appg
on emergency care

APPG on Emergency Care: Corridor Care

This report was researched and funded by the Royal College of Emergency Medicine.

About the All-Party Parliamentary Group on Emergency Care

The All-Party Parliamentary Group on Emergency Care brings together MPs and peers committed to improving urgent and emergency services. Chaired by Dr Rosena Allin-Khan MP, it provides a vital forum for parliamentarians to hear directly from frontline staff, patients, and system leaders, ensuring that the realities of emergency care are not overlooked in national debate. The APPG works to highlight the pressures facing services, champion practical solutions, and keep emergency care high on the political agenda.

The Royal College of Emergency Medicine is the single authoritative body for Emergency Medicine in the UK. Emergency Medicine is the medical specialty which provides doctors and consultants to Accident and Emergency Departments (EDs) in the NHS in the UK and to other healthcare systems across the world. The Royal College has nearly 15,000 members, who are clinicians in Emergency Departments working in the health services in England, Wales, Scotland, and Northern Ireland. Between them, they cared for nearly 20 million patients in 2024.

Foreword

Emergency Departments are the first port of call for many patients accessing NHS services. People often come to A&E departments in their most desperate times of need - they are the beating heart of our health system. Despite this, across the country, Emergency Departments are under immense strain. Corridor care has become the most visible sign of an overstretched system. It is now all too common for patients to be treated in waiting rooms, corridors, and other unsuitable spaces, because there is simply nowhere else for them to go.

This report, created by the All-Party Parliamentary Group on Emergency Care with the Royal College of Emergency Medicine, reveals the true scale and human impact of this crisis. It draws on powerful testimony from patients, the experiences of clinicians on the frontline, and data to outline the risks associated with corridor care. We must remember that behind this report are patients deserving of the very highest standards of care and staff at every level who care deeply but are working with their arms tied behind their backs.

The causes are systemic and longstanding. Lack of capacity, delays in discharging medically fit patients, and a lack of funding that goes back many years all drive this crisis. This report lays bare the issues as they stand and takes the initiative to focus on how improvements can be made. Focus must be on addressing inequalities, improving targets and increasing capacity, among other goals.

Ending corridor care is not only a clinical necessity but a moral imperative - there simply is not, and never can be, any such thing as proper care in hospital corridors. No patient should ever be left without privacy, dignity, or safety. While this report illustrates the issue and demonstrates that improvements must be made, patients must always know that our NHS is there for them when they need it.

Dr Rosena Allin-Khan MP,
Chair of the All-Party Parliamentary Group on Emergency Care

Dr Ian Higginson,
President of the Royal College of Emergency Medicine

Executive summary

Corridor care has become a defining feature of the crisis in Emergency Medicine. Increasing numbers of patients are treated in corridors, waiting rooms and other inappropriate spaces, not because of clinical need but because there is nowhere else for them to go. What was once an occasional response to winter surges is now a daily reality. In a survey of Emergency Department Clinical Leads in summer 2025, almost one in five patients were being cared for in corridors.

This report, produced by the All-Party Parliamentary Group on Emergency Care and the Royal College of Emergency Medicine, draws on new survey data, Freedom of Information requests, public polling, and patient testimony. Together these sources paint a stark picture. Emergency Department (ED) attendances reached record levels in 2024, yet this is not the sole cause of overcrowding. The true driver is system-wide undercapacity. Bed occupancy has exceeded the safe threshold of 85% for years, averaging 93.1% in 2025, with nearly 13,000 beds occupied by patients medically fit for discharge but unable to leave hospital. This "exit block" means patients wait in EDs for hours or even days, and staff are left delivering care in unsafe and undignified spaces.

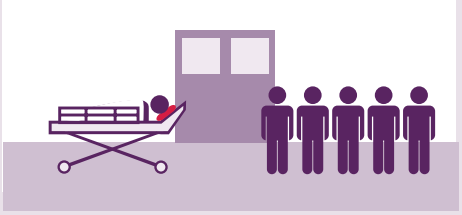
The consequences are grave. In 2024, 1.7 million patients experienced 12-hour waits, more than twelve times the number a decade ago. Evidence shows that such delays cost lives: an estimated 16,644 excess deaths occurred in 2024 as a result of long stays before admission, equivalent to 320 lives lost each week.

Increasing numbers of patients are treated in corridors, waiting rooms and other inappropriate spaces, not because of clinical need but because there is nowhere else for them to go.

Patients and families describe feeling forgotten, exposed and vulnerable. Clinicians confirm that harm is occurring, with three-quarters reporting that patients are being treated in corridors and are coming to harm as a result. Ambulance handovers remain dangerously delayed, with some patients left in vehicles outside hospitals and others brought into overcrowded departments without safe triage.

Corridor care also undermines the workforce and wastes resources. Staff report moral injury and burnout from working in ways that contradict their professional values. Emergency Medicine already has the highest proportion of resident doctors at high risk of burnout, at 30% compared to 20% overall. Financially, inefficiencies linked to overcrowding, delayed discharges and litigation now cost the NHS billions each year.

In a survey of ED Clinical Leads in summer 2025, almost one in five patients were being cared for in corridors.



In 2024, 1.7 million patients experienced 12-hour waits

The burden of this crisis is not shared equally as patients in deprived areas are 1.7 times more likely to attend A&E, older patients are more than three times as likely to wait 12 hours as those in middle age, and people experiencing a mental health crisis are two and a half times more likely to face long delays.

Corridor care is not inevitable. It is the visible symptom of a health and social care system that lacks sufficient capacity, struggles to discharge patients safely, and too often pushes risk onto EDs. The evidence in this report shows that with enough staffed beds, improved integration between hospital and community services, and hospital-wide responsibility for patient flow, the indignity of corridor care can be ended. This will require investment and reform, but the alternative is continued harm to patients, further erosion of staff morale, and the ongoing loss of public trust in one of the NHS's most vital services.

Finally, whilst the phrase 'corridor care' is commonly used it should be emphasised that the term itself is problematical. It is not possible to provide high quality care in corridors. Everything about corridor care is wrong.

Introduction

Corridor care refers to the practice of providing patient care in clinically inappropriate areas such as corridors, waiting rooms or other temporary spaces. These environments are not designed or equipped for clinical use, and they often lack the privacy, dignity and safety of a designated treatment area. While staff work hard to provide the best possible care, the conditions in which this care is delivered place both patients and staff under significant strain. The British public are clear that it is unacceptable with new polling showing that almost 9 in 10 people (88%) think that it is never or rarely acceptable.

