Date published: 11 December, 2025
Date last updated: 11 December, 2025

Principles for providing patient care in corridors

This guidance replaces the Principles for Providing Safe and Good Quality Care in Temporary Escalation Spaces, published on 16 September 2024.

Publication (/publication)

Content

The term ‘corridor care’ is inclusive of any non-designated clinical space. The term ‘temporary escalation space’ (TES), as used in previous guidance, has been removed.

Introduction

Our aim is always to deliver high standards of care for patients in the right place and at the right time. NHS England’s position is that corridor care is unacceptable and must not be normalised.

We are committed to the total eradication of corridor care, recognising it as a clinical and moral imperative.

NHS England considers the delivery of corridor care in departments or wards experiencing patient crowding to be unacceptable and should never be considered standard. Patients should only be placed in corridors in extremis and for the shortest possible duration, to ensure the time patients are cared for in this environment is kept to a minimum

Care should be person-centred, focusing on the needs of the individual and ensuring that privacy and dignity are maintained, to the best ability, given environmental constraints.

Decisions about corridor care must be made transparently, with clear governance and oversight. Trust boards, quality committees and senior clinical leaders must be actively involved in both escalation and de-escalation processes. It is essential that trust executives and boards are fully

sighted on the scope and scale of corridor care within their organisations, ensuring they understand the associated risks and challenges. Decisions on corridor care require strategic leadership and system-wide co-ordination.

Where corridor care is unavoidable, trusts should have active plans to eliminate its use entirely. Published evidence examining patient safety and crowding in emergency departments and wards reports worse clinical outcomes and poorer experiences for patients, their loved ones and healthcare staff.

Delivering care in corridor areas can be physically and emotionally challenging for staff. A survey and subsequent report by the Royal College of Nursing (RCN) (https://www.rcn.org.uk/Professional-Development/publications/corridor-care-unsafe-undignified-unacceptable-uk-pub-011-635) highlighted the detrimental impact of this care setting on patients and staff and calls for total eradication. In these settings, sustaining infection prevention and control (IPC) practice, privacy, dignity and a good patient experience become even more difficult, further amplifying the risk to patient and staff safety.

In addition to the RCN report, a statement published by the Royal College of Emergency Medicine (https://rcem.ac.uk/wp-content/uploads/2024/12/Care-in-Temporary-Escalation-Spaces-RCEM-Position-Statement-1.pdf) said it is not possible to provide safe and good quality care in temporary care environments. A statement by the Royal College of Physicians (https://www.rcp.ac.uk/policy-and-campaigns/policy-documents/a-snapshot-of-uk-doctors-delivering-care-in-a-temporary-environment/) called for an end to corridor care, as it deems it unsafe and unacceptable for both patients and staff.

The following principles have been developed to support point-of-care staff in delivering the safest and highest quality care possible when corridor care has been deemed unavoidable.

Overarching corridor care principles

These principles should be applied alongside any local standard operating procedures and arrangements governing flow pathways, IPC, and safe and effective staffing. Risk sharing should be considered against the entire hospital flow pathways to minimise risk at every stage.

Corridor care does not include clinical spaces opened as part of winter pressure planning and refers to care given in any unplanned setting. However, the current healthcare landscape means that some providers are using corridor care more regularly – and this use is no longer in extremis.

The use of corridor care is never acceptable and must be avoided when caring for the following patient groups:

- children
- mental health patients
- patients with learning disabilities, neurodivergence or autistic patients
- patients with physical disabilities
- patients who have dementia, confusion or delirium
- patients who are confirmed or suspected of being infectious
- any patient with a National Early Warning Score (NEWS) 2 score over 5
- patients who are pregnant or breastfeeding
- patients who are severely frail
- patients who are at end of life

This is not an exhaustive list, and each patient must be assessed before being placed in corridor care. An equality impact assessment should be undertaken whenever corridor care is being considered for a patient.

The core principles

The core principles for corridor care for patients are:

1. Assessment and mitigation of risk
2. Escalation
3. Quality of care
4. Raising concerns and reporting incidents
5. Data collection and measuring harm
6. De-escalation

1. Assessment and mitigation of risk

Patients should, where possible, be seen, assessed and treated within a clinically appropriate trolley, bed or chair space. Care delivered outside of these clinically appropriate spaces should only be used when all other capacity and escalation options have been exhausted.

It is essential that local health and safety policies can be adhered to for the safety of patients and staff.

It is imperative that all healthcare partners across the system and patient pathway, from pre-hospital care to point of discharge, work collaboratively to share and manage risk, ensuring safe and effective patient flow. They must have clear, open lines of communication and have processes for the escalation of concerns. Clear lines of accountability must be established to ensure that each patient in a corridor is under the oversight of a designated healthcare professional who is responsible for their care.

