Tackling temporary care environments

Delivering care in temporary environments – such as corridors, gyms and converted offices – is a year-round challenge which increasing numbers of physicians are forced to experience. These spaces often lack essential equipment, access to necessary medications, or even privacy to consult or examine patients.

Throughout 2025, the RCP has shone a light on the extreme pressures being faced by physicians in NHS hospitals. Two snapshot surveys of our members have highlighted the extent of this issue with a recent survey finding that three in five (59%) of doctors reporting they had provided care in temporary settings over the summer.

The RCP is clear that corridor care is unsafe and unacceptable. Throughout this year, the RCP has continued to call on the NHS, Health and Social Care Northern Ireland, and governments across the 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.

Until corridor care is eliminated, staff need support to protect patients and safeguard their wellbeing in these environments. As a result, the RCP has updated its clinical guidance to help safeguard patients and support physicians that are being forced to work in temporary care environments.
Commentary speaks to Dr Zuzanna Sawicka, RCP clinical director for patient safety and clinical standards, about temporary care environments.

The RCP's new guidance recognises that corridor care is now a reality for many clinicians and patients, all year round. How have we reached this point?

There are reports that we increase the patient numbers as the age of our population and frailty increases; that more patients are presenting at hospital. But [the issue is] actually the number of patients who don't need to be in the hospital – often stuck in the system due to lack of social care or other complications.

There is a real burden on secondary care when patients or relatives cannot access primary care efficiently or effectively. Somebody once told me, 'the lights in the hospital are always on'– we don't close the doors [at weekends or at night], like general practice.

For many years, we've seen trolley waits in our emergency departments (ED), but we're seeing the further emergence of corridor care on the wards. The problem arises when we get extra beds, but no increased medical or nursing resources. Time for people to be seen becomes precious; people are having to wait for assessments.

Another reason for an increase in corridor care is that we're seeing a rise in social care demand. Many people during the COVID pandemic supported their relatives at home, but now – in a [difficult] financial climate where people need to work – they are less able to cope with the demands of looking after relatives. People can't easily offer support on a daily basis, so we're seeing this rise in the need for social care; particularly as we continue to advocate to maintain people's independence, in their own homes, for as long as possible

What has been your experience of delivering care in temporary environments?

As both an acute and a community geriatrician, I have seen corridor care both in emergency care and on wards. In EDs, I've seen people being lined along corridors with lack of dignity, lack of facilities, agitated – particularly over the winter periods. Something that is really close to mine and RCP clinical vice president RCP clinical vice president Dr Hilary Williams' hearts is that some people are dying in ED corridors.

I've also had the opportunity to see corridor care in wards; extra beds being put into places designed for fewer. To enable that, the curtains there for dignity might only slightly cover patients or you have to pull a [screen] across – but it's never the same privacy.

It's really difficult to deliver information. The available spaces where we would normally have private and important conversations – such as end-of-life or diagnostic discussions – have been lost. We can't necessarily speak to a patient or relative away from a busy world.

We've seen the use of patient lounges and other spaces; only yesterday I had to use our relatives' room,

which doubles as a staff room, to speak to two relatives. I had to move staff into another area to break bad news and have sensitive conversations somewhere other than a corridor.

I was at a clinical service for over 5 years, and I used to pride myself that there were no extra patients on the corridors. People did, however, wait longer in ED. The problem is that the longer it takes to see a senior decision maker, the higher the likelihood of much poorer outcomes.

What are some of the key risks and problems that arise from delivering care in temporary environments for staff and patients? Have you seen any of these in action?

The first and foremost risk has to be patient experience; their dignity or ability to access appropriate facilities like toilets. And as I mentioned, there is obviously the compromising of conversations. When I've seen beds being left on the corridor – just due to pressures yesterday, people were in the actual corridor for a couple of hours at a time – you can't easily have staff or a relative sit with that person, because you're then blocking the corridors.

I've known of situations where there's been a lack of access to equipment, like oxygen and suction. I've also sadly heard of somebody dying in their sleep on a corridor. It's really sad to think that things like that may have happened in other places which aren't appropriate.

For patients, there are simple things – access to a plug point, a TV or other people to speak to – which, as physicians, we don't necessarily recognise. The work that we've done with our Patient and Carer Network (PCN) really shows that we don't always think what the patient may need in these hospital environments.

