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Cite this as: *BMJ* 2026;395:e101206
http://doi.org/10.1136/bmj-2026-101206

The label "corridor care" is hiding the true scale of the NHS hospital crisis

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Corridor care is a symptom of failing systems. It has become a convenient label that masks the normalisation of prolonged waits in emergency departments and profound deterioration in NHS patient safety. We need to be honest with the public about the harm that is happening to patients.

In September 2026, only 74.4% of the 2.4 million patients who attended emergency departments in England were admitted, transferred, or discharged within four hours. More than 50 000 patients in September waited over 12 hours from the decision to admit to admission. Across 2025-26, there were 570 957 of these waits, an increase of 7.2% on the preceding year.[1 2]

This was not always the case. I was clinical director at Croydon University Hospital between 2010 and 2015, where the emergency department (like most across London) consistently achieved or was close to the national standard of seeing, treating, admitting, or discharging more than 95% of patients within four hours.[3 4] If a patient waited more than 12 hours for admission, we undertook a root cause analysis. The circumstances were scrutinised and reviewed by NHS London. We examined what had gone wrong, what harm might have occurred, and what needed to change. Prolonged waits were seen as exceptional events that required investigation, not an inevitable feature of hospital care.

What once demanded individual investigation has become routine today. Patients are examined, treated, and sometimes spend prolonged periods on trolleys in corridors, waiting areas, and other spaces that were not designed or staffed for clinical care. They may lack privacy, adequate monitoring, timely medication, access to toilets, or the dignity of a proper bed.

Corridor care is the consequence of hospitals operating beyond their capacity. Moving patients into corridors or elsewhere in the hospital may temporarily ease pressures in the emergency department, but it does not create additional staffed beds, clinical capacity, or safer care.

The pressures in emergency medicine reflect wider systemic challenges and backlogs. Rising attendances, increasing clinical complexity, ambulance handover delays, shortages of staffed inpatient beds, workforce gaps, delayed investigations, and constrained specialist capacity interact to obstruct the movement of patients through hospitals.[5] Much of this pressure is driven by what happens beyond hospital walls. Frail older people, frequently living with multiple conditions, cognitive impairment, and functional dependency, account for a substantial proportion of emergency admissions and inpatient care.[6] Many are medically ready to leave hospital but cannot be discharged safely because social care support is not available.[7]

Substantial evidence associates prolonged emergency department waits with increased mortality. A study published in the *Emergency Medicine Journal* analysed more than five million patients admitted through emergency departments in England. Mortality increased progressively when admission was delayed beyond five hours. The authors estimated one additional death for every 82 patients whose transfer to an inpatient bed was delayed beyond six to eight hours from arrival.[8]

The Royal College of Emergency Medicine has estimated that 15 860 excess deaths were associated with prolonged emergency department waits in England during 2025, compared with 1657 in 2015.[9] These are modelled estimates based on observed associations, not a count of individually adjudicated preventable deaths. Nevertheless, their scale should demand urgent action.

We should be clear about what this means. Delayed assessment, treatment, and admission can lead to missed signs of deterioration, delayed treatment, inadequate monitoring, avoidable complications, and excess deaths. Harm can be long term, including loss of function, prolonged rehabilitation, and diminished quality of life. We are having to tolerate failures in the delivery of evidence based care that is causing widespread patient harm.

NHS leaders have understandably highlighted improvements in the absolute numbers of patients treated within four hours, even during periods of record demand.[10] These achievements reflect considerable effort by clinical teams and deserve recognition. But reporting higher activity without equal prominence for prolonged waits, corridor care, and associated patient harm risks present a misleading picture.

We need a more honest national conversation informed by published data. Hospitals should report not only emergency department performance but also the number of patients spending prolonged periods in unsuitable clinical environments, the duration of these waits, delays to definitive treatment and admission, and the availability of staffed beds. We should measure discharge delays alongside the capacity of local social care services. Serious incidents involving prolonged waits should trigger proportionate clinical review such as root cause analysis, with findings used to improve systems rather than assign blame.

Patient flow, staffing, bed capacity, discharge processes, and access to social care are determinants

of clinical outcomes that demand scrutiny and urgency, and we should apply the scientific rigour to improving service performance as we do to clinical research.

NHS England, ministers, trust boards, and clinical leaders must acknowledge that corridor care is not a sustainable or safe model of healthcare delivery and commit the resources to resolve the underlying causes. Improvement requires investment in acute capacity, workforce, and diagnostics, but also properly resourced community services, rehabilitation, and social care. Shifting patients between departments without increasing effective capacity simply transfers risk.

Most importantly, we owe candour to patients and their families. A patient waiting 12 to 24 hours for a hospital bed should not be led to believe that this represents normal, safe care simply because it has become commonplace. Nor should staff be expected to reassure patients about conditions they know fall below acceptable clinical standards.

We should ask not only how we reached this position, but also why we have become willing to accept it. When services are overwhelmed every day, and winter pressures are all year round, the pressures on staff are relentless. The first step towards restoring safe hospital care is to stop normalising its failure.

Competing interests: AQ is founder of MedShr Ltd and an elected council member of the Royal College of Physicians.

AI use: AI was used to review spelling and grammar in this article.

Provenance and peer review: not commissioned; not externally peer reviewed.

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