Royal College of Nursing

Corridor care: unsafe, undignified, unacceptable

The impact on patients and staff of providing care in corridors and other inappropriate areas

POLICY REPORT

Acknowledgements

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Foreword

There's nothing about corridor 'care' that resembles caring. Patients left on trolleys or chairs for hours on end, often soiled, in pain and suffering – it's tantamount to torture. There's no part of our society that should consider this acceptable. So why are we accepting it? On the pages that follow you'll read the harrowing reports of our members, forced to examine and treat patients in public spaces where they feel exposed, vulnerable and violated.

Just 1 patient being treated without privacy, or dignity, is 1 too many. But this is happening time and again – our member survey shows that corridor care has been steadily increasing over the last 4 years. As well as affecting patients' privacy and dignity, more than half of respondents said it means patients don't have access to life-saving equipment, with examples of nursing staff running out of oxygen for patients being treated in corridors. The impact on our patients is horrific, and we must not understate or underestimate that.

This type of 'care' is so commonplace that it has become normalised. I've walked those wards myself and spoken to nursing staff who love their jobs but are resigned to nothing changing. They are forced to care for too many patients and must either work longer hours or leave necessary care undone. They shouldn't be put in that impossible position. It creates a huge moral burden and the turmoil of providing this substandard care is forcing over half of respondents to consider quitting. We can't let that continue.

Treating people in inappropriate areas is unsafe, undignified and unacceptable. We are speaking up on behalf of our patients and our profession – we all deserve better. This is a symptom of wider systematic failures – it shouldn't be this difficult for patients to access the health and care services they need. Nursing staff can't continue to work in a system where demand for services is rising but the workforce remains in crisis.

Enough is enough. We are calling for corridor care to be eradicated and we will hold governments to account to make sure it happens.

Professor Nicola Ranger
Acting Chief Executive and General Secretary, Royal College of Nursing

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Executive summary

Corridor care is unsafe and unacceptable for both patients and health care staff. Corridor care images in the media are most often associated with treatment that is inappropriately given in corridors in accident and emergency departments (A&E), but this is not the full picture.

Too often care is delivered in car parks or break rooms, additional beds are added to patient bays[1], storerooms are used for triage areas. Sometimes patients receive care in chairs, rather than trolleys or beds. But it's not just hospitals: we hear from nursing staff working in primary care, public health, social care, and even criminal justice settings. So, throughout this report, we use the term 'corridor care' to describe any care being delivered in non-clinical spaces.

Patient privacy and dignity can be compromised when care is provided in inappropriate settings. Access to life-saving equipment such as oxygen, suction and monitoring can be unavailable, and patients can have limited or no access to toilet facilities and handwashing provision. Emergency call buttons are unavailable. Infection prevention controls are compromised. Health and safety regulations are breached. Medication cannot be stored safely, and patients' personal belongings are not secured. There are typically no additional staff, meaning that the caseloads of staff on shift are higher. This is not an exhaustive list of reasons why corridor care compromises patient safety and dignity.

In response to our recent survey, 11,000 nursing staff told us about their experiences of corridor care. The findings included:

- More than a quarter (27%) told us that corridor care is happening. When we exclude settings where corridor care doesn't occur, such as call centres, this figure rises to 37%.
- Nearly two-thirds of nursing staff (63%) worried that patients were receiving unsafe care and half of respondents reported leaving necessary care undone.
- 67% indicated the most common impact of corridor care is compromising patient privacy and dignity.
- 54% have considered leaving their role as a result of the stress of corridor care.

Corridor care doesn't happen in a vacuum – it reflects a system in crisis. It happens when demand isn't managed effectively and there is insufficient capacity to meet demand – including the supply of staff and physical clinical space to provide appropriate care.

Decades of underfunding for prevention has led to worsening population health across the UK, with rising need and complexity. Successive governments have failed to ensure there is a sustainable health and care workforce to meet the population's needs and continued to focus on short-term funding packages to plug gaps in secondary care, neglecting primary, community and social care services. Despite claims of progress towards a 24/7 health service, people are often waiting weeks for GP appointments and turning to A&E for help, and as social care budgets become further strained, vulnerable people are being left without the support they desperately need.

[1] A patient bay is an area within a multi-bed ward/room which allows patients to make a private space by drawing the curtain for dressing or consulting with their care team.

"This is now regular practice within A&E, it is deeply upsetting. We regularly run out of oxygen for patients being nursed in the corridors. There is zero privacy and dignity. Patients are soiled for long periods of time because there is nowhere to change them. Corridor care is a fire risk. Families are distraught. I've witnessed DNACPR decisions being made/signed in the corridor. I've had to move a deceased patient into a corridor in order to generate resus capacity before. Its horrific." **Registered nurse, NHS hospital, England**

Additional attendances increase the flow into hospitals, without any additional capacity. Clinicians are faced with difficult choices to care for people in corridors, or by adding extra beds to patient bays, in A&E and on wards. What once would have been considered emergency measures in exceptional circumstances are now being normalised.

Nursing staff and patients have had enough. This unsafe practice cannot continue to be the 'norm', patient safety and staff wellbeing must not be compromised any longer. **The RCN is calling for normalised corridor care to be eradicated.** This is only possible through decisive, immediate actions across the health and care sector.

Our recommendations include:

- **Invest:** governments across the UK should take a 'whole system' approach to funding and additional investment in health and care services with additional, sustained investment in prevention, primary and community care and social care to address short-term capacity issues, manage demand and improve the population's health to move towards a more sustainable model that is not perpetual crisis management.
- **Accountability:** health and care ministers across the UK must be responsible for reporting publicly on the instances of corridor care each quarter, along with the actions underway to reduce occurrences.
- **Workforce:** governments to invest in boosting nursing supply through higher education and apprenticeship routes and take the necessary steps to support and increase the recruitment of nursing staff and address retention issues. This must include a fair pay rise for nursing.
- **Understand demand:** governments should develop and publish assessments of current and projected population demand and open dialogue with the public about their expectations for the provision of health and care support and use this to inform and support health and care workforce planning and funding.
- **Fix and utilise appropriate space:** governments must increase investment to address the maintenance backlog to allow clinicians to access additional clinical spaces, and based on the assessment of demand, increase staffed bed capacity.
- **Report:** service providers should be required to collect data and report on instances of corridor care, including details about the likely impact on patients and staff. Nursing staff should raise concerns (through incident reporting systems) every time they observe corridor care, or prolonged treatment given to patients in chairs. This will support providers to better understand trends and pinch points. Members of the public who experience corridor care should use local procedures to log complaints. This will put pressure on local decision makers to act.

What we know about corridor care

Our members are clear that corridor care has been normalised, and in some cases are actively being told not to report it using their normal incident reporting systems.

Corridor care negatively impacts on the quality of care the public receives in terms of safety, dignity, and privacy. Access to life-saving equipment, such as oxygen and suction is also challenging in a corridor, and patients do not have access to medicine lockers or water jugs.

Participants in our survey told us that nursing staff are negatively impacted as they suffer moral distress and moral injury when they are unable to provide high quality compassionate care to their patients in corridors.[2] Workload is also significantly increased. This has led to some wanting to leave the profession, as well as increased stress-related sickness and absence.

The impact of corridor care is felt by the whole nursing workforce, including students, nursing support workers, registered nurses and nurse leaders.

Members emphasised that a systems approach is needed to ensure that there is adequate funding for both health and social care.

RCN safe staffing survey

We recently surveyed nursing and midwifery staff across the UK to share their experiences of corridor care. Around 11,000 respondents provided valuable insight into the realities of this issue, based on the last shift they had worked.

Overall, at the UK level, in environments where corridor care is possible (i.e. excluding settings such as schools or call centres), over a third of all respondents (37%, equivalent to 2,935 people) agreed that clinical care took place in an inappropriate environment (i.e. 'corridor care') as shown in Table 1. There was variation among the countries, with respondents more likely to agree with the statement in Northern Ireland (49%).