None of us want to work like this. While it has become the 'new norm', it does upset us. There is a lot of dissatisfaction and increased burnout currently. We know that corridor care is increasing complaints [from patients]. But unfortunately, our hospitals are full to bursting.

What is some of the main advice for physicians who find themselves working in temporary care environments?

Safe and dignified care, and clear communication. I would urge physicians to document what is happening. Make it clear in patient notes that someone is being cared for in a temporary escalation space.

We are part of a team. This doesn't just affect us as medics – it affects the nurses, the advanced health professionals, and relatives and patients. There has to be clear communication that this isn't how we wish to care for somebody, that we're trying to do our roles in a very difficult situation.

Physicians also have an advocacy role and a leadership role – considering who goes into a temporary escalation space. We have a role in identifying which patient is most able to be in these spaces. We have to think about alternative pathways; that is only achievable through efficiency and collaboration. We not only need to ensure safe discharge, but increase the use of things like virtual wards, hospital at home programmes, early supportive discharge and discussions with relatives about discharge.

We also have a role in advocating from a patient safety point of view and making sure that incidents are properly reported, so that we can really understand the burdens and patient safety issues that are attributable to these temporary escalation spaces.

How can physicians best support patients who may end up being treated in these environments?

One of the big things is to advocate for our patients. The PCN has made good suggestions about how patients may feel, and how we can best support them. These include making sure that patients are not forgotten and are kept honestly informed about their situation, and how it might change. The PCN also emphasised to ensure that patients are receiving adequate treatment and not getting worse. Most of all, keep patients safe, respect and maintain their privacy and dignity – and enable contact with family and carers, keeping them informed.

I think those are really valuable points to think about when we are managing patients in those areas. When we are maintaining patient flow with structured, evidence-based assessments, the better we can care for people and understand who can appropriately be cared for in temporary environments. Then we can perhaps prevent patients at the end of life from dying on those corridors, and work together to get a beneficial solution for all.

What can managers and healthcare providers do to support their staff?

Burnout compounds these problems. There is a great deal of importance in solidarity – and the visibility of senior staff members and healthcare providers.

Acknowledge key successes when temporary escalation spaces get closed, but acknowledging the hardship is also really important.

I'd advocate for the power of a cup of tea or an offer of support to colleagues – it may mean the difference between managing to keep them hydrated or going to lunch on time.

There is work that can be done on enabling discharges, supporting further development of the virtual wards, supportive discharges or hospital at home programmes.

A home-first approach will take time to build, but start by thinking about whether people must stay in hospital. What are the possibilities? For example, we keep some older people in hospital for constipation that can be managed easily by district nurses or virtual wards. The longer somebody is in hospital, the less mobile and used to their normal environment they become. Some support will be about changing the culture of an organisation and driving for improvements at the front door.

What steps need to be taken to tackle this at a national level? What is the RCP doing to minimise the use and impact of temporary care environments across the NHS?

The government is determined that corridor care will end. They're clear that it is unacceptable and undignified.

We know that the shift from hospital to community needs to be in place. We can see the development of neighbourhood working and hospital at home programmes, but we can't neglect the need for specialists to be reaching out into the community.

Last year, half a million patients received more appropriate care in the community, so there is a real need for national messaging about the appropriateness of hospital admission and vaccinations.

We also need the strengthening of social care services to enable people to reach out before reaching crisis; often the people that don't need to reside in hospitals have reached a crisis, essentially because they haven't had access to carers or simple equipment that may have made a difference.

From an RCP point of view, we are continuing to advocate. We're continuing to work on emergency and urgent care, looking at how to support that home-first approach, but we're also looking at what we can do to support our physicians within temporary working environments. How can we advocate for our members and fellows? How can we advocate for the patients we serve and make sure that the patient voice is heard alongside the voice of physicians?

We continue to highlight the definition of temporary escalation spaces, not just classifying it as 'corridor care'. This isn't just about corridors, this is also about day rooms, bathrooms and other spaces that have been converted. We're also encouraging the building of medical workforce models and doctor–patient ratios that will further support the work being done.

We will also continue the work that the RCP does around prevention – advocating for vaccinations and what people can do to prevent themselves being admitted to hospital.

At the RCP, we firmly believe that there needs to be an end to corridor care. That is not going to be achievable unless all three shifts – community, prevention, digital – are delivered. The implementation of those shifts will hopefully enable us to make a real impact in reducing temporary care environments.

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