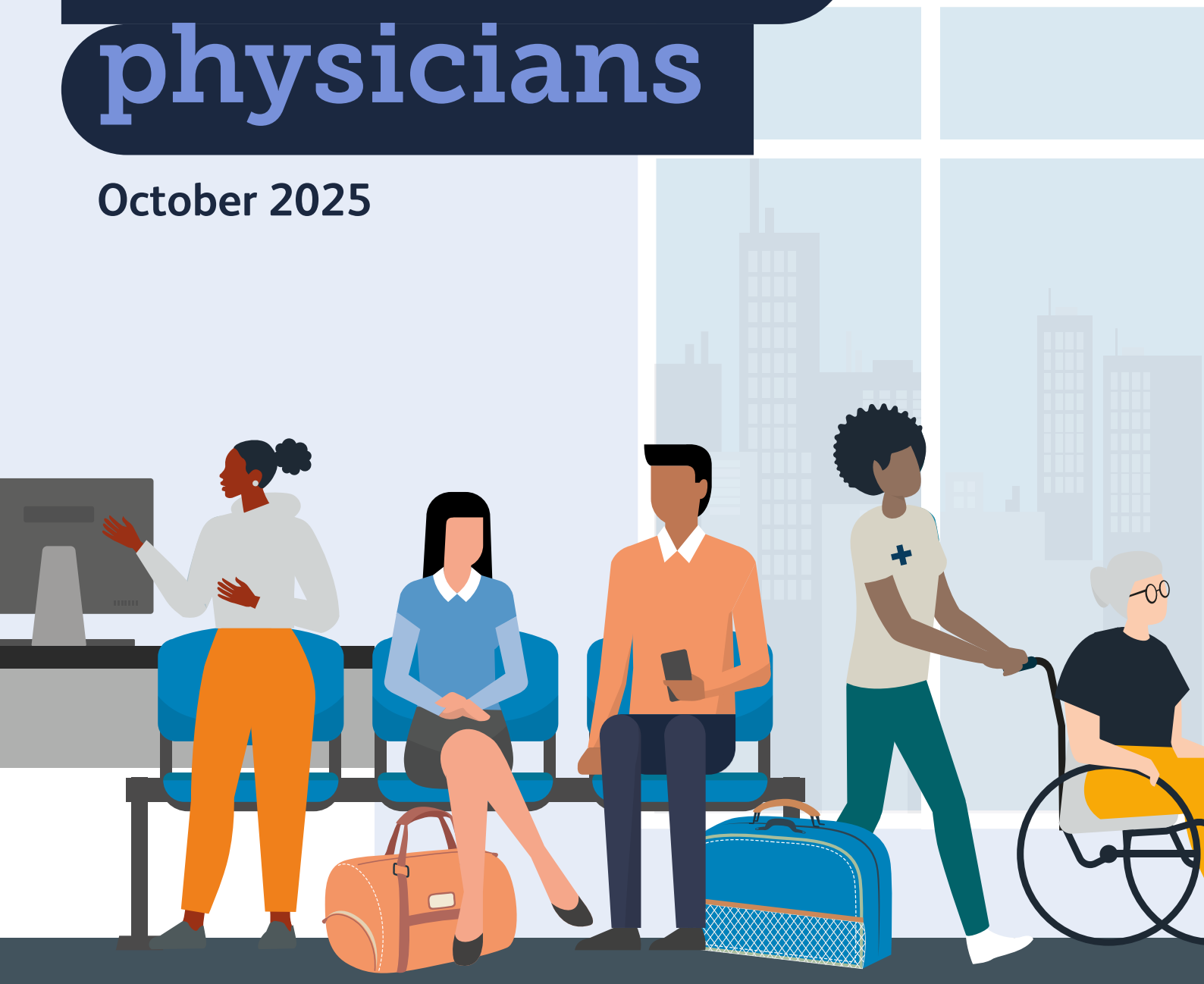
Royal College of Physicians

Confronting corridor care: guidance for physicians

October 2025



Introduction

The Royal College of Physicians (RCP) is calling for an end to 'corridor care', which is unsafe and unacceptable for both patients and healthcare staff.

Across the NHS, many patients who require hospital admission or assessment are receiving care in environments that are not designed, equipped or staffed for patient care. These include waiting rooms, corridors, ambulances outside emergency departments (EDs), additional spaces on wards without normal bedside facilities, and other areas of the hospital not designed for inpatient care. The RCP calls these spaces 'temporary care environments'.

Insights from doctors in the NHS show that this happens all year round. An RCP survey in February 2025 found that nearly four in five (78%) doctors had provided care in a temporary environment in the previous month (961 respondents). A follow-up survey in September 2025 confirmed that challenge persists beyond the winter months, with three in five (59%) doctors reporting that they provided care in temporary settings over the summer.

Delivering care in temporary spaces has serious consequences. Of the 328 doctors who reported providing care in temporary environments over the summer, 94% said that patient privacy and dignity had been compromised. Physicians themselves are also significantly affected – 72% said that they felt 'forced' to deliver care in these environments, while 66% said that they felt this was the new norm. Concerningly, 8% said that they had considered leaving their role because of it.