Table 1: Statement: clinical care took place in an inappropriate environment e.g. an additional bed in a bay, waiting room, a corridor or a location not designed for patients.

Level of agreement with the statement	Agree	Neither agree nor disgree	Disagree	Row total
Northern Ireland	49%	7%	44%	100%
Wales	45%	8%	47%	100%
Scotland	38%	9%	53%	100%
England*	35%	10%	55%	100%
Not specified	35%	9%	56%	100%
UK	37%	9%	54%	100%

*includes Channel Islands and Isle of Man

[2] Moral distress occurs when institutional constraints prevent doing the right thing. Moral injury refers to the lasting psychological, behavioural and spiritual effects of carrying out or witnessing acts that go against deeply held moral beliefs/expectations. See Houle S A et al. (2024) Measuring moral distress and moral injury: A systematic review and content analysis of existing scales, Clinical Psychology Review, 108, p. 102377.

It should be noted that at the UK level the number of respondents who agreed to the statement that clinical care took place in an inappropriate environment has gradually increased, compared with previous years' surveys when we asked the same question. In 2020, 27% agreed, which increased to 31% by 2022 and is now at 37%, which suggests an acceleration in how widespread corridor care has become.

Of those who agreed to the statement that corridor care did take place in our 2024 survey (2,935 respondents), we asked where they had witnessed or been involved in providing this type of care.

Table 2 shows that most commonly, respondents saw care in inappropriate environments taking place where extra chairs or beds were created to accommodate patients (39% of the 2,935 respondents). Similar numbers also saw care in inappropriate places conducted in corridors (36%) and other areas/locations that were not originally intended for patient care (31%).

Table 2: Of those who saw/were involved in clinical care in inappropriate environments, the following percentage of respondents indicated that this care was provided in the following areas:

Locations where clinical care took place	Yes %
Additional chair or bed in a bay	39%
Corridor	36%
Location not designed for patients	31%
Waiting room	23%
Other (not listed)	23%
Community setting while waiting for ambulance	2%

The impact of corridor care on patients

Respondents who had witnessed corridor care were also asked to indicate what they believed the impact of such care was on patients. Table 3 shows how common each impact is based on how often it was selected as a response. We are very concerned that two-thirds of respondents (67%) indicated the most common impact of corridor care is compromising patient privacy and dignity.

Around half of the respondents indicated issues around patient safety. This includes safety being compromised, difficulty in monitoring patients, and problems accessing vital equipment.

Table 3: Of those who saw/were involved in clinical care in inappropriate environments, the following percentage of respondents said that this care impacts patients in the following ways:

Impact on patients	Yes %
Patients' privacy and dignity was compromised	67%
Patient confidentiality was compromised	55%
A lack of access to vital equipment / facilities eg oxygen, toilet, call bell, hand washing facilities	53%
It was difficult to monitor patients	50%
Patient safety was compromised	49%
Patients and families were less satisfied with the care they received	49%
Patient distress was increased	45%
Infection prevention control measures were compromised	44%
Clinical practice was physically difficult eg administration of IV therapies	43%
Relatives became distressed	35%
None of the above	6%

The impact of corridor care on staff

"I am leaving my role for another area. I feel a large amount of my communication with patients and their families involves apologising for 24 hours and longer stays in chairs, lack of privacy and dignity, lack of warm meals and inability to meet other basic needs, and poor communication from nursing and medical staff. Constantly needing to apologise on behalf of the health board for the patient's experience and agreeing that this is not good enough has a huge toll on my mental health."
Registered nurse, NHS hospital, Wales

Four in every 5 respondents (81%) who witnessed or were involved in corridor care felt stress in these circumstances (see Table 4). This psychological strain is further highlighted by nearly two-thirds of respondents reporting that they feel emotionally burdened or worried about having to provide clinical care in this manner. Furthermore, 45% of nursing staff reported being on the receiving end of increased violence and aggression because of corridor care, while 4 in 10 respondents expressed concerns about being struck off the NMC register due to patients being harmed.

Table 4: Of those who saw/were involved in clinical care in inappropriate environments, the following percentage of respondents said that corridor care impacts staff in the following ways:

Impact on staff	Yes %
It made me feel stressed	81%
Increased emotional burden	63%
It may me feel worried that patients may be receiving unsafe care	62%
It took me longer than usual to provde the care I needed to	61%
I've considered leaving my role	54%
Due to the increased volume of patients I had to leave necessary care undone	50%
I've faced increased violence or aggression from patients and relatives due to their frustration that care is not provided in appropriate locations	45%
My mental health has suffered	44%
I'm worried about patients being harmed and being struck off the NMC register as a result	39%
I'm worried about patients being harmed and this leading to a court case involving myself or my colleagues	37%
None of the above	4%

The current evidence base

The RCN commissioned the University of Sheffield to undertake a rapid review of UK and international evidence on corridor care in nursing (including peer-reviewed journal articles from January 2013 onwards, as well as media stories), which identified themes relating to staff experiences and patient experiences.[iii]

The review revealed that relevant research came nearly exclusively from studies conducted outside the UK, and mainly focused on emergency departments and mental health settings. The following themes emerged from the evidence base.

- Care quality and safety: negative feelings related to neglected patient needs, including basic needs such as hydration and hygiene. This included concerns from staff about compromises to patient dignity and privacy, and in some settings providing inadequate care for the presenting patient (that is, inability to provide psychiatric care). Such chaotic environments are not helpful to already distressed patients and their recovery from illness or injury.
- Overcrowding is directly related to lower levels of patient satisfaction. This covers aspects such as increased noise, long wait times, poor communication from staff and a lack of security and privacy.

- Patients boarding[3] in the emergency department often talk about frustration, being uncomfortable, and lacking food, general care, and responsiveness from staff. It is particularly difficult for children and adolescents boarding in emergency or non-psychiatric settings.
- Care in inappropriate places also risks patient safety, as makeshift settings are not properly set up to provide clinical care. Patients are not getting the specialist treatment they need, and nurses are sometimes redeployed from ward care where they are needed to support corridor care. Staff are aware they are unable to provide safe care, which also breeds fear that their professional registration may be at risk if patient harm occurs.
- Stress related attrition: corridor care adds to health care staff feeling overwhelmed, stressed and exhausted, as a result of increased workload, stress inducing fatigue, frustration from long A&E waiting times, a lack of beds, treatment of patients in non-bedded areas, and continued influx of patients. Overcrowded settings also pose problems for communication between staff and patients, and having insufficient time to explain and reassure are evident.
- For staff, including nurses in A&E and those dealing with ambulance ramping, verbal and physical conflict can arise between them and patients and their families. Nurses who are working in these conditions are often left anxious and stressed. Staff can be left feeling stressed when some patients are 'left behind' because the care of others may need to be prioritised. This can have a big effect on staff morale. Staff may experience angry and aggressive behaviour from patients and other members of the public because of the extreme conditions patients are being treated in. Equally, some patients understand the difficulties and pressures staff are under, and that corridor care happens because of failures of the wider health system.
- Staff dealing with patients being treated in ambulances in the car park was also identified as stressful, as was missing out on breaks. Staff are stressed by feeling unable to provide adequate care in very challenging circumstances. This can lead to increased use of unhealthy coping mechanisms, such as self-medication or drinking, and staff feeling undervalued, pushing many to leave their roles.

[3] The term 'boarding' relates to patients who have been assessed in the emergency department and are awaiting admission to an inpatient ward where there is no space to receive them. They are left waiting in the emergency department or outside of the receiving inpatient area. In Wales, the term is used to mean a situation in which a patient is transferred to a ward and is being treated in areas such as the middle of a bay or treatment room which do not have a funded staff member allocated to.

