Department of Health & Social Care

Karin Smyth MP
Minister of State for Health (Secondary Care)

39 Victoria Street
London
SW1H 0EU

07 May 2026

Dear Layla,

Thank you for your letter of 26 March following the Health and Social Care Committee's evidence session on corridor care on 11 March.

I am grateful to the Committee for its thoughtful and constructive engagement on this serious issue, and for recognising the leadership and focus being brought to bear across the Department, NHS England and the wider system. Corridor care is unacceptable for patients and staff alike, and we are committed to addressing both its immediate impacts and underlying causes.

Corridor care data and transparency

I welcome the Committee's support for the introduction of a national definition of corridor care and NHS England's plans to begin publishing data from May 2026. This will, for the first time, provide consistent national visibility of the issue.

I recognise the importance of ensuring that progress is assessed in the round. NHSE currently publishes a range of data on UEC each month, including on 4 hour waits and ambulance response times. Our monthly publication of corridor care data going forwards will - alongside this - support a balanced view of performance.

While we have not set interim national targets at this stage, our approach is to establish a clear baseline and ensure the right behaviours and system responses are in place to deliver sustained improvement over this Parliament.

Leadership, culture and accountability

The Committee is right to highlight the central importance of leadership. Eliminating corridor care requires a whole-hospital response, with ownership extending beyond emergency departments to all clinical specialties and senior teams.

NHS England's guidance, supported by GIRFT and regional improvement teams, is explicit that Trust Boards are accountable for identifying, understanding and eliminating corridor care within their organisations. This requires active use of data, direct engagement with frontline staff, and visible leadership, including outside of core hours.

We continue to scrutinise local performance through established regional and national oversight arrangements, reviewing corridor care alongside wider urgent and emergency care metrics. We provide both challenge and support to local systems, ensuring that they make progress and that targeted assistance is directed where pressures are greatest.

Learning from other sectors and fatigue management

The NHS continues to draw on established safety approaches from other sectors, including aviation and rail, embedding principles of safety science and systems thinking alongside human factors. These are reflected in the NHS Patient Safety Strategy and the Patient Safety Incident Response Framework, which focus on learning and preventing recurrence of harm. NHS England is also working with partners across safety-critical industries to strengthen the application of safety management systems in healthcare.

I recognise the Committee's concern regarding fatigue. Staff wellbeing is fundamental to safe care. We are taking action through the introduction of NHS Staff Standards for modern employment from April 2026, expanded occupational health and wellbeing support, and a continued focus on workforce sustainability through the upcoming NHS Workforce Plan. We expect trusts to use staff experience data, including the NHS Staff Survey and Pulse Survey, alongside safety data to identify risks and take appropriate local action.

Patient flow, discharge and integration with social care

The Committee is right that improving patient flow is essential to eradicating corridor care. This requires both strong clinical leadership within hospitals and effective partnership with community and social care services.

The Better Care Fund continues to support local systems to reduce admissions and improve discharge, particularly for older people. In 2026–27, there is a stronger emphasis on aligning pooled funding with neighbourhood health approaches, including intermediate care, rehabilitation and reablement. We are also continuing to expand and embed approaches such as discharge to assess, which enable patients to leave hospital as soon as it is clinically appropriate, with ongoing care provided in more suitable settings.

This year represents a transition in the evolution of the Better Care Fund. We will consult on future reforms to be implemented from 2027–28 to further strengthen joint working between health and social care, and to address the capacity and flow challenges that contribute to corridor care.

Clinical negligence

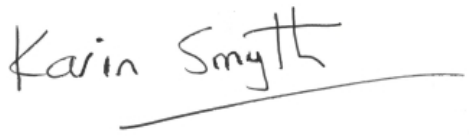
The Committee asked about the relationship between corridor care and clinical negligence. Although emergency medicine claims have increased in recent years and now account for a growing share of overall costs, these cannot be attributed to corridor care alone. While claims are not routinely coded as "corridor care", our analysis of cases referencing corridor or trolley care identified a small number of claims with relatively low overall cost.

However, we should not understate the risks of clinical negligence associated with corridor care. Claims are more commonly attributed to delays in care, missed deterioration or communication failures – all of which can be exacerbated in overcrowded or inappropriate environments. Reducing corridor care, alongside making wider improvements in patient flow and safety, therefore has the potential to reduce avoidable harm and associated costs

– as well as improving patient and staff experience. Information on claims related to the broader category of Emergency Medicine is set out in the NHS Resolution annual report.

I am grateful to the Committee for its continued scrutiny and challenge. This is a complex issue that requires sustained national leadership, strong local accountability and close partnership across health and social care. I remain committed to ensuring transparency and will keep the Committee updated on our progress towards eradicating corridor care.

Kind regards,



KARIN SMYTH MP
MINISTER OF STATE FOR HEALTH