made sure that all those in our consultant body, when they were a specialist, had to come down to the emergency department and help our colleagues in ED if they needed them to make the decision. We leaned into radiology to make sure that they were doing the scans in time and had a turnaround time. We called it "internal professional standards", but we changed that language and said it was a buddy system. We walk the corridors day and night, and on weekends, and we show that, from the execs down to any member of staff, we are all



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in this together. There are many things that you see up and down the country. When people come and ask me what we did, I had SDECs and I have assessment areas. Everybody is doing the same thing. Ultimately, you have to change the culture and the leadership. Until you do that, nothing will change.

- Q81 **Gregory Stafford:** I suppose that brings me on to my next question about how sustainable your changes are. To paraphrase Mike Tyson, everyone has a plan until you're punched in the face. If some other crisis was to come along, how sustainable do you think the changes you've made are to deal with that crisis?

Kelly McGovern: I tell my team, "Change happens fast." Change happened in four weeks for us, but it was the sustainability and the embedding. Since November, we had to go into our corridor three times, and that was for the 45 minutes. We have been doing this over a number of years, and we are sustaining it. We are improving. We were one of the worst in the country; we are now regularly in the top five of the country. Although there will never be a day that we are not in crisis, we are able to work ahead of a crisis. We do not work in that moment. It is not practical to be always firefighting. We have allowed our teams to take a breath, do their roles, and think about, when a crisis hits, "What are we going to do?" That is all of our jobs together.

One last thing: they are never allowed to open the corridor until they wake me up, and they do not wake me up to open that corridor. If I said to them, "Open the corridor", they would be really upset, because they are so proud of what they are doing. Nobody wants to work with a corridor.

- Q82 **Gregory Stafford:** It comes back to a point that I have made in previous sessions on different subjects. Worryingly, change in the NHS often comes down to effective individuals, and you cannot necessarily have stellar individuals in every single trust, in every single department, at every single level of management. There needs to be a thought about how we manage that—maybe the leadership college that the Minister just talked about might do that. Minister, moving on to community care capacity, what plans do the Government have to increase intermediate and community care capacity?

Karin Smyth: That is about the left shift. That is writ large through all of this. To Sarah-Jane Marsh's point, these are mainly elderly, very frail women who generally should not be there. That is support to primary care. I am also surprised about—we have been checking on this throughout both the last two winters—the support across the country to primary care colleagues to then support people in care homes, nursing homes and in their home. We will talk more about this in the future, but we know that the increase in resources has been into the acute sector. The increase in nursing has been into the acute sector and not into community. I think it is a 35% increase into the acute sector and 5% over that period of time into the community. That tells you, as does the shift away from primary care—my area of work was in primary care, so I am a big fan—that you cannot keep people there. For me, that is crucial. It is



why the left shift into neighbourhoods, and making neighbourhoods work—particularly bringing in AHPs, who do such a fantastic job across that great spectrum of the workforce to keep people at home—is absolutely critical. As we have heard from Ms McGovern, in places that is working better, and that is why it is so urgent to make that shift. Does that answer your question?

- Q83 Gregory Stafford:** It does, to a degree. To follow up, the Royal College of Emergency Medicine says that 85% bed occupancy is the optimum level of occupancy to deal with fluctuations. Do you agree with that figure, and if you do, how are you changing primary care and community care to get to that level? I know you have set a target for something else. Is that a target that you are working towards? If so, when would we meet it?

Karin Smyth: I am going to bring in my clinical colleagues here. I am going to be unusual here in saying that I am not sure about that one.

Chair: That is very refreshing and helpful, thank you.

Karin Smyth: The 85% has been around for a long time. It has not been met for a very long time. That does demonstrate that it is about resilience and safety, and so on. That is why it has been there. It is about pressure, which is not good for staff or patients. Whether that is a helpful figure right now, in a changed system and as we are changing it, is probably quite a live discussion, but I may have landed my fellow panellists in it.

Sarah-Jane Marsh: From my operational background, there is no doubt that if you are working at 85% occupancy, everything works, and therefore you can focus on other elements of transformation. Based on where we are now, the figure that we use operationally in NHS England is 92%. If we go over 92%, that is when we start to see much greater issues with flow. We monitor that through the National Operations Centre. There are periods of time when that happens but, at the moment, it is trying to get back to 92%. If we could get back to 92%, there is probably a further step beyond that, but 92% is the figure that we work to.

- Q84 Gregory Stafford:** I suppose the question is, what actions are the Department or, indeed, NHS England taking to get to those points, whether it is 85% or 92%? I accept that stuff has to be done in the acute sector, but I am really interested in what demonstrable difference is being made in the primary and community area to ensure that we get to those points.

Karin Smyth: It is an important discussion. Overall, as I have said, it is about reducing pressure. As has been well outlined, nobody can continue to work and operate at that pressure—it is 95%-plus in some places. It is a good indicator. It is not acceptable for staff. As Mr Fenton-Glynn said, there is an issue around burnout. All those things are known, and we absolutely accept that. That is why Lord Darzi's report is balancing that and getting that all out there. I know the Secretary of State was criticised for some of his comments, but I think it was important. It absolutely acknowledged that pressure. We cannot run a system that hot. That is



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why it has to be remodelled. That is why we have to change where people are working and how they are working.