The RCP is calling on the NHS, Health and Social Care Northern Ireland, and governments across the four nations of the UK to:

- **protect** patients and staff by supporting them when care is delivered in temporary care environments
- **prevent** this practice by implementing systems and processes to improve patient flow and discharge
- **pledge** long-term investment in social care and public health initiatives to tackle avoidable admissions and improve health
- **publish** data all year round on how many patients are being treated in temporary care environments.

We must adopt a 'zero-tolerance' approach to this inadequate delivery of care and take steps to eliminate it. A robust social care system will be critical to have any chance of improving the situation. This is why we desperately need a long-term comprehensive plan for social care.

The NHS must also play its part to prevent ill health. Many of the pressures experienced during winter months are driven by seasonal illnesses, particularly respiratory infections. Strengthening public health initiatives such as smoking cessation and vaccination uptake is key to reducing avoidable admissions and easing the burden on acute care services.

No clinician or healthcare provider wants to deliver care for patients in inappropriate spaces. But this is the current reality of what it is like to work in the NHS. The RCP has developed this guidance to support physicians and healthcare providers until the provision of care in temporary environments can be eliminated.

Every patient admitted to hospital deserves the same dignity, safety and quality of care – no matter where in the hospital they are being cared for.

A note on definitions

The RCP uses the term 'temporary care environments' to describe the delivery of care in spaces that are not designed, equipped or staffed for patient care. Care is taking place in these environments because there is a lack of capacity to provide it in appropriate, safe places that are designed for care delivery.

Why is this happening?

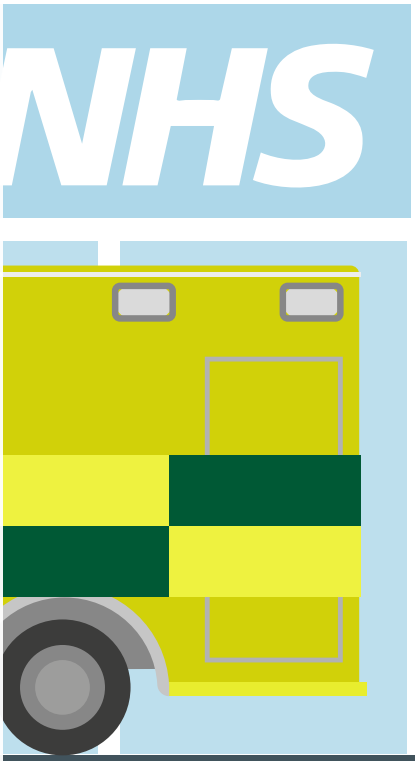
Care provision in temporary care environments reflects a lack of capacity within health and care systems to manage the demand for patients requiring urgent and emergency care (UEC).

Crowding in EDs has become increasingly prevalent in the UK over several years, and the RCP is clear that this is a year-round issue. In August 2025 alone, there were 2.27 million A&E attendances across England – the busiest August on record. Nearly 36,000 patients endured waits of over 12 hours from the decision to admit them to hospital to their actual admission, compared with just 371 in August 2019.

As NHS England's UEC plan rightly recognised, worsening population health is a key driver of increasing demand for emergency care. This deterioration is closely linked to social factors such as poverty, poor housing conditions, food insecurity and reduced access to preventive services – all of which contribute to higher rates of illness and hospital attendance. These pressures are compounded by operational strategies designed to manage patient flow, but can unintentionally worsen overcrowding.

NHS England promotes the continuous flow model, which transfers patients from EDs to wards at set intervals regardless of bed availability, to ease ED pressure. However, without timely ward discharges, effective use of discharge lounges and alternatives to hospital admission (eg hospital at home programmes), this can simply shift overcrowding onto wards, prompting the use of temporary care environments. Delays in discharging medically fit patients – driven largely by limited social care capacity – exacerbate these pressures, forcing admitting teams to deliver ward-level care in EDs, often without appropriate equipment, compromising safety, privacy and staff wellbeing.

These bottlenecks are forcing hospitals across the UK to rely on temporary care environments, many of which have become permanent fixtures. It is becoming increasingly normalised for care to be delivered in temporary spaces throughout the year.



RCP standards for inpatient care

All patients admitted to hospital deserve to receive the same standard of care, regardless of whether care is provided in a permanent or a temporary environment. Physicians are committed to delivering this level of care, yet many are forced to deliver care in environments that fall short of what they know is best for patients. The RCP does not endorse 'corridor care' as an acceptable form of healthcare delivery and advocates for a zero-tolerance approach. However, the RCP recognises that, for many working in the NHS, care in temporary environments has become a daily reality.

In January 2025 the RCP published a position statement, offering guidance to help clinicians and providers deliver inpatient care safely. This was in response to the RCP's concerns that NHS England's existing guidance was insufficient.

Building on this, the RCP has developed a set of core inpatient care standards specifically for physicians. These standards should be applied consistently across both permanent and temporary care settings. They are intended to complement NHS England's current guidance and could also be applied to other parts of the hospital.