Assessments of risk for potential harm and safety for staff and patients who are being considered for corridor care must be completed, and organisational governance processes and full capacity protocols must be followed. Local patient safety checklists should be used to ensure the patient can be safely cared for in this setting. This should include an inclusion and exclusion checklist.

Providers should refer to NHS England's Emergency care improvement support team (ECIST) guidance (https://future.nhs.uk/connect.ti/ECISTnetwork/groupHome) (FutureNHS login required), which details best practice measures, principles, tools and evidence to support decision-making that balances patient and organisational risk across a system in extremis.

IPC is a key component of the risk assessment. Corridor care environments often limit the ability to adhere to fundamental IPC practices (such as patient isolation, hand hygiene compliance and environmental and equipment cleaning), increasing the risk of healthcare-associated infections (HCAIs) transmission. Therefore, ensuring adherence to local IPC policies and national IPC guidance is mandatory before placing any patient in a corridor.

The Care Quality Commission's (CQC) fundamental standards (https://www.cqc.org.uk/about-us/fundamental-standards) should be adhered to.

Further considerations and requirements

- The clinical, psychological and functional suitability of the patient.
- A clear clinical plan for each patient must be in place, where all patients must have a named consultant and an identified responsible clinical team.
- Appropriate staffing and skillsets that ensure the safe monitoring of patients and the ability to recognise deterioration.
- Induction and training on caring for patients in corridors should be given to staff and must include strict IPC practices, such as hand hygiene, personal protective equipment (PPE) use and waste disposal.
- Only permanent staff or those temporary employees who are familiar with the environment and IPC risk controls should be allocated to deliver care in corridors.
- Staff are not to be routinely and continually allocated to work in corridor care environments.
- The provision of daily senior nurse quality rounds and safety huddles should include a review of the staffing requirements for the additional patients and their individual needs, in line with expectation 3 of the National Quality Board (NQB) guidance: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016) (https://www.england.nhs.uk/publication/national-quality-board-guidance-on-safe-staffing/).
- Access for staff to use observation charts and medication charts at the ‘bedside’ and have full access to patient records and electronic systems.
- The ability for staff to secure storage and safe handling of medicines.
- Access for staff to use oxygen, air, suction and resuscitation equipment and the ability to provide safe quality care and an emergency response within it.
- Adherence to local IPC policies.
- Staff providing care and treatment should have clear visibility of their patients’ location (patient tracking).
- The ability for patients, families and care partners to summon assistance easily, without delay.
- Allow for patient visitors in line with local policies.
- Executive leadership and senior accountable clinical staff must be visible and actively support decisions about corridor care, including governance.
- Work as multi-professional teams with other departments to assess, manage and transfer patients efficiently, in line with expected discharge and admission times and rates.
- The level and profile of risks will continually change and will need to be assessed using a dynamic risk assessment (DRA) approach. This assessment should also consider risk across the pathway or system, recognising that increasing a risk in one area may reduce a risk in another part of the pathway, which may be the ‘least worst’ scenario.

System-wide risk considerations

- **Integrated care boards (ICBs)** must adopt a risk-sharing approach that includes IPC as a critical quality and safety domain.
- Providers and systems can use tools such as the **GIRFT Summary Emergency Department Indicator Table (SEDIT) dashboard** to assess demand, capacity, flow, IPC risks and outcome metrics, helping to reduce reliance on corridor care.

2. Escalation

All providers must have established working escalation models in place and follow organisational governance and reporting structures at all stages of patient care, including episodes of corridor care. The escalation process must prioritise patient safety, including adherence to IPC protocols, to minimise risks associated with increased occupancy (crowding) and corridor care environments.

Local policies on internal escalation should be triggered once a patient has been allocated to receive corridor care. This should include the senior clinical and management teams (triumvirate) responsible for the department, as well as the trust executive team, who should escalate to the board.

Escalations should adhere to organisational governance processes. Providers should follow any local policies regarding patient flow and safe staffing.

Providers should escalate to system quality groups and use the NHS England Operational pressures escalation levels (OPEL) framework (https://www.england.nhs.uk/long-read/integrated-opel-framework-2024-to-2026/) to allow systems to have a clear vision of urgent and emergency care pressures and awareness of the potential risks and harm. Systems will be able to escalate to regions, who will escalate to the national team accordingly. Providers must also report the number of patients receiving corridor care in emergency departments or wards via the daily sitrep.

3. Quality of care

Corridor care areas must uphold the same high standards of care for patients as those in planned clinical non-corridor settings.