Corridor care is a visible symptom of the pressures facing the entire system. These pressures include shortages of staffed hospital beds and delays in discharging patients due to gaps in community and social care provision. This creates a bottleneck in patient flow, with those requiring admission remaining in EDs for extended periods and care being delivered wherever space can be found.

This is a worsening problem and staff report that corridor care is not just an occasional phenomenon. Overcrowding in EDs has increased markedly in recent years. In the last year, 1.7 million patients experienced 12-hour waits, more than 12 times the figure compared to a decade ago with almost 1 in 10 attendances destined to wait more than 12 hours in major EDs.

While staff work hard to provide the best possible care, the conditions in which this care is delivered place both patients and staff under significant strain.

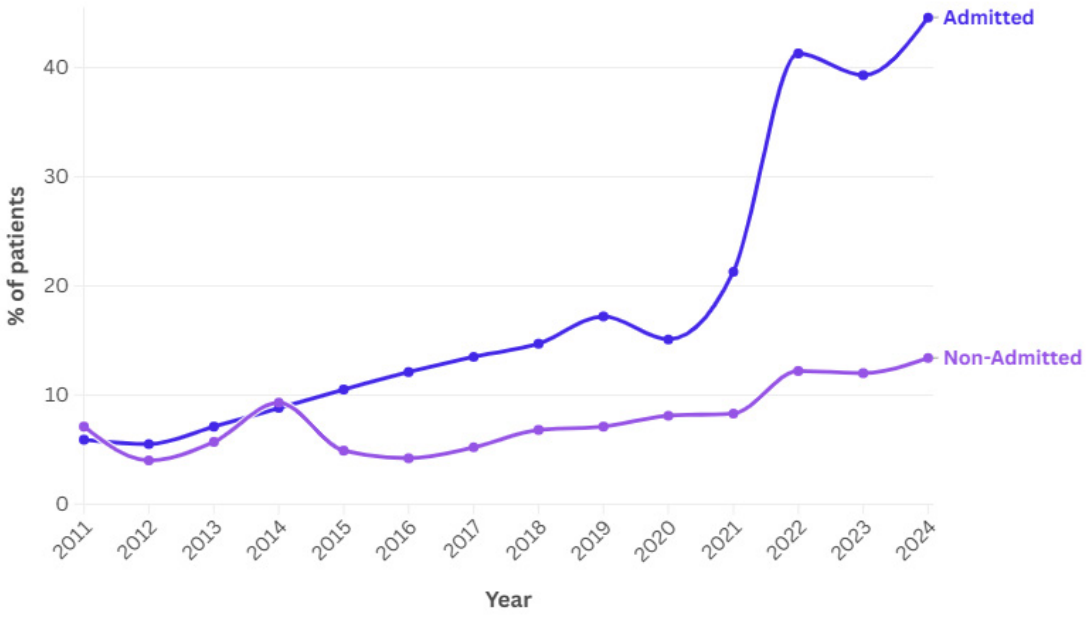
The Royal College of Emergency Medicine and the All-Party Parliamentary Group on Emergency Care have produced this report to better understand the scale and impact of corridor care across England. The report brings together new data from a membership survey of Emergency Medicine leads, public polling on confidence in A&E services, testimony from patients, and Freedom of Information data on waits for specific patient groups whilst drawing on existing literature.

The scale of the issue

NHS performance metrics demonstrate the pressure on EDs and how crowding has become more widespread over the past decade. Attendances to the ED have continuously risen in recent years, with 2024 reporting the highest on record, and 7% higher than in 2023. However, an increase in attendance alone may not necessarily cause crowding in EDs if good patient flow is maintained throughout the rest of the hospital system. The deterioration in the percentage of patients admitted, transferred, or discharged within four hours, and especially the increased proportion of patients staying 12 hours or longer from their time of arrival, show that maintaining flow has become a significant problem, something that cannot be solely attributed to the number of those attending.

The NHS constitution mandated in 2010 that at least 95% of patients attending A&E in England should be admitted, transferred, or discharged within four hours. In major EDs, this target has not been met since June 2013 and as of July 2025 performance currently sits at 63.1%. NHS England has since lowered this target to 78%, but such an unambitious goal risks creating perverse incentives. Trusts may prioritise patients who can be discharged quickly in order to meet the target, while the sickest patients needing admission end up waiting even longer.

Figure 1 - Annual average % of England four-hour breaches that go on to wait 12 hours



Source: NHS Digital Freedom of Information data

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Figure 1 shows the percentage of four-hour breaches that go on to wait 12 hours or more, split by admitted and non-admitted patients. While it has always been the case that patients requiring admission are more likely to wait a long time, in the last few years this likelihood has tripled with 44.6% of admitted patients going on to wait more than 12 hours compared to 13.4% of non-admitted patients. This indicates that the flow, in other words moving patients out of the ED to other areas of care, remains to be the primary driver of long stays and corridor care. In August 2025, RCEM sent out a snap survey to Clinical Leads of Type-1 EDs in England and received responses from 58. The survey found that 19% of patients in the department at that time were on trolleys or chairs in department corridors. That's almost one in five attendances who were being cared for in an inappropriate setting, during a summer month, when there has historically been respite.