Why corridor care happens

Corridor care is a symptom of a system in crisis. It is the water leaking through the dam. No clinician would choose to care for patients in public corridors or staff break rooms if an appropriate clinical treatment space were available. Corridor care should only be deployed by exception in response to an occasional extreme adverse event. It should not be a daily occurrence.

In this section we assess the systemic issues across the health and care sector and analyse how they contribute to nursing staff being forced to care for people in inappropriate settings.

Investment has not been made equally or sustainably across the health and care system

Although the health and care systems across the UK have many differences, 1 common theme is that there are varying funding and commissioning arrangements for primary and secondary health services, public health, and social care. Different funding mechanisms at local and national level provide the opportunity for parts of the systems to grow at different rates. As the gap in growth and investment rates increases, the system becomes more unstable. Demand naturally shifts towards areas with more capacity, regardless of whether that is the most suitable setting to meet their needs.

An example of this can be observed in a lack of additional funding for primary care (to varying degrees) across the UK. In practice, this means that people are often unable to access GP appointments when they need them. If they need treatment or attention more urgently, they may present to an urgent care or A&E service. In turn, this puts more pressure on those services, who are then required to support both the people who attend in emergency circumstances, or following an accident, and those who cannot access the support from primary care which would better meet their needs.

Likewise, a lack of investment in the district nursing workforce often leaves social care services without the capacity and support they need. If a resident becomes unwell, they are more likely to take them directly to A&E, rather than being able to access community nursing provision. This is made worse by a lack of capacity within community and social care settings to care for patients safely once they are ready for discharge.

We can observe these types of trends across the UK. In its latest report on the NHS[iv] ('NHS in Scotland 2023'), Audit Scotland noted that "rising demand, operational challenges and increasing costs have added to the financial pressures on the NHS and, without reform, its longer-term affordability" and that "even if ambitious future savings targets are achieved, boards are likely to require further financial support."

In Scotland, there has been a fall in bed capacity and in the number of registered nurses working in the care home sector. Social care in Scotland is delivered by independent providers under contract. Registered nurses working in social care often do not receive the same rates of pay as their colleagues in the NHS, for whom pay is negotiated nationally and is typically higher. Latest Scottish Social Services Council (SSSC) figures show adult social care services are facing challenges, with 76% of care homes for adults reporting vacancies, the highest since these reports began in 2017. Insofar as NHS vacancy rates are comparable (which they are not, precisely) they are 8.5% for the NHS as a whole and 10% for the NHS Board within which that local authority sits.

In Wales, while NHS bed capacity has fallen, as well as capacity in care homes and community nursing teams. There are currently 614.7 full time equivalent district nurses working in NHS Wales. Until 2013, such low numbers had never been seen in Wales[v]. To manage or be a deputy manager of a community nursing team, a registered nurse needs to be either a district nurse (a registered nurse holding a district nursing specialist practitioner qualification) or hold a community nursing master's degree. The Welsh government commissions post-registration nursing education and each year it commissions the number of education places available for these courses.

Local authorities in Wales commission independent social care providers to deliver most social care in Wales (including care homes). In 2022, commissioned care providers employed just 1,057 registered nurses in 2022, compared with 1,545 in 2018. On top of this, the age profile of the registered nurse workforce in social care is concerning: 30% of nursing staff working in social care are over 56 years old.

This fall in the number of registered nursing staff working in social care in Wales is alarming, given the challenges the sector faces and the ageing social care nursing workforce. If there are not enough registered nurses in the care home workforce then the quality of the nursing care provided will decline, leading to poorer health and reduced life expectancy for people who rely on the sector. The challenges faced in care homes and community nursing translate into pressure on NHS Wales. The system lacks capacity to enable people to leave hospital when they are ready, and to deliver the care they need to avoid readmission. Consequently, delayed discharges and repeat admissions both increase.

In 2019 NHS England published the *NHS Long Term Plan*, designed to be an ambitious roadmap for the following decade of care. One of the key ambitions within this was to shift care from secondary health services (such as hospitals) into community settings. At the time, it was stated that "these reforms will be backed by a new guarantee that over the next 5 years, investment in primary medical and community services will grow faster than the overall NHS budget.[4]" Ultimately, this commitment has not played out in practice, and even before the COVID-19 pandemic there was a continued focus on and increased resources directed towards bringing down waiting times within secondary care services.

The COVID-19 pandemic underlined the importance of robust public health services and further exposed the significant health inequalities that exist in England. Despite this, the public health grant which funds local authorities to commission essential public health services has been cut by 24% on a real-terms per capita basis since 2015/16, with cuts disproportionately affecting those living in the most deprived areas of England, who also tend to have poorer health. Underinvestment has impacted on the vital public health services provided by local authorities to promote wellbeing and prevent ill health, including smoking cessation, sexual and reproductive health, health visiting and school nursing.

In Northern Ireland, the district nursing workforce grew by just 12% between March 2011 and March 2023. During the same period, demand for community nursing services escalated by an estimated 70%. This illustrates how workforce growth has not kept up with rising demand, helping to fuel the crisis manifesting now in acute hospitals. The same point applies as in Wales in relation to the fact that an estimated two-thirds of those employed in district nursing do not hold the appropriate specialist qualification. More generally, the Northern Ireland Audit Office pointed out in 2020 that: "for some time, the demand placed on the local health care system has been increasing due to a growing population which is living longer and developing more long-term conditions.

[4] This commitment – an NHS 'first' - creates a ringfenced local fund worth at least an extra £4.5 billion a year in real terms by 2023/24

Although the HSC registered nursing workforce has increased by 8.8% between 2012 and 2019, this has been insufficient to meet the rising demand. Assuming similar delivery structures, workforce levels should have grown by over 23% to match this increased level of demand."

In recent years, additional investment has often tended to be short term and focused on the NHS, particularly in terms of recovering from the pandemic and addressing the backlog. While this is welcome, there are many areas of the health and care system which have not received appropriate uplifts in funding. This has a knock-on effect; demand is higher than it naturally would be. This is a poor return on investment – public money is being spent on plugging gaps in other parts of the system.

The most acute impact of this imbalance is that services cannot meet the level of demand they are faced with, and there is nowhere else in the system for that demand to be met. The demand spills out into ambulance bays, corridors, staff rooms and waiting areas.

Infrastructure investment has not kept pace with service requirements

We have already demonstrated that demand is rising without a reciprocal rise in service capacity. It is important to note that building new services and hospitals is expensive and long-term; there is no quick fix. A pressing issue to address is that there is some capacity within the system which cannot be utilised due to problems and delays in undertaking essential buildings maintenance.

As an example, the maintenance backlog in England (2022/23) is estimated to be £11.6bn, up 13% on the previous year[vi]. Resolving this backlog could allow vital clinical areas to return to working order and be utilised to meet excess demand.

In Northern Ireland, 42% of the HSC estate is not fully compliant with statutory regulations and 21% remains classed as 'unacceptable for physical condition'. No significant in-roads are being made to address the estimated £1,324m backlog in maintenance liability, £256m of which has been classified as high risk. (Source: Department of Health State of the Estate report 2022, published August 2023)

A February 2024 report by Audit Wales found that the maintenance backlog of NHS Wales was £793m in 2022-23[viii]. This has grown from £560m in 2019[viii]. Despite this, the Welsh Government's final budget for 2024-25 includes a capital spend of £439m – representing just 55% of the cost of the backlog[ix].

Scottish government's capital investment in health will see a reduction of at least 10% in the next 2 years. The impact of this has been the postponement of a significant number of new and replacement health care facilities. The lack of funding has halted the development of national treatment centres and will have an impact on the timely replacement of aging district general hospital sites. There are also reports of postponement of plans to modernise health facilities in remote and rural areas. At the end of 2022 the NHS Scotland backlog maintenance bill sat at £1.1bn.[x] The impact on care will be felt in terms of overall capacity as well as the patient safety and experience. Audit Scotland's *NHS in Scotland 2023* report noted that "capital funding will not be sufficient to deliver new healthcare facilities and also maintain the current estate."