It is essential to maintain the delivery of high-quality care throughout the entire episode of corridor care, ensuring patients receive the same standard of care as those in allocated clinical spaces.

The following principles should be followed:

- patient safety is paramount: all patients being considered for corridor care must be assessed using a safety checklist that includes IPC risk factors such as infectious status and vulnerability to cross-contamination
- patients should be registered on local IT systems or the Electronic Patient Record (EPR) to ensure access to all relevant electronic systems to record their care
- while it is recognised that patient experience will not be optimal, it is important to always maintain privacy and dignity during their episode of care; this should include screens, when requested or required, and access to a fully private area for confidential discussions or certain examinations
- it is recognised that maintaining patient confidentiality is challenging. However, trusts must ensure that all staff are supported to uphold these standards to meet all legal and ethical standards despite the challenges that corridor care presents
- ensuring IPC practices are followed rigorously is essential, as these environments often present heightened risks of HCAIs. It is imperative that IPC principles are integrated into the delivery of care, ensuring the safety and wellbeing of patients, staff and the broader healthcare environment
- all care should be person-centred, ensuring that the focus is on the needs of the individual and ensuring that the patient's preferences and values guide any clinical decisions
- patients should be informed of why they are being cared for in a corridor and reassured that they will still receive safe and essential clinical care. Appendix 1 provides an example of a

patient information leaflet; this should be available in multiple languages or explained via a translator
- trusts should ensure adherence to the Accessible Information Standard (https://www.england.nhs.uk/long-read/accessible-information-standard-requirements-dapb1605/) in all communications with patients; National Voices offers guidance on community languages, translations and interpreting services (https://www.nationalvoices.org.uk/publication/community-languages-translation-and-interpreting-services/)
- patients should be allowed visitors in line with local visiting policies in the area where they are being cared for
- patients should be orientated to the area where they are being cared for, and efforts should be made to create a risk-controlled environment in the corridor, including easy access to hand hygiene stations, PPE and clinical waste disposal
- patients should be instructed on how to alert staff to their needs
- easy access to bathrooms should be maintained, and hourly comfort rounds should be undertaken. Personal hygiene requirements should be identified
- patients should have access to nutrition, including hot meals and hydration. Reasonable adjustments should be made for any patients identified as requiring support
- patients should have space for personal possessions and private items
- if appropriate, patients should be supported to move around regularly if they are in a corridor care area for more than a few hours
- good quality sleep is important for patient recovery, and efforts should be made to create a sleep-friendly environment, minimising disruptions
- regular communication with patients, families and care partners is essential, with transparent updates on the patient's treatment plan, condition and expected transition to a more suitable clinical area
- patients and families should be encouraged to raise concerns or complaints in real time. Feedback should include concerns related to infection risks or patient safety, and appropriate IPC actions should be taken as part of any response
- clinical staff should maintain regular reviews, observations and NEWS2 scoring of a patient's condition to identify early any changes or deterioration that may require the patient to be moved out of corridor care areas and into another area of the emergency department. Medications should be given as per the prescription plan and should be monitored
- appropriate discharge planning should always be focused on reducing corridor care. This includes ensuring patients are not delayed unnecessarily and that discharge processes are safe, efficient and person-centred

4. Raising concerns

In high-pressure environments like corridor care, maintaining a strong culture of speaking up is essential to patient safety, infection prevention and staff wellbeing.

Staff must abide by their code of practice and, if this feels undermined, they should raise concerns. It is imperative that staff delivering corridor care have a voice and feel heard. Staff should be encouraged to raise concerns immediately, and these concerns should be dealt with in a timely manner.

Staff should always feel safe to report and raise concerns and be reassured that these are being taken seriously. Staff should not be fearful of raising concerns and reporting complaints.

Staff should have access to the freedom to speak up (FTSU) guardians and be aware of the FTSU process to raise concerns. Senior management teams should promote this and embed it in their organisation's culture.

Staff should have the opportunity to debrief and discuss areas of concern further.

Staff need to be heard and supported. Areas should have mechanisms to support staff psychological and welfare needs, for example, open door policies, staff forums, drop-in sessions, visible senior staff support and debrief sessions after a patient safety event. Local staff surveys can also be used.

Patient experience must be monitored, and patients, families or care partners should be given the opportunity to raise concerns and complaints in real time. Local policies on raising concerns and complaints should be followed.

Patient welfare must be measured. This can be done using surveys (such as the Friends and Family Test) or a trust might develop a specific survey about their corridor care.

5. Data collection and measuring harm

All trusts need to formally measure and report corridor care data for emergency departments and wards. This should be reported using the metrics on the national daily sitreps, including instances where no corridor care is being provided (nil returns).