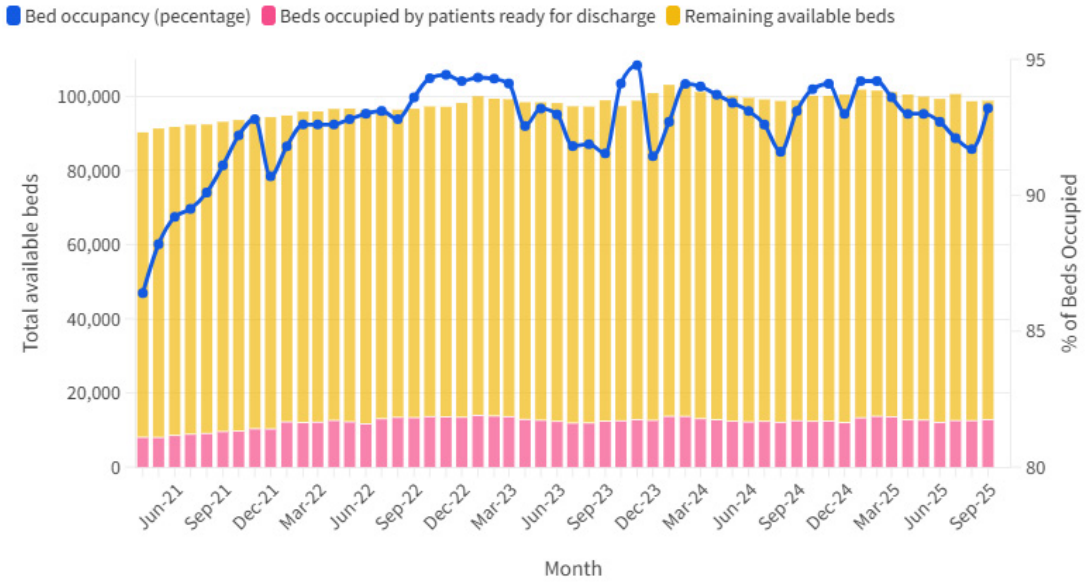
System-wide capacity

In recent years, as demand for inpatient hospital care has increased, the capacity to meet this demand has come under increasing pressure due to an insufficient number of hospital beds. So far in 2025 there have been 100,461 available General and Acute beds, though bed occupancy remains dangerously high at 93.1%. RCEM, along with other organisations, recommends 85% as a safe level of bed occupancy to ensure surge capacity during periods of high demand, though this level hasn't been achieved since March 2020, the month of the initial Covid-19 quarantine. The UK also has one of the lowest bed-to-population ratios in the OECD, falling from 4.1 per 1,000 people in the year 2000 to 2.4 in 2022[1]. With fewer beds and consistently high occupancy, hospitals struggle to absorb surges in demand and can be quickly overwhelmed, meaning patients cannot be admitted from the ED. This phenomenon is known as 'exit block' and is a key driver of corridor care.

Bed availability depends not just on physical beds but also on an efficient discharge process. Based on bed occupancy in 2025, an average of almost 8,000 additional beds would be required to bring occupancy down to 85%, yet this could be achieved without opening new beds. So far on average in 2025, 13,000 beds (13% of the total bed base) were occupied by patients medically fit for discharge but still remained. Freeing just 60% of these beds would bring occupancy to safer levels and ease pressure on EDs.

1 Hospital beds indicators, Organisation for Economic Co-operation and Development (https://www.oecd.org/en/data/indicators/hospital-beds.html)

Figure 2 - Average no. of beds occupied by patients remaining in hospital who no longer meet the criteria to reside



Source: NHS England

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Delayed discharge

The reasons for delays in discharges are diverse and cannot be blamed on any one part of the health or social care system. Glasby et al. identified three main reasons for delays[2]:

1. Internal hospital factors, such as awaiting a second opinion or consultant decisions.
2. Limited rehabilitation services.
3. External factors such as delays in social care assessments or funding, patient or carer issues, and housing problems.

Greater integration between hospitals and social care services is essential to ensure smoother transitions and reduce duplication of work. A more coordinated, patient-centered approach would help people leave hospital safely and restore flow from the ED, reducing crowding, without having to increase the bed base.

System-wide pressures often manifest themselves in the ED. The risk of poor patient flow (at its heart, a whole-system issue) ends up being borne by EDs. While inpatient bed occupancy is a useful measure of capacity and system pressure, the true scale of occupancy is obscured by the fact that patients who are unable to be admitted due to lack of beds are absorbed by the ED.

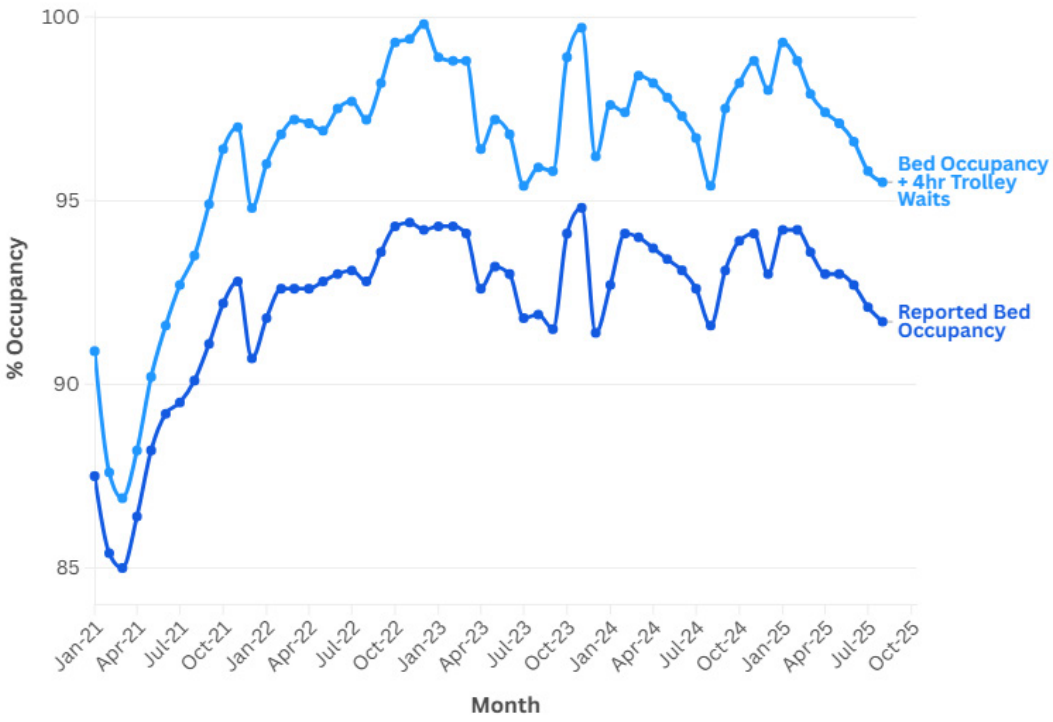
[2] J Glasby, R Littlechild, K Pryce, (2004), 'Show Me the Way to go Home: A Narrative Review of the Literature on Delayed Hospital Discharges and Older People', *The British Journal of Social Work*, 34(8) pp. 1189 – 1197. (https://doi.org/10.1093/bjsw/bch136)

One respondent to RCEM's snap clinician's survey shared:

> ***"Delays for admission [are] hidden by [a] large trolley base. Currently 22 [patients] waiting for beds."***

This raises an important point, which is that bed occupancy numbers taken by themselves do not paint a fair picture of system-wide capacity, or lack thereof. The graph below shows two lines, one which reflects the published bed occupancy data, and one that combines bed occupancy with four-hour ED trolley waits.