It is absolutely right that the Committee and others ask us to demonstrate the milestones into that movement. This is why it is so important that with GIRFT, we are saying, "This is how it can be done, and it is being done in certain places." I always say that it is not the same everywhere. It is not "bad" everywhere, and as we heard in the last session, not everything is bad even in the same place. We need to shine a light on that complexity and variation and why it is variable. Sometimes it is variable because my city and my part of south Bristol is very different to coastal Lincolnshire, for example. Being honest about that is helpful. That might be what my son calls a politician's argument.

Sarah-Jane Marsh: The NHS is just concluding the planning process. One of the things that systems have been working on is the delivery of the planning guidance standards via a left shift—how are we moving some of the resource that historically would have gone into the acute sector to help us solve some of these longer-term challenges? How does that then move into community and primary care?

It is going to take some time to do. I am not saying that you are suggesting this, but you cannot just pick it up and shift it all in one go. We need to see that transition as part of what systems are planning for over the next two to three years. That should be the main focus of ICBs as they move into strategic commissioning: how they get the right services for their populations in the community, closer to home, in the neighbourhood. Hospitals are for people who genuinely can benefit from secondary or tertiary care, which is not always the case at the moment, as we have heard.

Gregory Stafford: There are plenty of questions from that, but we have run out of time, so I will hand back to the Chair.

Q85 **Chair:** I have a quick question that comes from that, which it would be useful to have an answer to. On 4 March, NHSE published a letter that said that in the forthcoming workforce plan, you will be considering urgent and emergency care and acute staffing models. This flows from what you were just talking about, because if community care is going to change, staffing models in EDs might have to change, too. What is being considered? That may be a question for the Minister.

Karin Smyth: I think it is. The workforce plan for the next 10 years, as we look forward, has to and will reflect the change in models. We are serious about the shifts. We think that is the way, and I do not think there is much disagreement about that. There will obviously be disagreement about every aspect of getting it done, but I think there is now widespread agreement about the move to community, the move to digital, the recognition of frailty in particular and many other things we have touched on. The workforce plan will, of course, have to reflect those shifts.

Q86 **Chair:** Are you talking about having more virtual wards, or are we



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potentially looking at having a different mix of staff on wards or fewer of them? The workforce plan is forthcoming, but it should be published soon, so I presume you know. What can we expect to see in the plan in terms of corridor care and how an ED will look when there is no corridor care? It has been really clear from this session that even if we cleared corridor care and every hospital in the country did what the fantastic examples are already doing, that still would not get us back to 85%, would it? We are going to have to fundamentally change how a hospital looks.

Karin Smyth: Look at the whole system, yes.

Q87 **Chair:** Can you give us a flavour of what we will see in this plan? Is it virtual wards? What is going to look different?

Karin Smyth: I will bring in Sarah-Jane if she wants to add to that. The 10-year plan obviously sets out the direction, based on those shifts, and with the workforce plan, those shifts only happen by people making them happen. Clearly, all the work that we are talking about and the future models inform that plan.

Chair: I don't feel—

Karin Smyth: I can tell that I am not being very clear with you.

Sarah-Jane Marsh: I think the question is slightly ahead of where we are. We have got the things that we are doing in '26-27, which I think we are very clear on. We are then developing a UEC strategy—that is the change in the model of care—and that strategy will consider all the things that we have talked about here, including the way patients access urgent care and the sorts of services that there are in the community.

I think that with a lot of the things we have talked about, we are already doing the right things but there is a lack of consistency in the way that they are available. As Dr Higginson said, things close at a particular time. If it is 3 o'clock in the afternoon, you might get community support, but if it is 7 o'clock at night, you go to the ED. It is trying to make that more consistent. Also, there are some of the things that Professor Ranger talked about in terms of what we can do to smooth discharge pathways, particularly when patients need community and social care support, and so on. The workforce then drops out of that.

The general thrust of everything that we have discussed is that we need the right balance between generalism and specialism. In our hospitals, there has been a lot of specialisation and it has led to some fantastic services and outcomes. But a lot of the patients that we see coming to the front door for support in the hospital really need that general medicine, older persons' care, and someone who looks at them holistically. Some of the problems that you encounter on your visits, Tim, are where people are looking at the heart or the lungs—things independently—rather than having one person who will just take whole responsibility.

Q88 **Chair:** This is echoing evidence that we heard from Professor Sir Chris Whitty on ageing.



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Professor Briggs: A good example is frailty. How do we keep frailty patients fit in the community, working with primary care? We manage them there, so that they do not come through the ED. We know that that is not a good place for them to be, because of—again—the issues that we have at the moment regarding corridor care and what have you. Then, how do we use our community services, our virtual wards and what have you, and our frailty services—both in the community and in the trust, working together—to maintain those patients and keep them well outside?

Another good example is mental health. What are we going to do about mental health when you have a deteriorating patient? What are we going to do in the community that will bring all the services together and that will allow us to keep that patient in the community, which is where they should be and where they are known well?

When you have patients who require an emergency response, how—again—are we going to manage those patients, so that they do not arrive at the ED, which is not the right place for them? Again, how do we work with the adult crisis and home team in the community to keep those patients in the place where they should be and where they will be better managed?

I think that this is all going to play out and the workforce clearly will be cognisant around that to maintain services. But the shift has got to be right.

Chair: Thank you very much. We are out of time. Your evidence is much appreciated.