If followed, these standards can help physicians deliver inpatient care, in any space that is:

- **safe and dignified**, where every patient has a named consultation, regular monitoring, rapid access to medication and equipment, with privacy, dignity, nutrition, toileting and hygiene needs always met
- **clearly communicated**, so that patients and families are kept informed, and staff have immediate access to patient information, records and incident systems, supported by regular debriefs
- **efficient and collaborative**, with multiprofessional teams working across departments to prioritise the sickest patients, enable safe discharge or transfer, and maintain patient flow using structured, evidence-based assessments.

While these standards are intended for use in inpatient settings, these could be applied to other parts of the hospital.

Upholding these standards relies on healthcare providers ensuring that physicians are equipped with the right training, equipment and support. Without these foundations, even the most well-intentioned clinical standards cannot be fully realised. It is essential that providers take active steps to create environments where safe, dignified and effective care is possible, regardless of the setting.

We hope that the guidance in this document offers practical support to physicians and healthcare providers as they navigate the challenges of delivering NHS inpatient care. These standards are not a long-term solution to corridor care, but a necessary step to safeguard patients and support clinicians in the current reality.

RCP standards for inpatient care

Patient safety

- Prioritise the sickest patients, including patients who are dying, and those suitable for discharge or transfer, using evidence-based tools (NEWS2, Clinical Frailty Scale, 4AT delirium test) to identify and safely move patients who are stable.
- Ensure that a named consultant and responsible clinical team are assigned to every patient.
- Maintain readily available call systems, oxygen, suction and resuscitation equipment.
- Uphold safe medicines management by following the Royal Pharmaceutical Society guidelines.
- Mobilise patients regularly when care in a temporary environment exceeds a few hours.
- Work as multiprofessional teams to assess, manage and transfer patients efficiently, in line with expected discharge and admission times and rates.

Privacy and dignity

- Always maintain privacy and dignity, including the use of screens or private rooms when requested or required.
- Provide accessible nutrition and hydration.
- Ensure adequate access to nearby toileting, washing and dressing facilities.

Communication

- Coordinate with other departments (eg acute medical unit, ED) to support patient flow and timely assessments.
- Explain reasons, timeframes and care plans to patients and their families, including obtaining verbal consent before moving patients.
- Direct patients/families to facilities and inform them how to alert staff to their needs.
- Support patient and family debriefing about their care experience.

Governance

- Keep patient information and observation charts accessible at the bedside, with easy access to patient records.
- Proactively ensure access to electronic systems, including those for incident reporting.
- Report near misses or harm to patients encountered while in a temporary care environment.
- Lead or participate in regular team debriefs with Freedom to Speak Up Champions.