"Patient required oxygen in the corridor bed and we had no portable oxygen cylinders left on the ward so there was a period of the morning they were not receiving any oxygen until we could move them into a room" **Registered nurse, NHS hospital, Northern Ireland**

Lack of investment in prevention

There is significant evidence of the benefits of investment in prevention and public health[xi] A focus on prevention can support reduced rates of illness and premature mortality and a healthier population, which in turn contributes to reducing pressure on overstretched health and care treatment services and increasing productivity and economic activity.[xii] In the context of acute pressures on health systems across the UK where care is too often being delivered in inappropriate settings because of overcrowding and overwhelming demand, it is clear that the case for a refocus on prevention and public health is critical. This is even more apparent when considering the future projections for the population, with an ageing population, the growing burden of disease and more people living with multiple complex conditions.[xiii]

Across the UK, governments and policymakers have recognised that "prevention is better than cure" and made policy commitments to prevention and keeping people well and out of hospital for longer.[xiv] However, despite the rhetoric, there has been insufficient action to deliver on longstanding policy commitments to prioritise prevention and deliver more services outside of hospitals. Instead, there has continued to be a pattern of spending and focus on NHS treatment services and underinvesting in prevention.

Funding cuts and underinvestment in public health and community services exacerbate the pressures on the wider health and care system as opportunities for prevention and early intervention are missed. Furthermore, rising rates of poverty in the UK[xv] and the impacts of the cost of living crisis increase ill health and inequalities and increase the demand for health and care services.[xvi] For example, hospital admissions data shows a direct correlation between higher levels of deprivation and higher emergency admissions. [xvii]

Despite successive governments in England committing to prevention and the need to strengthen community services, public health services and interventions have been subject to significant spending cuts, despite increased demand. The cuts disproportionately affect those living in the most deprived areas of England, who also tend to have poorer health and higher rates of hospital admissions[xviii] and attendances at A&E.[xix]

The RCN has repeatedly raised concerns about the significant and widening gaps in the public health nursing workforce in England and the risks this poses for prevention and health equity. In relation to key areas of public health, notably health visiting and school nursing which are critical for prevention and early intervention in the early years, the RCN has highlighted concerns about funding cuts leading to services being decommissioned despite rising demand, and the resulting workload pressures affecting recruitment and retention, as well as concerning trends in skill substitution.[xx] Staffing gaps have also led to variation in service provision across different areas of England and a 'postcode lottery of support'. [xxi]

The Welsh government's plan for health and social care is set out in *A Healthier Wales* [xxii] and includes a commitment to a greater emphasis on "preventing illness, on supporting people to manage their own health and wellbeing, and on enabling people to live independently for as long as they can". This vision has not been followed up by significant investment in the nursing staff who can help deliver it. The investment there has been in recent years has focused on increasing the number of pre-registration nursing students, but hospitals, community care, and social care lack staff in certain types of nursing roles.

Post-registration nursing education develops specialist nursing skills, and often it is nurses with these specialist skills who ensure that a person's health is maintained or, with their timely intervention, prevent it from deteriorating. But there is no overall strategy published by the Welsh government to guide investment in post-registration education. In the last 2 decades, in the absence of a strategy, NHS Wales has invested steadily less in education for these roles which are so important for preventing illness and supporting wellbeing.

In 2024, the Welsh government has commissioned fewer places on nursing courses in almost every category of pre- and post-registration education. It has commissioned no community learning disability nurse courses or complete community psychiatric nurse courses at all.

Audit Scotland's *NHS in Scotland 2023*[xxiii] report concluded that "there is an increased focus on public health interventions and prioritising prevention, but this still remains secondary to more immediate operational pressures." While the Scottish Government has stated that prevention and early intervention remains one of its priorities for NHS recovery post pandemic[xxiv], health inequalities in Scotland continue to rise and Scotland continues to have the highest avoidable mortality rate in the UK.[xxv]

In Northern Ireland, the current health and social care strategy (*Health and wellbeing 2026: delivering together*) commits to "a new model of person-centred care, focused on prevention, early intervention, supporting independence and wellbeing" and explains how "this will enable the focus to move from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care". The strategy claims that "Instead of thinking about buildings and hospitals as the only place to deliver services, we will deliver care and support in the most appropriate setting, ideally in people's homes and communities". The failure to deliver this vision is underpinned by a continuing absence of any associated workforce planning, a lack of investment in the community nursing workforce, funding shortfalls and political inertia, with no devolved government functioning between 2017 and 2020 and again from 2022 until earlier this year.

Increasing health care demand

While some of the contributors to corridor care are a lack of available support, bed provision and workforce availability, many of the drivers come from increased demand amongst the population. In this report, we have highlighted the trends of increased demand in each part of the UK, and that levels of investment and the provision of support did not keep pace with the level and complexity of need. By 2035, it is estimated that 17% of the UK population will have 4 or more chronic conditions.[xxvi]

No government in recent years has had an honest conversation with the public about their expectations for how we take care of ill, vulnerable, and elderly members of society, and the level of investment and policy changes needed to meet these expectations. There is an over reliance on unpaid carers; putting tremendous pressure on families, which has been heightened by the cost of living crisis. When the pressure becomes too high, they are faced with a lack of available services, particular respite services, often resulting in additional trips to A&E or other urgent care services. This will further increase the demand on limited resources and personnel.

Like other parts of the UK, the population in Scotland is aging. There are now over 1 million people aged 65 and over (1,091,000). This is over a quarter of a million higher than the number of people under 15 (832,300).[xxvii] A key message from Audit Scotland's latest report on the NHS in Scotland was that "The NHS, and its workforce, is unable to meet the growing demand for health services," highlighting the fact that demand for planned care and mental health services were both rising. There is also strong evidence that Scotland's population is also becoming less healthy and more of the population has multiple health conditions[xxviii]. Using the latest comparable data (up to 2020), Scotland continues to have higher avoidable mortality than both England and Wales.[xxix]

As demand increases within any health system, it is important that steps are taken to increase capacity and to reduce demand through better preventative or health promotion services. Broadly speaking, neither of these things have happened sufficiently in any part of the UK. This means that the demand cannot adequately be met within services, forcing staff to find workarounds for additional patients – often in inappropriate, non-clinical settings.

While the number of nursing staff working for NHS Wales has increased over the years, there has also been a rise in patient acuity and nursing workload. Nurses are caring for an ageing population with increased dependency and comorbidities. Care home providers in Wales and RCN Wales members have reported an acute shortage of registered nurses in the care home sector. The Welsh Government's strategic objective to deliver care closer to home has meant that when people do enter residential care today, many do so with health conditions that have reached a more advanced stage than might have been the case in the past. Their needs are often greater and more complex, and this requires highly skilled nursing care. Put very simply, it takes a larger number of nursing staff with a greater level of knowledge and skill to care for a person with a broken hip if they are also physically frail and living with dementia, diabetes, a heart condition or a respiratory illness. This is all the more so if the person is being cared for at home, living alone or in poor or ill-suited housing conditions.