Figure 3 - Reported bed occupancy vs bed occupancy + four-hour trolley waits



Source: NHS England

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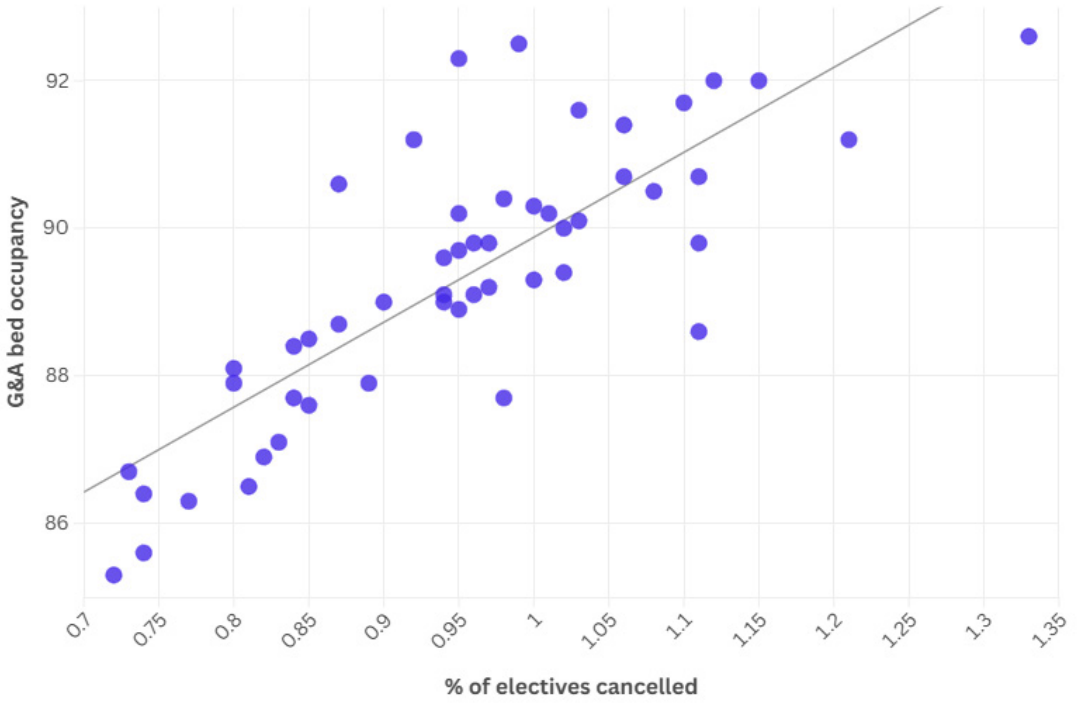
Aggregating the two data points in this way gives a better indication of system-wide pressure, and just how stretched trusts are. Corridor care obfuscates this reality, with EDs acting as a holding bay. As the graph above shows, in December 2022, bed occupancy sat at 94.4%, a figure that is already dangerously high. However, when taken together with four-hour trolley waits, this reaches 99.8%. Without an ounce of leeway or respite, a system running this hot is simply not safe for patients or staff.

Domino effect

Urgent and Emergency Care (UEC)

For the most part, elective care and unscheduled care share the same bed base, meaning high demand in Urgent and Emergency Care often displaces elective procedures, leading to cancellations and delays. The graph below shows the strong positive linear relationship between the two variables: General and Acute bed occupancy in major hospitals and the percentage of electives cancelled each quarter over the last 14 years (excluding the height of the pandemic). This is by no means a new phenomenon, yet there seems to be little consideration or mention of UEC from policymakers in plans to recover the elective backlog, which is understandably a key priority.

Figure 4 - Correlation between General and Acute bed occupancy and the percentage of electives cancelled



Source: NHS England

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Ambulance handovers

Ambulance handovers remain one of the most visible and damaging signs of pressure across urgent and emergency care. In the RCEM snap survey, 34.5% of Clinical Leads reported that patients were being cared for in ambulances outside their department. However, one clinician explained they had none, because:

> ***"everyone is chucked in ED, some without handover or triage."***

This reflects the impossible choices facing staff: either leave patients waiting in the back of ambulances or bring them into overcrowded departments without a safe handover. Both options compromise patient safety and dignity.

Efforts to improve ambulance turnaround times have led to the introduction of rapid release protocols such as W45, a policy that places a fixed time limit on how long ambulance crews wait at an ED before handing over a patient. While well intentioned, these approaches risk worsening corridor care, as patients are moved into EDs without the clinical capacity or space to look after them. There is understandably a need to reduce handover delays, but shifting risk from one part of the system to another is not a sustainable solution. RCEM continues to emphasise that handover delays are a symptom of exit block and system-wide undercapacity.

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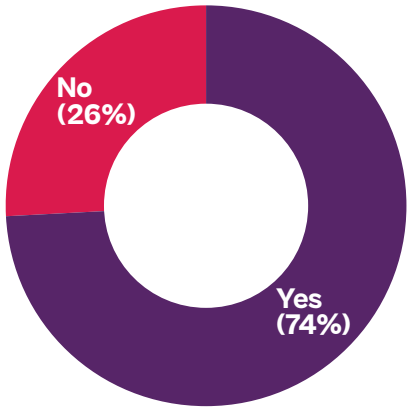
The human cost

The performance data is a stark reminder of the scale of the issue, but at its core, corridor care has a profound impact on patients and their families. Being treated in a non-clinical, overcrowded environment strips patients of dignity and privacy at a time of acute need. Instead of receiving care in safe and appropriate spaces, patients are left exposed, sometimes for hours or even days.