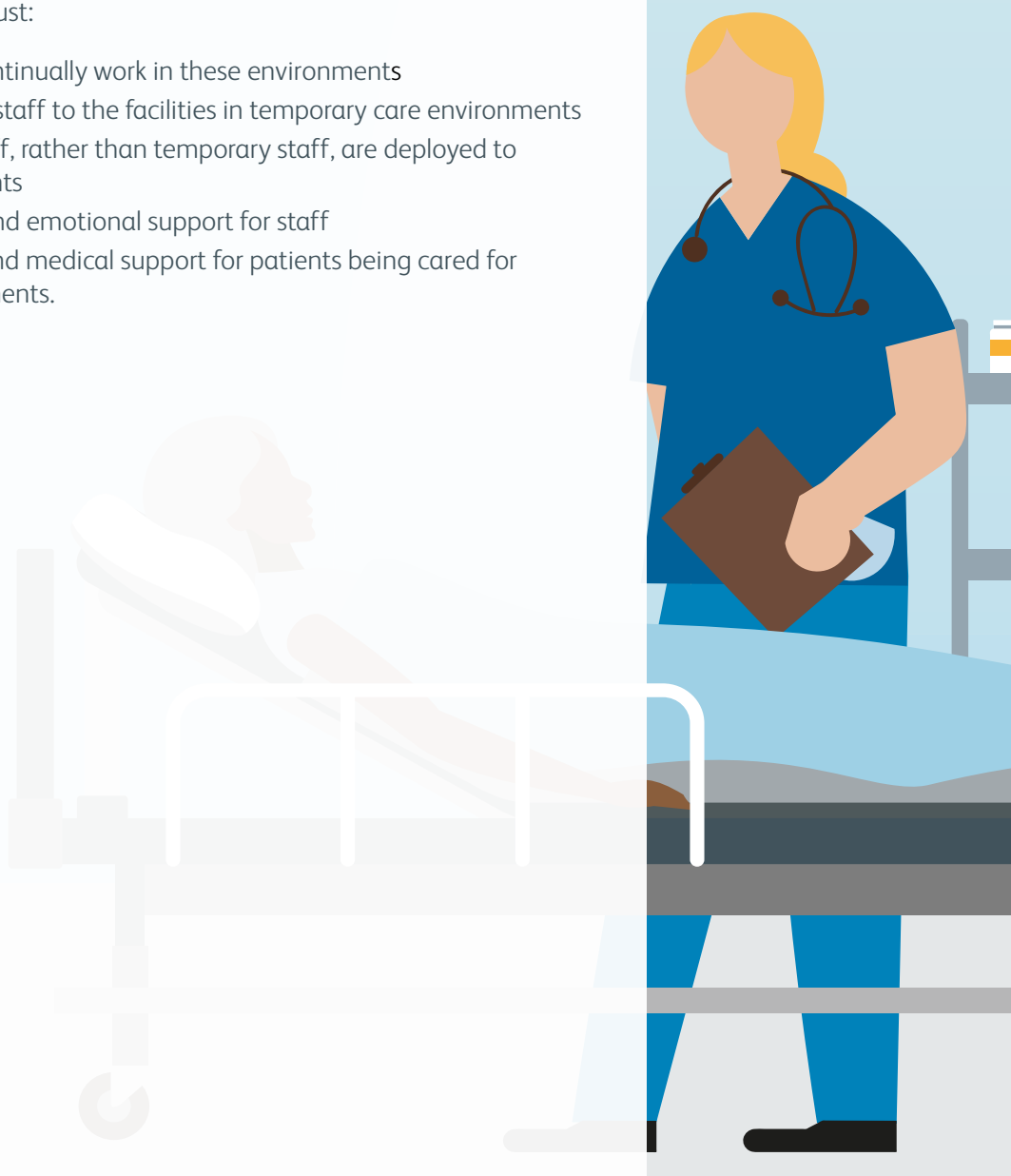
Safeguarding staff wellbeing

Particular attention needs to be given to the working conditions of staff who are consistently delivering care in temporary care environments. These environments present unique challenges, often with a lack of access to essential equipment and medications, significantly compromising patient safety, dignity and quality of care.

Insights from the RCP's snapshot surveys clearly show that delivering care in temporary care environments can be physically and emotionally challenging for staff. A Health Services Safety Investigations Body report examining harm caused by delays in transferring patients revealed poor staff wellbeing due to stress, moral injury, incivility and burnout as a consequence of ED crowding.

The emotional strain of working in these conditions is significant and, without targeted support, can diminish staff morale, increase the risk of burnout and compromise patient safety. To safeguard both patients and staff, it is essential that healthcare providers implement practical measures that support clinicians to maintain the same high standards of practice that are expected in permanent wards. Healthcare providers must:

- ensure that staff do not continually work in these environments
- provide inductions for new staff to the facilities in temporary care environments
- ensure that permanent staff, rather than temporary staff, are deployed to temporary care environments
- deliver regular debriefing and emotional support for staff
- ensure adequate nursing and medical support for patients being cared for in temporary care environments.

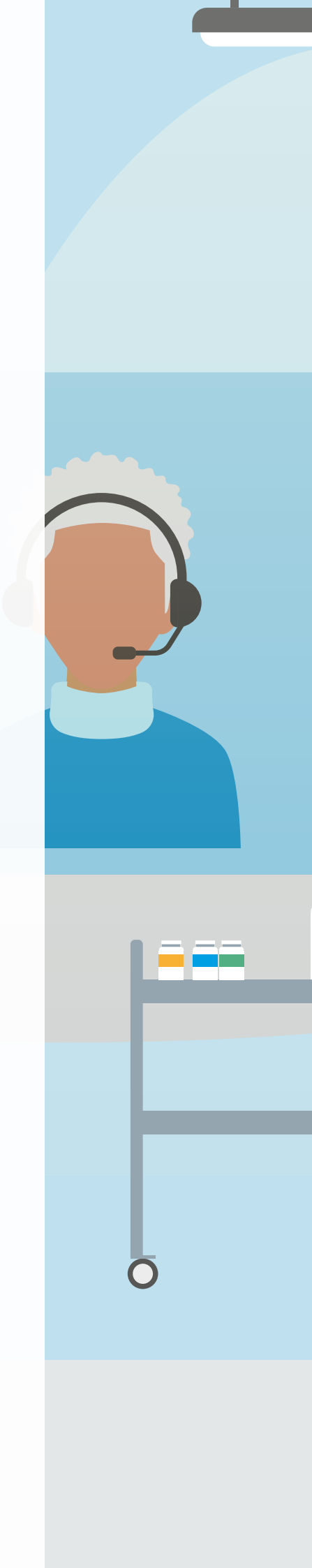


Laying the groundwork to prevent corridor care

Healthcare providers and local systems have a responsibility to continuously monitor and adapt to changing demands for inpatient care. This requires a proactive approach – anticipating surges in demand, mobilising resources swiftly, and ensuring that every patient receives care in an environment that is purpose-built for their clinical needs. It also means working in close collaboration with system partners, patients and clinicians to keep care pathways flowing smoothly, prevent unnecessary delays and safeguard capacity for the most vulnerable. In line with this, healthcare providers and local systems must:

- regularly review demand and capacity for inpatient care and assessment
- expand inpatient capacity when required, using appropriate facilities designed and staffed for inpatient care
- develop robust plans to meet the standards for inpatient assessment and care, which include clear criteria for when these would be used, staffed and de-escalated
- work with system partners and patients to ensure timely discharge or transfer from the acute hospital when patients are well enough to be cared for in other environments
- provide operational support to clinicians to ensure timely interventions that maximise patient flow, with a focus on the most vulnerable or unstable patients
- take steps to reduce hospital admissions, such as through promoting uptake of vaccines to prevent surges in seasonal illnesses and using community-based urgent care pathways where available.