Additionally, the 7% growth in the nursing and midwifery workforce between March 2017 and March 2022 is relatively small compared with other professional groups in the NHS. Over the same period, the number of medical and dental professionals increased by 23%. For allied health professionals, the figure is 28%.[xxx]

According to the Older People's Commissioner for Wales[xxxi], there are 320,487 people over the age of 75 living in Wales. The number is projected to rise to 384,000 by 2031 – a 20% increase. The number of people living with severe dementia in 2040 is projected to be 53,700, an increase of 98% from the 2019 estimate of 27,100.[xxxii] In the most recent National Survey for Wales data, 67% of over-75s report living with at least 1 long-standing illness. 34% report living with 2 or more, with 54% reporting that longstanding illness limits them.[xxxiii]

In Northern Ireland, the most recent (March 2023) annual Department of Health and Social Care (DHSC) workforce census demonstrates that nursing and midwifery staff experienced amongst the lowest rates of growth of all HSC workforce groups between 2014 and 2023, at just 20.3% for registered nurses and midwives, and 12.9% for nursing support staff. This compares, for example, with 34.9% for the professional and technical group, 28.0% for ambulance staff, 21.8% for social services staff and 23.1% for medical and dental staff. Moreover, this inadequate overall growth obscures a stagnation and even a decrease within some areas of practice.

Between March 2011 and March 2023 and measured by whole time equivalent, the mental health nursing workforce in Northern Ireland grew by just 2%, whilst the learning disability nursing workforce contracted by 30%. However, the DHSC has routinely estimated that demand for health and social care services increases by around 5%-6% each year. Indeed, the Department of Finance, in its 2022-2025 draft Budget consultation paper, stated: "The cost of providing the services DHSC delivers is increasing, with estimates suggesting some 6.5% annually. This is due to an increasing ageing population with greater and more complex needs, increasing costs for goods/services, and growing expertise and innovation, which means an increased range of services, supporting improvement in our population health. All of these bring increases in the funding required each year to maintain services and meet demand."

Problems with patient flow

In addition to the pressures leading to increased inflows into health and care services, it is also important to recognise that corridor care can also be caused by a reduction in the outflow from services. Typically referred to as 'bed blocking', delays in discharge can have a detrimental impact on patient flow through a service. People who are medically optimised and in need of a follow-on package of care cannot be discharged until that support becomes available. This means beds are being used by people awaiting discharge, preventing further admissions, or leading to additional patients being housed in corridors or waiting areas. There are significant workforce challenges within adult social care, meaning that there are often longer waits while staff are obtained to support care transfers and handovers.

There are several factors which contribute to delays in discharge. They can occur if the registered nurse's workload is so high that they have no capacity to support discharge planning from admission. Lack of staff and high workload can mean that patients are not accessing rehabilitation work whilst in hospital to reduce the risk of deconditioning which may then delay their discharge as their care needs increase. Poor leadership can also contribute to problems with patient flow, along with a high reliance on agency or bank staff who may be unfamiliar with local processes.

When patient flow has blockages, and no additional beds are available, it is often the case that capacity spills out into corridors or staff areas.

The Scottish Government and NHS boards have worked to reduce delayed discharges, but they remain stubbornly high," Audit Scotland's *NHS in Scotland 2023* report. According to Public Health Scotland's latest figures[xxxiv], "in the financial year ending 31 March 2023, there were 661,705 days spent in hospital by people whose discharge was delayed. This is the highest annual figure reported and is an increase on the totals in 2021/22 (540,302) and 2019/20 (542,204), the last financial year before COVID-19 measures were introduced."

There is limited public information on delayed transfers of care in NHS Wales. The Welsh government ceased publishing information on delayed transfers of care in February 2020. [xxxv] A new data collection called "pathways of care delays" began in 2023, encompassing a wider range of delays than the older delayed transfers of care. However, this data is only a snapshot of patients experiencing a delay of more than 48 hours on a specific day each month. As such, it does not reflect the total number of patients experiencing a delay in being discharged or transferred to the next stage of their care that month. Neither does it include the length of those delays.

It is, however, possible to use this data to estimate the number of NHS Wales patients experiencing delays. The available snapshots of "pathways of care delays" span the 12 months from April 2023 to March 2024 and average number of patients in the snapshots is 1,579. Assuming this is representative of any given day, this means around 47,370 patients experience delays in a 30-day month. Across a year, the estimate is 576,335 people. Making a conservative assumption that all delays last exactly 48 hours, the total number of patient days spent in hospital in a year due to these delays would be 1,152,670.

In Northern Ireland, information on the number of patients in hospital unable to be discharged as they were awaiting a domiciliary care package to be put in place is not held centrally.

"We don't complain for ourselves but for the patient. There are no screens to go round the patient. So, if they are being bed bathed or need a bed pan, you have to take a patient out of their bed space and move them into a corridor, then move the extra patient into the bed space to use the bed pan. It's time consuming, there is not enough space in the rooms. It's undignified for the patient." **Registered nurse, NHS hospital, Scotland**

Worsening workforce crisis

Safe and effective nursing staffing levels are critical for safe and effective patient care. Evidence shows that a combination of registered nurse shortages and higher levels of patients per registered nurse are associated with increased risk of death during an admission to hospital[xxxvi] and when shifts or services are short of registered nurses, staff are more likely to report poor quality care, which often results in vital care left undone.[xxxviii] In hospital settings, when fewer nurses are on shift, patients have an increased chance of missed care, longer stays and in-hospital deaths.[xxxviii]

Staff shortages across community and social care cause delays and blocks to patients being discharged into the community, leaving hospitals full and staff having to provide care in inappropriate settings. In England, as an example, between September 2009 and January 2024 the number of district nurses fell by nearly 44% and the *NHS Long Term Workforce Plan* projected that by 2036/37 there will be a 37,000 FTE shortfall in community nurses.[xxxix] This, alongside the crisis in social care which is also experiencing high numbers of nursing vacancies, is leaving thousands of people who are fit enough to go home delayed in hospital beds.

Demand continues to outstrip workforce growth in the UK's health and social care systems. For too long, the RCN has been highlighting our concerns about the lack of workforce planning and the gaps in the nursing workforce as a risk to patient safety. In our *Valuing Nursing* report (2023) we described the deepening nursing workforce crisis with more than 50,000 vacant nursing posts in the NHS across the UK,[xl] which is exacerbated by tens of thousands of skilled and experienced nursing staff leaving the profession every year, and too few joining.

For every nurse who leaves the profession (alongside the associated loss of valuable experience and expertise), it takes at least 3 years to educate a new nurse. New data from UCAS shows a 10% decrease in students accepted on to nursing degree courses across the UK compared to last year (UCAS, 2022).[xii] That is over 3,000 fewer nurses potentially starting their nursing degrees and joining the future workforce. The nursing workforce is already understaffed, patients are already being put at risk of unsafe care, therefore further delays and fewer new recruits will escalate these risks.

Pay is a key contributor to nursing staff feeling valued in their role. Fair pay, safe working conditions and sufficient staffing levels are key to retention. Between 2011 and 2021, average nursing earnings across all sectors across the UK fell 6% in real terms. This compares to 4.6% across the entire UK workforce. Nursing has sustained real-terms pay decreases over the past decade and saw the lowest year-on-year pay growth in 2022, and salaries offered to nurses lagged behind the wider labour market. Without a pay rise for nursing, there is a risk of further attrition within the workforce, leading to gaps and vacant posts, ultimately putting patients and the public at risk.

Another concerning trend is the high number of nursing staff applying to leave the UK to work in other countries: 15,728 nurses applied for a Certificate of Current Professional Status (CCPS) in 2022/23 compared with just 3,387 in 2018/19.[xli] The Health Foundation

has highlighted that in 2022/23, more than 4 in 5 CCPS applications were for Australia, New Zealand and the US and applications for the UK increased 10-fold between 2021/22 and 2022/23, where notably UK earn substantially less than their counterparts in those countries.[xxlii]

The RCN's 2024 *Nursing Workforce in Scotland Report*[xliii] sets out in detail the extent of the nursing workforce crisis in health and social care in Scotland. While the number of nursing staff employed by NHS Scotland has increased, the number of vacancies remains stubbornly high, staff turnover and absences have increased and the number of people applying to study nursing in Scotland has continued to fall. As at 31 December 2023, nearly 4,000 whole time equivalent nursing posts were vacant, accounting for around 8% of all posts. As a result, health boards have increasingly had to rely on agency staff, with the equivalent of 1,741.2 whole time equivalent nursing and midwifery staff being employed via agencies in 2022-23.