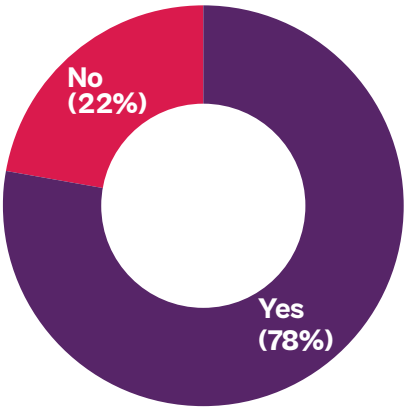
In November 2024, RCEM ran a snap survey of clinicians across UK EDs on the use of non-designated care areas, such as corridors. Of the 61 departments that responded in England, 80% (49) reported patients being treated in corridors or similar spaces. Furthermore, when asked whether they believe patients are coming into harm in their department due to the quality of care that can be delivered under current conditions, 85% of Clinical Leads said yes. The follow up survey in August 2025 with 58 clinicians found 74% (43) reported care in non-designated areas and 78% (45) reported patients coming to harm. While proportions fell slightly, the number of clinicians citing these issues remains above 40, reinforcing the notion that summer no longer brings respite. While proportions fell slightly, the absolute number of clinicians citing these issues remained largely constant, reinforcing the notion that summer no longer brings respite. This echoes findings from the Royal College of Nursing in their 'Corridor Care' report[3] which found that 66.81% of the respondents to their survey had treated patients in an inappropriate setting daily.

Figure 5 - Results from RCEM snapshot surveys on corridor care

Snapshot survey August 2025: Are patients receiving care in non-designated areas?



Snapshot survey August 2025: Is patient harm occurring in your department due to current care conditions? (58 responses)



Source: RCEM snap survey of membership

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[3] Royal College of Nursing, (2025) On the Frontline of the UK's Corridor Care Crisis. (https://www.rcn.org.uk/Professional-Development/publications/rcn-frontline-of-the-uk-corridor-care-crisis-uk-pub-011-944

From the perspective of clinicians, the risk of patient harm is pervasive. Given that corridor care has become a perennial issue, it is no surprise that this concern has penetrated the public consciousness and is impacting confidence in A&E departments. Public polling conducted by Ipsos[4] revealed that more than half (58%) of respondents are not confident that their A&E department would provide a timely service (37% reported "not very" confident, and 21% "not at all" confident"). Furthermore, over a quarter of respondents (28%) said that they were not confident that they would be treated in a clinically appropriate area (20% "not very" confident, and 8% "not at all" confident). This lack of confidence driven both by lived experience of the issue, and perception of the issue, may well be having an impact on the public's hesitation to attend departments. When asked to think about the past 5 years, 42% reported hesitancy around attending due to concerns about long waiting times.[5] Hesitancy was more prevalent amongst younger age cohorts with half of 16–24-year-olds surveyed (50%) expressing hesitancy about A&E attendance compared to a third (32%) of 55–75-year-olds.[6]

It is no surprise that in the most recent British Attitudes Survey, levels of dissatisfaction in the service have reached an all-time high, with over 50% of respondents saying they are either 'very' or 'quite' dissatisfied.

[4] For RCEM, Ipsos interviewed a representative quota sample of 2,095 adults aged 16-75 in Great Britain using its online i:omnibus between 29th August – 2nd September 2025. The sample obtained is representative of the population with quotas on age, gender, region and working status. The data has been weighted to the known offline population proportions for age and working status within gender, and also region, education and social grade.

[5] Respondents were asked: "Now thinking about any times when either you, or someone you would have accompanied may have needed to attend an NHS A&E department … In the past 5 years (i.e. since late August 2020), have there been any occasions where the following happened, or not? - *The person who may have needed to attend A&E hesitated about attending A&E due to concerns about long wait times."*

[6] n=248 16–24 year-olds surveyed, n=687 55–75 year-olds surveyed.

For patients, this erosion of confidence is deeply personal. An RCEM survey shared with members of the Patient's Association sought to gather real life accounts of those who have received care on a corridor. One respondent explained:

> ***"Corridor care has affected my confidence. I would think twice about going to A&E again unless it was absolutely unavoidable. The experience of being left on a corridor made me feel forgotten and vulnerable. I worry that if I went back, I might not be treated in a timely or safe way."***

Another said:

> ***"While I know staff are doing their best, the environment didn't feel like the right place to receive care, and that has shaken my trust."***

However, it is not just the perceived or potential risk to patients that is of grave concern. It is well accepted that long waits and corridor care lead to actual avoidable harm. In 2022, Jones et al. found that between 2016 and 2018 there was a statistically significant linear increase in mortality from 5 hours after time of arrival at the ED. The study found that there will be one additional death for every 72 patients that experience an 8–12-hour wait prior to their admission. RCEM estimates that there were 16,644 associated excess deaths related to stays of 12 hours or longer before being admitted in 2024. That's the lives of 320 people lost every week. Although these figures were initially challenged by NHS England, the Office for National Statistics (ONS) has since replicated this study using data from 2022, reaching a near identical conclusion.

These stark figures are reflected in patient testimony, which lays bare the risks of receiving care in inappropriate spaces. One patient described:

> ***"There was nobody overseeing patients in the corridor. I'm diabetic and the ambulance team had told me to ask for food. There was nobody to ask. Others needed to go to the toilet but again there was nobody to ask. There was no way to call for help."***

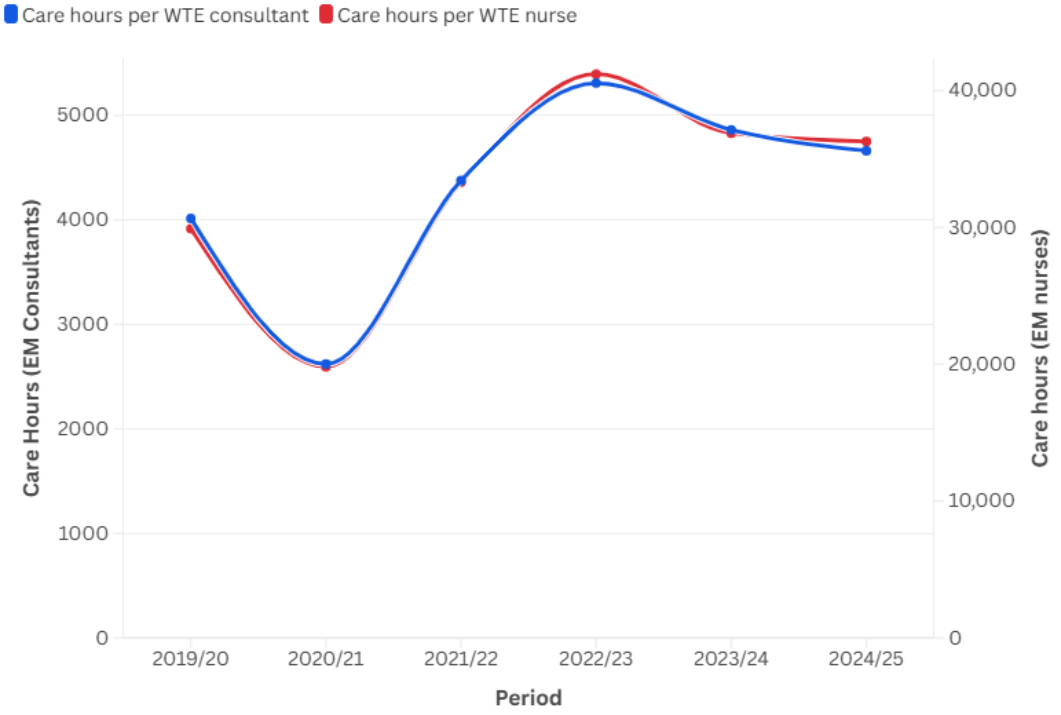
Taken together, the evidence paints a consistent picture: corridor care is unsafe, it damages trust in emergency care, and it undermines the very values of dignity and compassion that the NHS is built on.