Reducing demand on hospitals must also include a stronger emphasis on alternatives to admission. Services such as hospital at home, and community-based urgent care can play a vital role in preventing unnecessary hospital stays. This is particularly important for frail patients and those with advanced care plans. These models allow patients to receive high-quality care in familiar environments, often improving outcomes and reducing the risk of hospital-acquired complications.



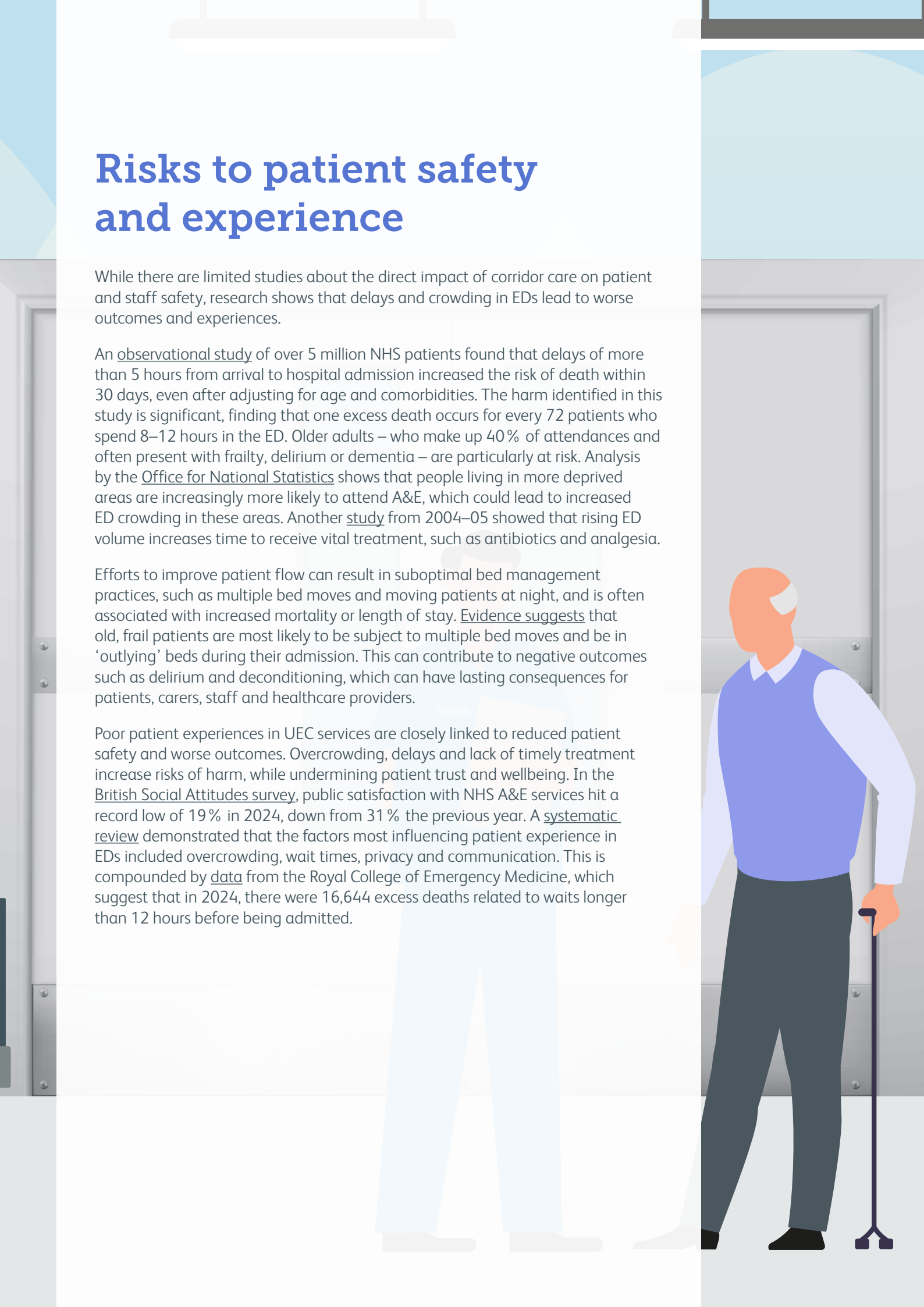
Risks to patient safety and experience

While there are limited studies about the direct impact of corridor care on patient and staff safety, research shows that delays and crowding in EDs lead to worse outcomes and experiences.

An observational study of over 5 million NHS patients found that delays of more than 5 hours from arrival to hospital admission increased the risk of death within 30 days, even after adjusting for age and comorbidities. The harm identified in this study is significant, finding that one excess death occurs for every 72 patients who spend 8–12 hours in the ED. Older adults – who make up 40% of attendances and often present with frailty, delirium or dementia – are particularly at risk. Analysis by the Office for National Statistics shows that people living in more deprived areas are increasingly more likely to attend A&E, which could lead to increased ED crowding in these areas. Another study from 2004–05 showed that rising ED volume increases time to receive vital treatment, such as antibiotics and analgesia.