A full description of the pressures on the nursing workforce in Wales is available in RCN Wales's annual workforce report, the latest edition of which was published in September 2023[xliv]. In it, RCN Wales estimates that there are 2,717 full time equivalent registered nurse vacancies in NHS Wales. Significant nursing vacancies compromise the delivery of safe and effective care, but the situation is also unacceptable for the nursing staff who are committed to delivering that care. Despite this, the Welsh government has commissioned fewer places for pre-registration nursing students in 2024-25 compared with the previous year,[xlv] and the lack of potential students taking up the commissioned places will exacerbate this situation.

In June 2023, following a long campaign by RCN Wales, the Welsh Government began publishing official NHS Wales vacancy statistics. The latest update, published in April 2024, estimated that there were 2,059 full time equivalent vacancies among registered nursing, midwifery, and health visiting staff as of 31 December 2023, a vacancy rate of 7.3%[xlvi]. However, the Welsh Government warns that this is likely to underrepresent the true vacancy figure. Indeed, RCN Wales's vacancy estimate, which uses data provided by NHS Wales, is 32% higher than the Welsh government's, despite covering a more restricted staff group.

In Northern Ireland, strike action by RCN members during December 2019 and January 2020 secured a commitment by the Department of Health (and endorsed by the Northern Ireland Executive) to a safe staffing framework. This included increasing the number of pre-registration commissioned nursing and midwifery places by 300 per year for three years between 2020 and 2022. However, the number of commissioned places fell back to its previous level in 2023 and will remain at that level for 2024, despite the fact that there are currently 1,725 vacant nursing posts across the Health and Social Care system and many more in the independent sector. The safe staffing legislation (including a statutory commitment to workforce planning) promised within this safe staffing framework is still at the drafting stage, over four years later.

In England, the workforce crisis has continued due to a successive failure in recent years to produce a comprehensive, funded workforce plan with clear objectives and deliverables. In 2023, we analysed workforce planning at Integrated Care System (ICS) level and found that the majority of ICSs do not have specific workforce planning in place. Just seven out of 42 had substantive separate workforce plans, or dedicated sections within their Joint Forward Plans or Integrated Care Strategies. A further 27 had limited references to workforce planning within their forward plans.

The 2023 *NHS Long Term Workforce Plan* also failed to deliver clear actions to underpin the level of ambition they have outlined. It is not clear how they will be recruiting or retaining significantly more nursing staff.

Eradicating corridor care

The RCN calls for the eradication of corridor care, everywhere in the UK.

Corridor care should only be undertaken in response to emergency, adverse event situations. Whenever care is delivered in non-clinical spaces it must be immediately reported to relevant local and national commissioners.

We recognise that there are several steps needed to eradicate corridor care. It is vital that we avoid moving the problem from one area to another; instead, system leaders should focus on tackling the causes of corridor care.

Below we set out the actions needed to ensure that corridor care can be eradicated. Given the importance of this issue to our members and the public, we will regularly report on progress towards eradication.

We set out here our recommendations for immediate action by the various stakeholders across health and care systems in the UK, noting that health policy is devolved, so there will be different approaches in each country:

Actions for Governments

Address the workforce crisis

While it is vital that service provision and overall investment is increased, it is essential that the nursing workforce crisis is also resolved to ensure that services can deliver their full potential. Safe and effective levels of nurse staffing are critical to patient safety, outcomes and experience. Appropriate levels of nursing staff can reduce patient complications and overall length of stay, which contributes to seamless patient flow through health and care services.

We call on governments to urgently invest in boosting nursing supply through higher education and apprenticeship routes, and take the necessary steps to support and increase the recruitment of nursing staff and address retention issues. It is vital that growth focuses on registered nurses so as not to increase the risk of inappropriate substitution through disproportionate growth in the support workforce. While apprenticeships offer choice for those wishing to enter the profession, it is vital that the higher education route is recognised as the pathway which can deliver growth in workforce supply at scale.

Additional investment should be accompanied by detailed national workforce plans which should provide the facts and figures to support the more general ambitions set out in strategies; go beyond those plans produced by individual employers; and outline the interventions needed and the responsibilities for delivering key actions on recruitment, supply and retention. These must be informed by robust assessments of population needs.

Pay is a critical factor in attracting new recruits into the workforce as well as retaining and rewarding existing staff. We request a substantial and an above inflation pay rise for nursing that delivers pay justice to one of the lowest paid professions in the public sector. Only by awarding a substantial and an above inflation pay rise will this begin to restore nursing pay.

The RCN will campaign for safety-critical nurse-to-patient ratios enshrined in law, leading work to define evidence-based standards for the maximum number of patients per registered nurse in every health and social care setting in every part of the UK.

Understand the 'true' demand and how this correlates with the provision of beds and services.

Corridor care is a clear indicator that the health and care system is not coping with the level of demand it is faced with. We do not have assurance that governments have a clear understanding of what the true demand for health and care support is within the population. Often 'demand' indicators (such as attendances at A&E or waiting lists for treatment) are artificially low due to restrictions of access to support.

We ask that governments urgently undertake an exercise to better understand what level of need and demand exists within the population, and projections for the next 15-20 years. This should go alongside an open conversation with the public about their expectations for the provision of health and care support and should be used to inform and support workforce planning and funding allocations across health and care. We expect this information to be published.

This information is vital to making decisions for now and the future. For too long, health and care decisions have been made based on arbitrary constraints around funding allocations, rather than need, which leads to a gap between demand and provision.

Governments should also use this information as the basis for boosting the provision of prevention and health promotion services. Additional, sustainable investment upstream can help to reduce the level of demand for health and care services in the longer term, making it easier for future services to eradicate corridor care. Adequate financial support for local authorities, the voluntary sector and local communities could also help to reduce health inequalities and deliver local health and care services to meet needs.

Governments must increase long term sustainable investment in community and social care services to make sure that people can leave hospital (and/or avoid it in the first place) and to ensure that prevention and public health services are prioritised and supported to improve the population's health and reduce pressures on acute services in the longer term.

The RCN will measure progress towards this action by scrutinising funding announcements and the extent to which they are based on demand and needs assessments.

Address the maintenance backlog.

It is clear that the current level of physical provision of staffed health and care beds is insufficient, and so it is vital that governments take steps to unlock additional clinical spaces to tackle the problem of corridor care. There are significant budget gaps and backlogs in maintenance and underinvestment in capital spend.

We call on governments to immediately increase investment to address the maintenance backlog. This could allow clinicians to access additional clinical spaces, which should always be prioritised above inappropriate, non-clinical areas.

Based on a robust, transparent assessment of need and demand, governments should take steps to increase staffed bed capacity, and expand community care provision so that patients can receive more care in appropriate community settings and be discharged more quickly.

The RCN will monitor announcements made relating to capital investment and maintenance backlogs.

Uplift investment in all parts of the system

When governments invest in 1 part of the system, without a reciprocal increase in other parts, it leads to a situation where demand is inappropriately moved from one setting to another. This siloed approach is harming staff and patients.

We therefore call on governments to ensure that when investing in one part of the system, they must also increase the level of investment in services that are likely to receive a higher level of demand in response. For example, if a government were to invest in increasing the provision of mental health awareness and community support services, they should also invest in secondary mental health services, knowing that there will be an increase in demand. There is a need for long-term sustainable investment as part of a coherent approach which considers the needs across all parts of the system.

Governments should provide transparency about their decision making, setting out how they have projected the level of demand, and how they have assessed which services will be impacted by increased investment. This will allow for a higher level of transparency and assurance, along with the opportunity for public scrutiny.