It is important that the executive team and trust boards have visibility of the numbers of patients being cared for in the corridor and the actions to eradicate this.

Trusts need to monitor the risks of potential harm, the actual harm that has occurred, and the impact on patients and staff of the use of corridor care. This should include, but not be limited to, complaints, 'duty of candour' incidents and information from external sources such as patient and staff surveys.

Real-time quantitative and qualitative harm data should be visible to senior clinical and management teams, trust executives and boards. Providers should apply their own processes and incident reporting systems. These can be used to escalate concerns to system, regional and national colleagues.

There must be mechanisms in place to evaluate any harm caused (for example, after-action reviews). These mechanisms should allow learning to be fed back to frontline staff and to trust executives.

The SEDIT dashboard (https://gettingitrightfirsttime.co.uk/sedit/) can also support analysis of demand, capacity, estates space and outcomes to evaluate potential harm and realised harm.

The Summary Acute Medicine Indicator Table (SAMIT) dashboard (https://gettingitrightfirsttime.co.uk/samit/) can also provide valuable insights into patient flow, safety and performance across systems.

De-escalation

It is essential that providers and systems have robust de-escalation models.

De-escalation should mirror escalation plans in reverse and use the dynamic risk assessment approach. The same communication channels used for escalation should be used for de-escalation. Situation reports should be provided for senior teams, trust executives and system leadership.

The chief executive or executive team should oversee de-escalation and ensure care is delivered in appropriate areas immediately. The trust board's quality committee should also be sighted, given the risk that the provider could potentially breach CQC registration by using corridor care.

There should be a process in place to debrief staff, identify lessons and review internal standard operating procedures, policies and processes.

These principles are intended to support point-of-care staff in delivering the safest and highest quality care possible in situations where corridor care has been deemed unavoidable. Corridor care should only be used in extremis and must not be considered an acceptable or sustainable model of care.

Appendix 1: example patient information leaflet

Your care in our hospital today

Right now, you are being cared for in a corridor or another temporary space.

This is because the emergency department/hospital ward (delete as appropriate) is extremely busy.

We apologise and realise that this isn't an ideal environment. We want you to know that your safety, wellbeing, privacy and comfort remain our top priority.

You will still receive safe, high-quality care, and we are following all measures to protect you and others from infection.

Below are answers to some common questions. If you have any other concerns, please speak to a member of staff nearby – we're here to help.

Why am I being cared for in this space?

The hospital is very busy. Because of high numbers of patients, there are currently not enough cubicles or beds available.

To make sure everyone gets the care they need, we sometimes use alternative spaces temporarily. You will still receive safe, high-quality care, and we are following all measures to protect you and others from infection.

How long will I be here?

It's hard to give an exact time. Staff are checking patients all the time and will move you to a bed, room or more suitable space as soon as one becomes available.

Your team will let you know as soon as this happens.

How will my dignity and privacy be protected?

We understand this is not the ideal environment, and we are doing everything we can to make sure you have privacy. Screens may be used to make sure you feel as comfortable as possible during assessments and care.

Will I still be seen by a doctor as quickly as other patients?

Yes. You will be seen based on how urgent your care needs are – not where you are.

Being in a corridor or other temporary space does not delay your treatment.

Will I still get food and drink?

Yes. If it is safe for you to eat and drink, meals will be provided at set times.

Please tell staff if you have any allergies, dietary needs, or if you need food or drink outside these times.

Can I use the toilet and washing facilities?

Yes. There are toilets and washing areas nearby.

Staff will show you where they are or help you if you need it.

Do I have an allocated nurse?

Yes. You will have your own nurse who will tell you their name.

They will help you with your medicines and care.

If you have any worries or questions, please speak to them.

Can I get staff attention if I need help?

Yes. Staff are always nearby and will check on you often.

Your nurse will explain how to get help if you need anything or if you start to feel worse.

Can I have visitors?

Yes. Please try to keep visitors to a small number because this area can be busy and it helps us keep people safe and comfortable.

[Add more details about local arrangements]

All visitors must clean their hands and follow hospital safety rules.

Who will talk to my family or carers?

Your nurse, doctor or therapist can share information with your family or carers if you wish.

If I need to be admitted to a ward, will this delay me?

No. If you need to go to a ward, your bed will be arranged as soon as one is ready.

Your care will continue while you wait.

How can I give feedback about my care?

If you have any questions or worries, please speak to a member of staff.

We welcome your feedback. You can also contact our Patient Advice and Liaison Service (PALS) on: [Insert phone number] or [Insert email address].

Publication reference: PRN01967

Date published: 11 December, 2025
Date last updated: 11 December, 2025

▲Back to top