Efforts to improve patient flow can result in suboptimal bed management practices, such as multiple bed moves and moving patients at night, and is often associated with increased mortality or length of stay. Evidence suggests that old, frail patients are most likely to be subject to multiple bed moves and be in 'outlying' beds during their admission. This can contribute to negative outcomes such as delirium and deconditioning, which can have lasting consequences for patients, carers, staff and healthcare providers.

Poor patient experiences in UEC services are closely linked to reduced patient safety and worse outcomes. Overcrowding, delays and lack of timely treatment increase risks of harm, while undermining patient trust and wellbeing. In the British Social Attitudes survey, public satisfaction with NHS A&E services hit a record low of 19% in 2024, down from 31% the previous year. A systematic review demonstrated that the factors most influencing patient experience in EDs included overcrowding, wait times, privacy and communication. This is compounded by data from the Royal College of Emergency Medicine, which suggest that in 2024, there were 16,644 excess deaths related to waits longer than 12 hours before being admitted.



Measurement and elimination of corridor care

Following campaigning from the RCP and others in the medical and health community, the UK government and NHS England have recognised corridor care as unsafe and unacceptable for patients and staff. We welcomed the UK government committing to 'end the disgraceful spectacle of corridor care' in the 10 Year Health Plan published in July 2025.

Following calls from the RCP and others for regularly published data on corridor care, in early 2025 NHS England began to collect data, but these have not yet been published. These data alone will not fix the issue, but they help us establish a baseline to determine whether any measures introduced to prevent corridor care are working. **The RCP will continue to call for these data to be published regularly as part of NHS England's monthly performance statistics release.**

The UK government and NHS England have committed to transform UEC services in the NHS and work towards eliminating corridor care. In June 2025, NHS England published its urgent and emergency care plan for 2025/26, with several targets including:

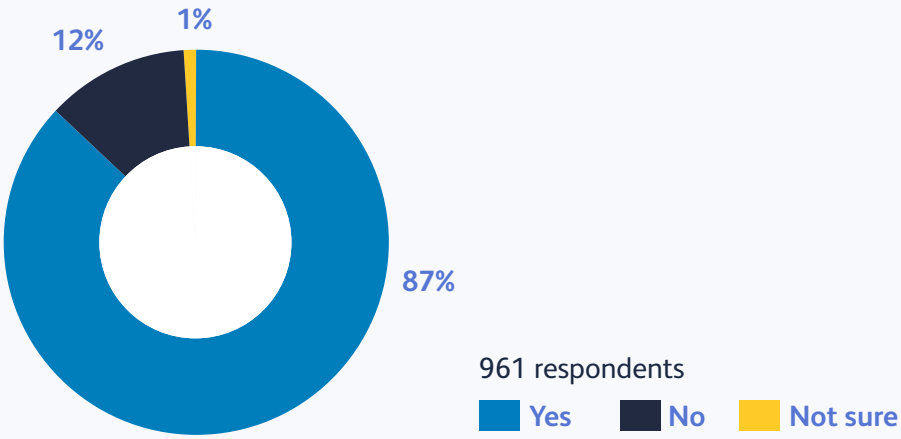
- ensuring that at least 78% of patients who attend A&E are admitted, transferred or discharged within 4 hours
- reducing the number of patients waiting over 12 hours for admission or discharge from an emergency care department by 10% compared with 2024/25
- tackling discharge delays by eliminating internal delays of more than 48 hours and targeting patients staying 21 days over their 'discharge ready' date
- making progress on eliminating corridor care.

To achieve these targets, the plan focused on redirecting non-emergency A&E visits to more appropriate settings, such as urgent treatment and same-day emergency care centres. The plan was accompanied by over £370 million of capital investment to support the expansion of these services. The 10 Year Health Plan for England builds on this by shifting towards community-based urgent care, supported by new neighbourhood health centres in every community. Urgent treatment and same-day emergency care centres will be expanded over the next decade, and the NHS App will become the digital front door for patients to navigate and access appropriate UEC services.

Addressing the systemic issues that are causing the growing use of temporary care environments will take time. The RCP will continue to call on government to take steps to address these systemic issues, and for action by government and the NHS across the four nations of the UK to end and prevent the use of temporary care environments.

February survey

In the last month, have you delivered care in a temporary environment?



When you last cared for a patient in a temporary care environment, where was it?

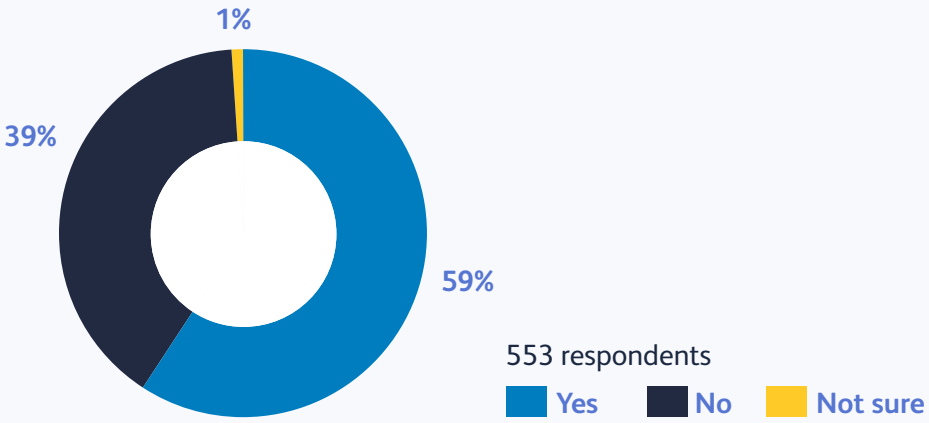
889 respondents

Waiting room	8 %
Additional bed or chair in a bay	26 %
Corridor	47 %
Ambulance outside ED	3 %
On a ward without dedicated bed space	12 %
Another location not designed for patient care	4 %