Impact on staff

The impact of corridor care is not confined to patients. It takes a profound toll on the clinicians and wider healthcare staff who are forced to deliver care in unsafe, undignified environments. Furthermore, delivering care in this way leads to inefficient use of finite workforce capacity. Staff hours that could be devoted to delivering timely, high-quality treatment are instead consumed by monitoring patients in corridors, rearranging care around overcrowding, and managing the fallout of unsafe conditions. The knock-on effect is fewer care hours available for patients in appropriate clinical settings.

Through a Freedom of Information Act request, RCEM obtained the total time spent by patients in Type-1 EDs over the last six years. The graph above shows the total time spent by all patients each year, divided by the number of whole-time equivalent (WTE) EM consultants and WTE EM nurses. Since 2019, attendances at EDs have risen by 6.7%. Over the same period, consultant care hours have increased by 16% and nursing hours by 21.2%. Despite a growth in staffing numbers over recent years, this trend demonstrates that additional staffing is not translating into safer or more efficient care because capacity is being swallowed up by managing patients in inappropriate spaces.

Figure 6 - No. of care hours by Emergency Medicine consultants and nurses



Source: NHS Digital Freedom of Information Request data

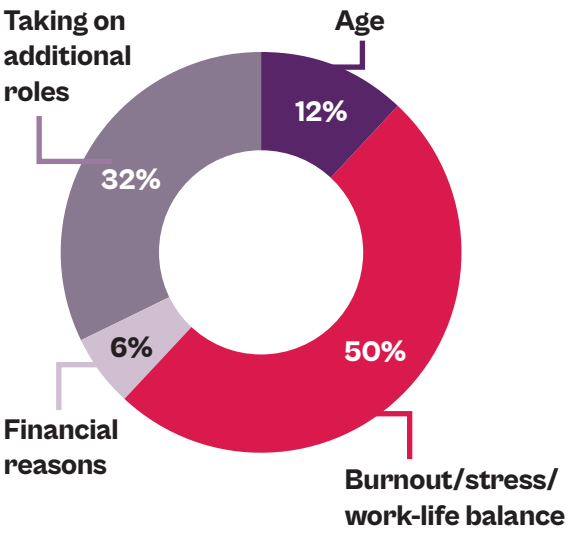
Corridor care, in effect, erodes the value of workforce investment. There are two variables here, the length of stay of patients, and staffing numbers. Increasing staff to bring care hours is an expensive way of fossilising a system that is neither working for patients nor staff. This represents a diversion of finite workforce capacity into reactive, inefficient care. Increasing care hours also explains why the job feels more and more unsustainable despite there being the highest number ever of EM consultants currently working.

Aside from the inefficient use of staff time, operating in this fashion is a reliable predictor of burnout and moral injury. Moral injury is the psychological distress that results from actions, or lack of them, that go against one's values. Caring for patients in corridors is not what Emergency Medicine staff set out to do when they chose the specialty, and this misalignment fuels burnout. In RCEM's England Workforce Census, 81% of

respondents revealed that consultants in substantive posts have been reducing direct clinical care shifts over the last year. By far, the most common reason cited was stress, burnout, and work-life balance.

Moreover, the most recent GMC Training Survey[7] revealed that Emergency Medicine had the largest proportion of trainees at high risk of burnout at 30%, compared to 20% overall. 70% of Emergency Medicine trainees also described their workload as heavy or very heavy, compared to 42% overall.

Figure 7 - Reasons consultants in substantive posts have reduced their Direct Clinical Care hours



Source: RCEM England EM Workforce Census

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[7] General Medical Council: National Training Survey 2025 results (https://www.gmc-uk.org/-/media/documents/national-training-survey-2025-results-report-111657596.pdf)

The financial cost

Corridor care and overcrowding carries with it a heavy price tag. Patients treated in inappropriate spaces are more likely to experience repeated handovers, delayed investigations, and interrupted treatment. These inefficiencies consume staff time, inflate costs, and increase the risk of avoidable harm. When incidents occur, the consequences are expensive: Emergency Medicine now accounts for 11% of NHS liabilities, with litigation costs equivalent to 14% of the specialty's annual running costs. Nearly £20 per attendance is spent on the consequences of litigation linked to unsafe conditions.

The causes of corridor care are equally costly. Delayed discharges alone place a vast burden on the NHS. In 2002, the House of Commons Health Committee estimated the cost at £720 million per year. By 2022/23, the King's Fund calculated that this had risen to £1.89 billion. Freeing up beds more efficiently would not only restore patient flow but also release significant resources for better use.

Finally, the downstream consequences compound the problem. Patients who experience delays are more likely to develop complications, require longer stays, or return for repeat attendances. What may appear to absorb short-term pressure in reality generates greater long-term expenditure.

These costs are not abstract. At Queen's Hospital in Barking, the ED was originally designed to see 325 patients per day but now sees more than double that number. To manage this pressure, the trust estimates it spends around £100,000 each month on additional staffing to care for patients in inappropriate areas. This is money diverted into mitigating the effects of corridor care rather than delivering safe care.

Yet, change doesn't have to be expensive. The continuous flow model, highlighted by a respondent in RCEM's snap survey, offers one example of how local changes can reduce the impact of corridor care:

> ***"We have restarted the continuous flow model in the past 2 weeks with significant improvement. We now typically have 3 medical patients awaiting beds rather than 30."***

While not a perfect solution, continuous flow recognises that crowding in the ED is a system-wide problem and seeks to spread risk across the hospital rather than concentrating it in the ED. It also demonstrates the value of effective and invested leadership. This approach helps prevent patients from being parked in corridors, ensuring that delays are more evenly managed across clinical areas.