The RCN will scrutinise investment announcements to ensure that some areas are not receiving disproportionately low levels of funding.

Introduce new parliamentary reporting requirements.

Corridor care shouldn't happen if the system is working properly. We believe that public transparency is key to making progress towards eradication.

We call for parliamentary-level reporting on the instances of corridor care every quarter alongside an overview of the actions governments are taking to reduce occurrences, with the opportunity for politicians to debate the issue. This will become an additional duty for the relevant minister, to ensure that their briefing includes specific responsibility for reporting on corridor care.

The opportunity for scrutiny and accountability is essential to tackling the root causes of corridor care. Without this, the impact of insufficient investment and workforce crisis will continue to grow in the shadows.

It is likely that legislation will be required to place this duty upon the relevant secretary of state or minister within each country.

The RCN will campaign for ministers to be mandated to provide this level of transparency and will scrutinise the reporting and actions once they are made public.

Actions for national and local health and care service commissioners

Use service contracts to restrict and report on corridor care.

Commissioners of services should increase their scrutiny of where and how care is provided, putting safeguards into contracts that there is sufficient provision to meet demand. Care being delivered in inappropriate settings does not represent good value for public money, and commissioners should pay close attention to providers who are regularly using non-clinical spaces to deliver clinical care.

We call upon commissioning bodies to amend contracts for publicly funded services to include specific restrictions on using non-clinical spaces for the delivery of care, and requiring reporting if breaches occur.

In our opinion, commissioners have a responsibility to report trends in corridor care to national decision-makers, so that they can take action on the systemic issues which lead to demand not being able to be managed within services safely.

In the process towards eradication, where cases of corridor care are happening there must be strict protocols in place that ensure that no patients who are seriously unwell, vulnerable (including elderly), or in urgent need of clinical care are placed in areas without adequate staffing or access to facilities. Where they do not already exist, all hospitals must have clear dedicated zones for patients who are well enough and waiting to be discharged and for those waiting to be admitted to a ward.

The RCN will lobby to include these provisions within relevant service contracts.

Capture data to identify trends.

Service commissioners should mandate reporting on instances of corridor care, which will be collated centrally and provided to government ministers at regular intervals. Service providers should be required to collect data about every instance in which care has been delivered in a non-clinical setting, including:

- what type of non-clinical area was involved (car park, corridor, additional patient in a ward bay or other options)
- how many patients were involved
- the reason as to why care was delivered in this way
- and what the likely impact on care was, both for patients and staff.

Additional data collection and reporting will allow both service commissioners and national decision makers to identify trends. In turn, this will allow those involved to make changes either up or downstream to resolve any patient flow issues. This will help make progress towards eradicating the practice.

When trends indicate that capacity is regularly above the planned and funded levels, commissioners should work with service providers to find ways in which staffing levels can be increased to reflect the actual level of need.

Establish ‘chair care’ lasting more than one day as a ‘never event’.

One of the reasons why care being delivered in chairs has become so widespread is because there are insufficient safeguards preventing it. Within health services, there are a range of issues classed as ‘never events’, those which are “serious, largely preventable patient safety incidents that should not occur if health care providers have implemented existing national guidance”. It is our view that chair care exceeding a 24-hour period should be placed within this category.

When patients are treated for long periods in chairs, rather than beds, their safety, comfort and mobility is compromised. Privacy and dignity are removed. Support for staff in manual handling is often compromised when temporary arrangements stretch into longer time periods; this puts the patient and the staff member at risk of serious injury.

Not only would adding chair care exceeding 24 hours to the ever events list increase the focus at provider level to reduce it from occurring, but it would also provide a basis for generating system-wide learning about strategies to reduce and ultimately eradicate corridor care, along with other ‘never events’. We are also keen for statistics about chair care and all types of corridor care to be published regularly to allow for more transparency and scrutiny. ‘Never event’ records are published at least yearly.

The RCN will lobby for chair care exceeding 24 hours to be included as a 'never event', and will scrutinise any subsequent reporting.

Actions for service regulators

Scrutinise corridor care during service inspections.

Service regulators have an important role to play in holding providers to account for delivering care in inappropriate settings. Likewise, they have a responsibility to report their observations about systemic issues to governments and other national decision-makers.

To facilitate this, service regulators should provide more specific detail about corridor care within their regulations for service providers and their inspection standards. Regular usage of non-clinical areas to provide care should be noted within inspection reports and factored into decisions about ratings. Regulators should work together to ensure that any guidance issued does not normalise the problem, or shift blame onto particular service areas.

The RCN will scrutinise any changes to regulatory inspection frameworks and input into the development of measurement relating to corridor care.

Actions for nursing leaders

Provide clear information to decision makers about the pressures facing the nursing workforce.

We know that nurse leaders at provider and commissioner levels are under immense pressure in relation to corridor care. Nursing leaders often have to work out how to spread the risk, and we want to support them to eradicate the risk. It is vital that within these pressures, nursing leaders are given space to share important information with the decision-making boards about the experiences of the nursing workforce. This is to ensure that the board fully understands the nursing workforce demands and are accountable for the decisions they make and the actions they take, as well as providing assurance on the provision of staffing for safe and effective care. The role of the executive nurse provides professional, strategic and operational assurance to corporate boards and commissioners on nurse staffing.

Nursing leaders at more senior levels, such as chief nursing officers, should provide similar insight and professional advice to governments and system leaders. It is vital that decision makers are regularly made aware that corridor care is unsafe and unacceptable. Nursing leaders can provide recommendations about improvements to care pathways and systemic issues to help make progress towards eradication.

We call on all nursing leaders to support our position that corridor care be eradicated.

The RCN will continue to support nursing leaders to undertake their roles and responsibilities and speak up about the issues which are restricting their ability to do so.

Actions for all nursing staff

Raise concerns every time corridor care occurs.

The NMC *Code*[xlvii] states that: "You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate."

Corridor care is a situation that puts patients and public safety at risk, and as such, we urge all nursing staff to take action to raise concerns. Typically, this will involve making a Datix report, or following other local processes. There is strength in numbers. If nursing staff across the country can consistently report corridor care every time it occurs, decision makers should take notice.

The RCN will continue to support members to speak up with tools and advice, including helping them to navigate difficult conversations with colleagues or managers. We will continue to represent the experiences of nursing staff in conversations with Governments and other national decision-makers.

Actions for the public

Complain about corridor care.

It is vital that corridor care does not become normalised. The public and patients have a unique position to be able to force decision makers to take action on eradicating corridor care.

We call on all patients and their families to put pressure on services providers. This can be done by raising concerns and making complaints when corridor care occurs. This may be through the Patient Advice and Liaison Service (PALS) for England and Wales, Patient Advice and Support Service (PASS) for Scotland, directly to the provider initially in Northern Ireland followed by escalation to the Ombudsman, or other local equivalents outside of the NHS. Other opportunities for giving feedback, such as the friends and family test, can also help put pressure on the boards of provider organisations.

The RCN will publicly advocate on behalf of patients, exposing poor practice and safety risks, continuing to lobby to the end of corridor care as a day-to-day occurrence for many.

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Appendix 1: RCN activity on corridor care

RCN members, along with nursing colleagues across the UK have long been raising concerns about widespread occurrences of care being delivered in inappropriate, non-clinical settings. In May 2023 at RCN Congress, members put forward a resolution "to lobby the government to completely abolish corridor care and ensure that the respect and dignity of patients is upheld", which passed.

Since RCN Congress 2023, we have undertaken a number of activities aimed at deepening our understanding of the issue, so that we can strengthen our campaign and build public support. These activities included:

- commissioning the University of Sheffield to carry out two reviews; a) a rapid evidence review of UK and international evidence on corridor care in nursing, and b) a review of UK and Irish media stories on corridor care
- reviewing internal RCN data for relevant intelligence
- including questions on corridor care in our all-member safe staffing survey
- inviting members to a series of listening events to better understand their first-hand experiences of corridor care
- inviting other royal colleges and system regulators to discuss corridor care and shared goals.