Impact on patient care – respondents were asked to select all options that apply

Patients' privacy and dignity were compromised	92 %
Patient confidentiality was compromised	83 %
A lack of access to vital equipment/facilities eg oxygen, toilet, call bell, hand-washing facilities	78 %
It was difficult to monitor patients	68 %
Patient safety was compromised	62 %
Patients and families were less satisfied with the care that they received	69 %
Patient distress was increased	59 %
Infection prevention control measures were compromised	63 %
Clinical practice was physically difficult eg restricted physical examination, administration of IV therapies	82 %
Relatives become distressed	41 %
Increased personal stress	66 %
None of the above	3 %

Between June and August 2025, did you deliver care in a temporary care environment?



How often did you deliver care in a temporary care environment between June and August?

328 respondents who responded yes

Daily or almost daily	45 %
Weekly	21 %
2–3 times a month	18 %
Once a month	13 %
Less than once a month	3 %
Once	1 %

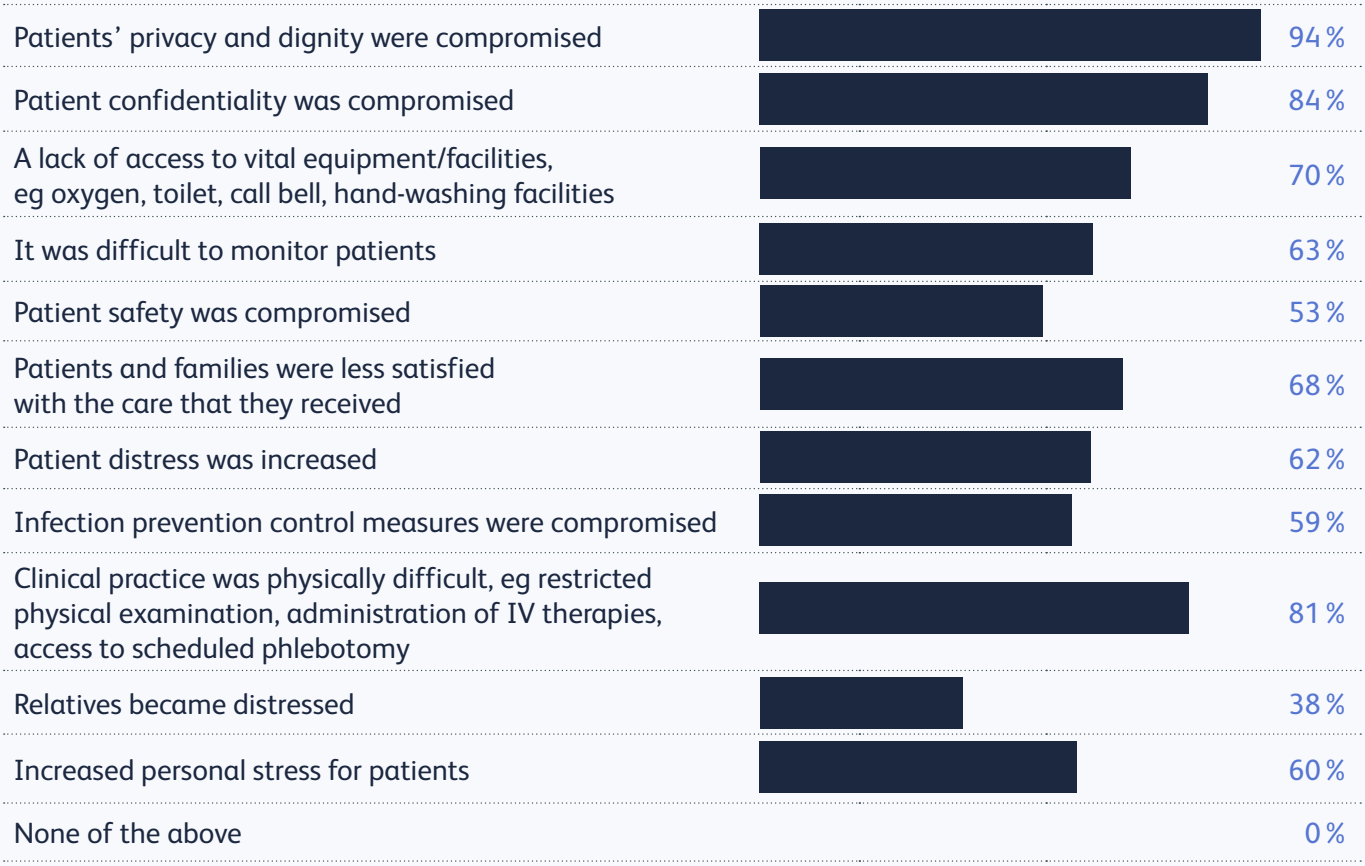
When you cared for a patient in a temporary care environment during these summer months (June–August), where was it? – respondents were asked to select all options that apply