Importantly, continuous flow does not require significant new investment. It is a behavioural and cultural shift and a commitment to hospital-wide responsibility for patient flow. While likely unsustainable and not a replacement for the need for long term solutions, such as increasing bed capacity and fixing delays in discharge, models like this demonstrate that immediate action is possible. In the short term, measures that redistribute pressure more fairly across the system could help reduce the worst excesses of corridor care and protect patient safety.

Perverse incentives in funding

At present, the manner in which EDs get paid does not incentivise good care and better patient outcomes. English EDs are paid by a block contract. While this is simple and minimises data collection, block contracts do not provide incentives to improve clinical quality. Much more care, that was previously delivered in an inpatient ward, is now being delivered in an ED with no penalty for poor performance. Moving beyond block contracts offers a real opportunity to better align funding with patient need enabling more care to be delivered in the right place, at the right time. It also offers an opportunity for emergency care to be properly valued, and not deprioritised when organisations focus on activities which generate income based on activity, such as specialist or elective care.

The 2024/25 Capital Incentive Scheme[8] allocated £150m to trusts meeting four-hour and 12-hour performance targets, but the impact was limited and short-lived. While some trusts saw improvements in March 2025, performance often declined immediately afterward, suggesting resources were mobilised temporarily to secure funding rather than to embed sustainable change. High-performing and specialist trusts disproportionately benefited, while trusts with Type-3 data mapping gained advantages that did not reflect genuine improvements in Type-1 care. Overall, the scheme reinforced inequalities and incentivised short-term gaming, highlighting the need for funding models that target systemic capacity issues and deliver lasting improvements in emergency care. This reinforces that tackling corridor care requires long-term investment in capacity and flow rather than short-term incentives that only produce temporary gains.

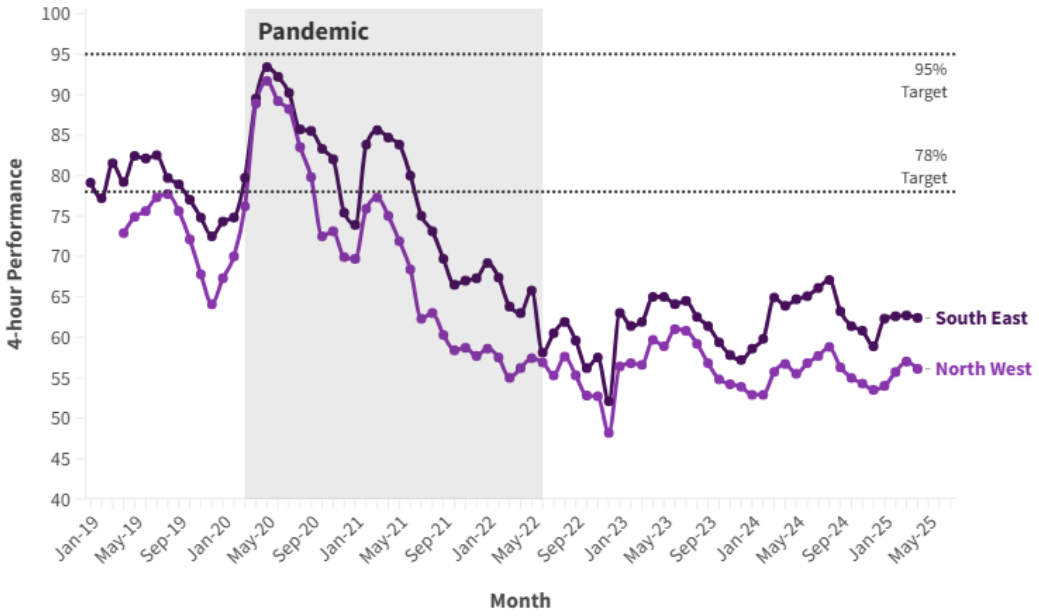
8 Royal College of Emergency Medicine, 'Acute Insight Series: Capital Incentive Schemes'. https://rcem.ac.uk/wp-content/uploads/2025/09/NEW-Capital-Incentive-Scheme-Analysis-2024-25-1.pdf

Inequalities

When it comes to A&E use, demographics play a huge role in how people interact with the service. Economic deprivation for instance has been linked to a much higher likelihood of attending A&E, with people living in the most deprived areas of England having a 1.7 times greater chance of going to A&E than people living in the least deprived areas.[9] People in deprived areas often find it harder to access primary care due to having fewer GPs than more affluent areas,[10] meaning that their conditions are more likely to deteriorate and require secondary care.

People in these deprived areas are more likely to have multiple health conditions at once[11] (comorbidities), which are associated with longer stays in A&E, and an increased risk of mortality.[12] The data shows that there is a north-south divide in terms of the number of people with comorbidities, with the north having the most, and the south having the fewest.

Figure 8 - South East and North West England four-hour performance



Source: NHS England

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9 Office for National Statistics, Inequalities in Accident and Emergency Department attendances (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/inequalitiesinaccidentandemergency-departmentattendanceengland/march2021tomarch2022)

10 The King's Fund, What are health inequalities? (https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-are-health-inequalities)

11 The Health Foundation, Quantifying health inequalities in England (https://www.health.org.uk/reports-and-analysis/analysis/quantifying-health-inequalities-in-england?gad_source=1&gad_campaignid=1642812643&gbraid=0AAAAA-DunFmQwnnGpylo5ubCgmiAGHje5V&gclid=CjwKCAjwpOfHBhAxEiwAm1SwEt5SAYjwvsNR28TomzS2f4eaDaIT-fLV7pb9kVoUNrr5gSggdO5jBWhoCqhwQAvD_BwE)

12 Y Yordanov, A Beauvais, P Thiébaud, (2024), 'Multimorbidity in Emergency Departments: urgent need for integrated care', *BMJ Medicine*. (https://doi.org/10.1136/bmjmed-2024-000989)

There is also a lot of regional variation across England in terms of how long patients wait on average when they get to the hospital. In the South East of England, an average of 62.9% of patients were seen within four hours in 2024, whereas in the North West of England, only 55.5% of patients were seen within four hours on average. The North West of England also had the highest percentage of 12-hour waits last year, with 15.5% waiting at least this long, whereas in the South East of England, this figure was 9.4%. Long waits like those seen most acutely in the North West will inevitably mean significantly more patients being made to wait in corridors. It's not just where you live that can contribute to your length of wait, but also your age. From the FOI data received from NHS England, it was found that the older you are, the longer you are likely to wait on average. To put that in perspective, last year a 90+ year old in A&E was more than 3 times as likely to wait 12 hours or longer than someone in their 40s. Elderly people therefore make up a large proportion of the patients made to wait in corridors, which is both extremely distressing for them, and puts further strains on clinicians.