Appendix 2: Wider health and care system context

As the UK's population continues to grow, so too does the demand for health and care services. Each UK health care body defines and collects system data differently, so this analysis is not meant to enable comparison between UK countries. Instead, it illustrates what has happened within each country over time according to three key measures on the numbers of:

- elective, non-urgent planned care pathways[xlviii] – more commonly referred to as patient waiting lists
- patients waiting over 4-hours for urgent care in accident and emergency departments
- NHS nursing staff (and midwifery for those countries where published workforce numbers do not split them out).

By presenting the changes over time in these measures, we can understand that corridor care is a result of the increasing demand for health care, with an insufficient supply of a health care workforce[5]. We have illustrated the 3 key measures below for each UK country. Due to differences in the availability of data published by each country, different time points have been used, but they all represent a 10-year timeframe.

England [6,7,8]

In England, between January 2014 and January 2024:

- the number of NHS patients waiting for treatment increased 2.6-fold, from 2,965,239 to 7,575,914
- the number of patients waiting over 4 hours in A&E increased 8.4-fold, from 19,001 to 158,721
- the number of NHS nursing and health visitors (FTE) increased 1.3 fold, from 279,401 to 352,125.

Wales [xlix,l,li]

In Wales, between September 2013 and September 2023:

- the number of NHS patients waiting for treatment increased 1.8-fold, from 416,937 to 760,853
- the number of patients waiting over 4 hours in A&E increased 3.6-fold, from 7,727 to 27,901
- the number of NHS nursing, midwifery, health visiting staff increased 1.2 fold, from 31,366 to 37,962.

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[5] For the purposes of relevance to our work, we have tried to focus on nursing staff, but recognise a broad range of other health care professionals' experience, and are impacted by, overcrowding.

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Scotland [lii,liii,liv]

In Scotland, between December 2013 and December 2023:

- the number of NHS patients waiting for outpatient treatment increased 2.2-fold, from 236,608 to 525,180
- the number of NHS patients waiting for inpatient treatment increased 2.8-fold, from 56,140 to 155,311
- the number of patients waiting over 4 hours in A&E increased 5.1-fold, from 8,287 to 42,600
- the number of NHS nursing staff (WTE) increased 1.2 fold, from 54,914 to 63,606.

Northern Ireland [lv,lvi.lvii,lviii.lix]

In Northern Ireland, between September 2013 and September 2023:

- the number of NHS patients waiting for outpatient treatment increased 3.9-fold, from 109,476 to 428,858
- the number of NHS patients waiting for inpatient treatment increased 2.5-fold, from 47,223 to 155,929
- the number of patients waiting over 4 hours in A&E increased 2.8-fold, from 11,515 to 32,199
- the number of NHS nursing and midwifery staff (WTE) increased 1.2 fold, from 14,178 to 17,283.

The figures above show that the demand for health care, as seen in the numbers of patients waiting for planned treatment and numbers waiting over 4-hours for emergency care, have rapidly increased over the last 10 years. These 2 measures in nearly every country have doubled, and in the most extreme case is over eight times higher in England on the measure of 4-hour waits or more in A&E.

Crucially, these increases contrast against much lower increases in the nursing workforce which have only increased 1.2 to 1.3 times over the 10-year timeframe.

We are left with more patients needing to be seen. However, due to only modest gains in nursing staff, patients are left to wait longer both for emergency and planned medical treatment. For example, in England the number of elective care treatments waiting to be undertaken in the NHS has steadily increased from 4.19m in August 2007 (when records began) to a near record high of 7.54m today.[lx]

Similarly, data on the demand for emergency health care confirms that the NHS in England has failed to meet the 4-hour target in A&E departments in every year since 2013/14.[lxi] It is therefore unsurprising that overcrowding is common in care settings, and the pressures on health care also appear in Scotland, Wales, and Northern Ireland. To illustrate this, we reviewed data over a 10-year period.

In fact, in England on average, patients waited 6.2 weeks for non-emergency (planned) care in January 2014, but this had more than doubled to 15 weeks by January 2024.[lxii] This leaves patients seeking medical care under increasingly difficult circumstances. Meanwhile, the workload of nursing staff intensifies, resulting in greater levels of work stress and physical fatigue.

Whilst rising demand is one side of the challenge leading to corridor care, the other side related to the capacity of the system, including levels of investment, workforce and beds.

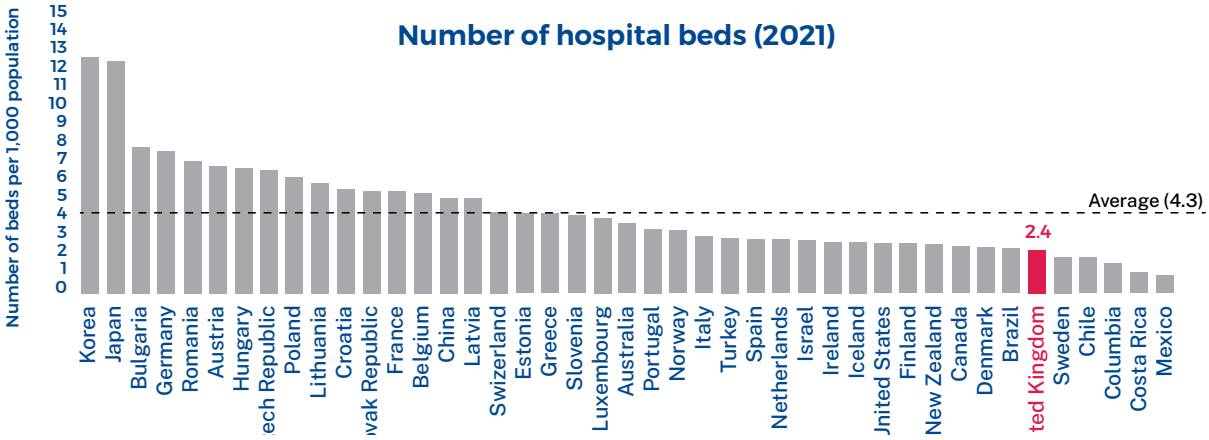
Hospital beds

The number of beds in the NHS (HSC in Northern Ireland) are shown in the table below. It should be noted that the data can fluctuate from 1 year to the next (up or down), so the differences shown should be taken as indicative trends only. However, they do suggest that bed numbers have decreased over a decade in all UK nations.

Table 5: Average number of hospital beds in each UK nation

UK nation	2012/13	2022/23	Difference	Change
England	148,515	142,003	-6,512	-4.4%
Scotland	14,020	13,695	-325	-2.3%
Wales	11,497	10,400	-1,097	-9.5%
Northern Ireland	6,280	6,127	-153	-2.4%

Looking further afield, according to the Organisation for Economic Co-operation and Development (OECD), the UK ranks poorly against most other countries in terms of the number of hospital beds available for its population.[lxix] The figure below illustrates that at 2.4 beds per 1,000 population, the UK ranks 6th from the bottom out of 43 countries. In fact, the UK has over 5 times fewer beds per 1,000 population than Korea and Japan, which are the countries with the highest numbers of beds.



Source: OECD[26]

Note: Australia figure represents data from 2017

Exploring the trends over time, the OECD data (not shown) indicates that most countries experienced a fall in the number of beds available from 2011 to 2021 (only 9 out of the 43 countries *increased* bed numbers). The UK had 2.9 beds per 1,000 population in 2011, which as shown in the figure above, dropped to 2.4 by 2021. This further illustrates the trend of reduced numbers of beds in each UK nation.

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