328 respondents

Additional bed or chair in a bay without appropriate bedside facilities	66 %
Waiting room	34 %
Corridor	74 %
Ambulance outside ED	9 %
On a ward without dedicated bed space	46 %
Another location not designed for patient care	13 %
Other	13 %

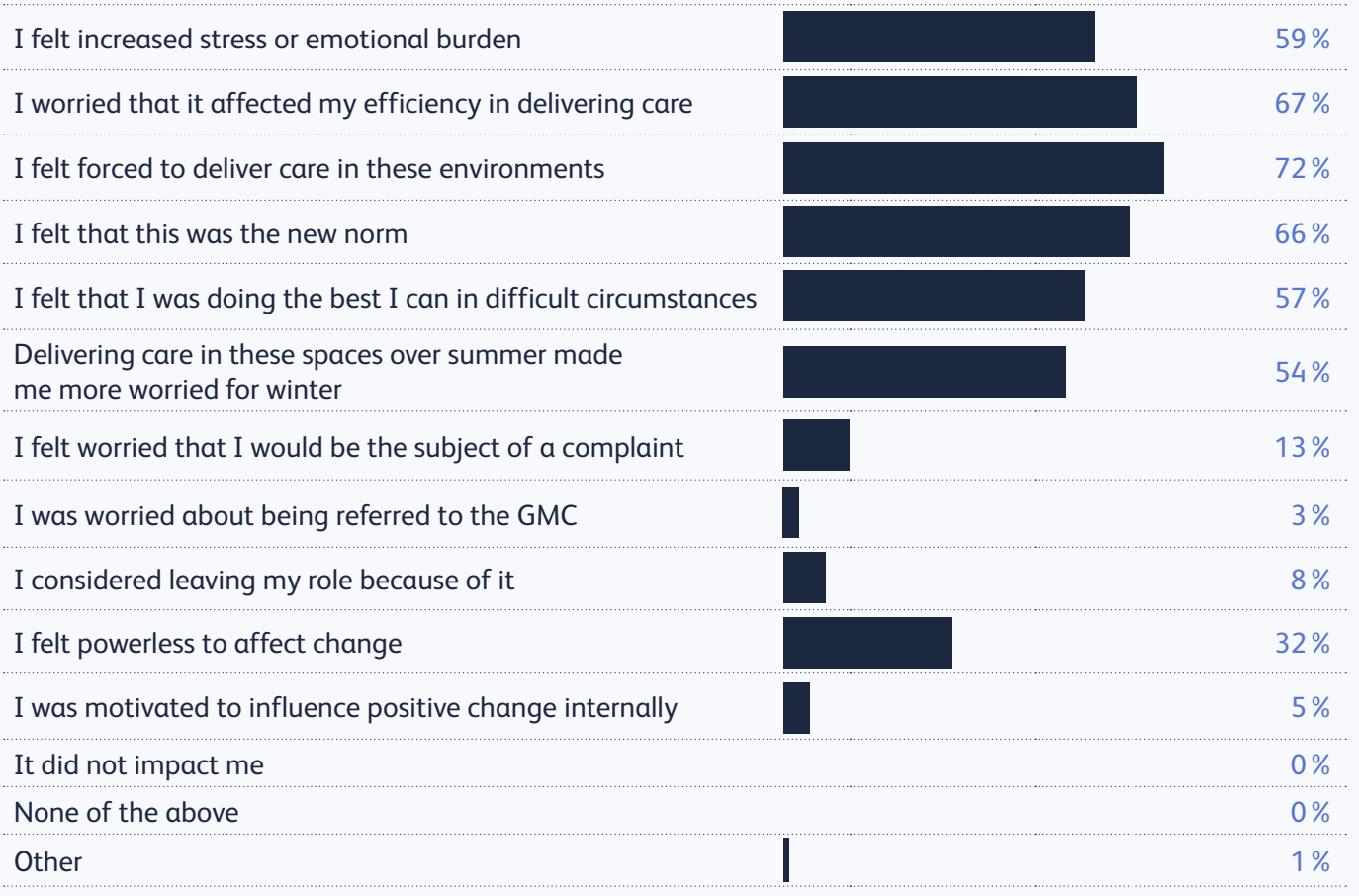
How did this care in a temporary environment impact patients? – respondents were asked to select all options that apply

328 respondents



How did this care in a temporary environment impact you? – respondents were asked to select their top five

328 respondents



If you are a physician and would like to share further experiences of temporary care environments, or if you're encountering new challenges in delivering inpatient care, we welcome your insights. Please get in touch by emailing policy@rcp.ac.uk.

Confronting corridor care: guidance for physicians was developed in consultation with the RCP's Medical Specialties Board. The document was approved by RCP Council.

Get in touch

Contact: policy@rcp.ac.uk

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