Figure 9 - 12-hour wait prevalence by age group in 2024

Source: NHS Digital Freedom of Information data

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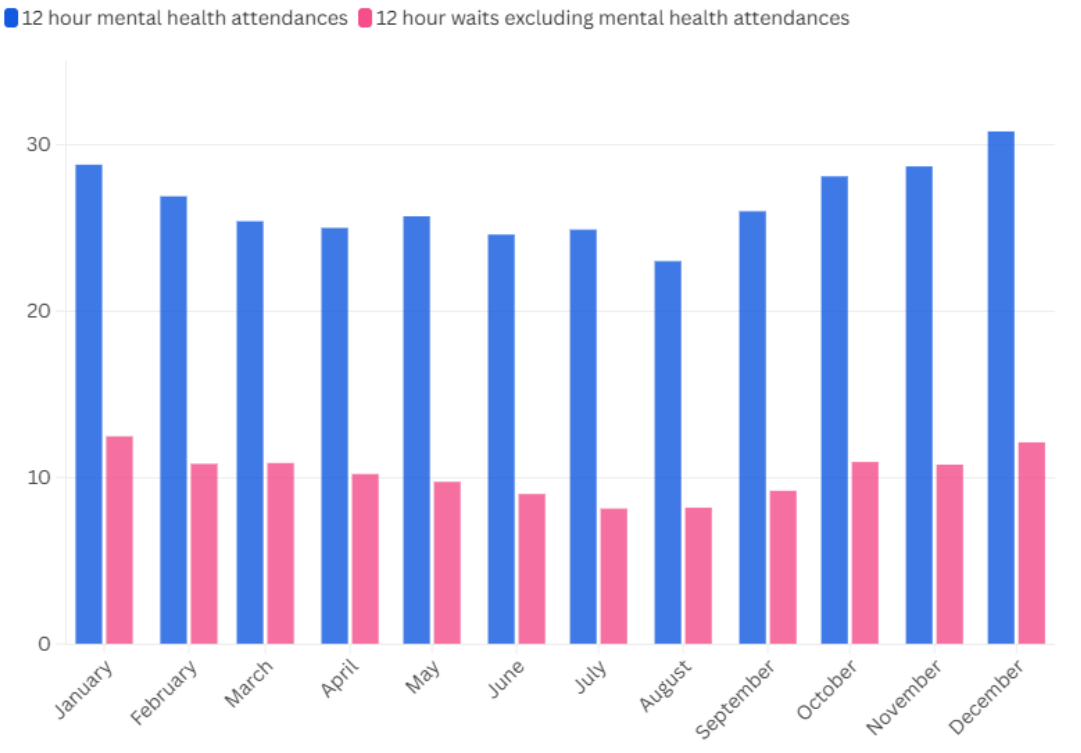
Mental health patients were 2.5 times more likely to wait 12 hours than non-mental health patients last year. Mental health patients are some of the most vulnerable patients who visit A&E, so it is likely that such long waits - especially in a hospital corridor - would cause them significant distress and potentially lead to their mental crisis becoming more acute.

Corridor care then is disproportionally putting the most clinically vulnerable patients in conditions that nobody should be forced to endure. The RCN report lays bare the difficulties of having these kinds of patients all in the same place, with mental health patients in extreme distress, and flu patients in proximity to elderly patients.[12] Having all these patients being treated right next to each other in cramped corridors means patient safety is constantly being compromised.

Corridor care has become the most visible sign of system-wide undercapacity in the NHS. It is unsafe for patients, damaging to staff, financially wasteful, and erodes public trust in emergency care. The evidence is clear that this situation is not inevitable: with sufficient investment in capacity, better integration across services, and a commitment to restoring safe patient flow, it can be ended. What is needed now is decisive action to protect patients, support staff, and rebuild confidence in one of the health service's most vital functions.

Figure 10 - Average percentage of mental health patients waiting longer than 12 hours compared to non-mental health patients in 2024



Source: NHS Digital Freedom of Information data

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[12] Royal College of Nursing, (2025) On the Frontline of the UK's Corridor Care Crisis. (https://www.rcn.org.uk/Professional-Development/publications/rcn-frontline-of-the-uk-corridor-care-crisis-uk-pub-011-944)

Recommendations

1. Restore patient flow by reducing delayed discharges

a. Establish a national target to reduce the number of patients medically fit for discharge but still in hospital.
b. Commit to reducing General and Acute bed occupancy to safe levels (85%).
c. Strengthen integration between hospitals, primary care, social care, and community services to ensure timely discharge and support at home.

2. Focus equally on four-hour and 12-hour performance

a. Place equal operational emphasis on reducing 12-hour waits as is placed on the four-hour target.
b. Resource the health and social care system to meet the 95% four-hour standard in the long-term, with the target being a whole-system-wide responsibility

3. Reform funding and incentives

a. Pilot and test alternative funding models that reward safe, high-quality care rather than throughput alone.
b. Ensure EDs are not financially penalised for the inefficiencies of the wider system.
c. Any financial incentive schemes should promote long-term improvements.

4. Spread responsibility for patient flow across the hospital

a. Mandate whole-system approaches to reduce the concentration of overcrowding in EDs.
b. Embed a culture of shared responsibility across specialties and departments within hospitals for managing capacity and patient movement.

5. Address inequalities in access and outcomes

a. Develop targeted interventions to reduce the disproportionate burden of long waits on deprived communities, older patients, and people with mental health needs.

6. Strengthen accountability and transparency

a. Require regular reporting to government on progress in tackling corridor care and overcrowding.
b. Involve patients and staff in monitoring the implementation of the 10-year plan to ensure that improvements are felt on the ground.

7. Increase transparent ways of measuring hospital performance

a. As provided in the 2025/26 Urgent and Emergency Care Plan, hospital-level performance figures must be published to improve transparency and enable comparisons of local health systems.

APPG on Emergency Care: Corridor Care

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