Royal College of Physicians

Measurement, management and elimination

of temporary care environments for patients admitted to hospital

January 2025

The Royal College of Physicians (RCP) recognises that care in hospitals is now frequently being delivered in areas not designed or equipped for patient care. We call on the NHS, the Department of Health and Social Care, and arms-length bodies across the four nations of the UK to:

> formally measure and nationally report the prevalence of care being delivered in temporary care environments

> put systems and processes in place to eliminate 'corridor care'

> support patients and staff when care is delivered in temporary care environments

> adopt a 'zero tolerance' approach to this inadequate care.

The RCP is one of a number of healthcare organisations calling for an end to 'corridor care', which is unsafe and unacceptable for both patients and healthcare staff.

NHS England's recent announcement to record the use of temporary escalation spaces across all NHS trusts from January 2025 is a welcome step forward. The RCP calls on NHS England to work with stakeholders to ensure that these data are clearly defined, published as soon as possible, and reported regularly all year round. These incidents of care are no longer a problem confined to the winter months.

Patients being cared for in temporary care environments must have access to the same standard of care that is offered to all patients admitted to hospital.

More broadly, the NHS should review which winter preparedness measures have made a difference so far – and which have not. The NHS England urgent and emergency care recovery plan has invested over £1 billion in the system – we need to understand what works and what doesn't, so that we never find ourselves in this situation again.

While the RCP continues to call for an end to the practice of care delivered in temporary environments, it is important to recognise that these incidents are becoming commonplace in the NHS.

This document therefore also sets out guidance for NHS staff and healthcare providers to support them to manage this issue until appropriate action can be taken to eliminate care in temporary care environments.

Background and context

Across the NHS, some patients who require hospital admission or assessment are receiving care in environments which are not designed for patient care. These include waiting rooms, corridors, emergency ambulances outside emergency departments (EDs), additional spaces on wards without normal bedside facilities, and other areas of the hospital not designed for inpatient care. We have termed these 'temporary care environments'. Care provision in inappropriate areas reflects a lack of capacity within health and care systems to manage the demand for patients requiring urgent and emergency care (UEC). However, the scale of this problem is not understood, as there is no requirement for local measurement or national reporting.

While NHS England has published *Principles for providing safe and good quality care in temporary escalation spaces*, sadly these spaces are no longer temporary, and patients, carers and staff are coming to harm. A survey recently published by the Royal College of Nursing (RCN) showed that almost seven in ten of the over 5,000 respondents said that they're delivering care in an inappropriate setting not designed for patient care, with 90% saying that patient safety is being compromised.

The RCP welcomes NHS England's recognition of this issue, but its guidance does not go far enough and does not give the detail that staff need to provide care safely in these environments. NHS England's guidance highlights important aspects of care, such as the use of NEWS2 to identify acute deterioration and the need to maintain privacy and dignity, and acknowledges the need to support staff. With the guidance being reactive rather than proactive, it is less focused on delivering care in a way that would see the elimination of care delivered in temporary environments and falls short of recommending formal measurement of the prevalence of care being delivered in temporary care environments.

Emergency department crowding

Crowding in EDs has become increasingly prevalent in the UK over several years, but has particularly escalated over the past 12–18 months. There are multiple reasons for crowding in EDs, which may vary from day to day and from hospital to hospital. Crowding is usually a consequence of rising demand and inadequate capacity, leading to poor patient flow through a UEC admission pathway.

The delays in 'outflow' from EDs for patients requiring admission for care means that the care that would have been given in assessment units and wards needs to be delivered by admitting teams in EDs, and often in temporary care environments. This means that it can take longer to deliver care, and care being less complete due to staff not having access to the appropriate equipment in these environments. It causes considerable distress to patients and staff, with a high risk of compromising patient privacy and dignity, as well as both potential and actual risks to patient safety.

Recent data published by NHS England showed that, in December 2024, over 54,000 patients waited over 12 hours in EDs for admission; this number stood at just 1,111 patients in November 2019. Crucially, the number of patients staying 14 days or more in hospital due to discharge delays stood at over 32,000 in December 2024. The greater the number of patients unable to leave hospital, despite being medically well enough to do so, the fewer beds there are for new hospital admissions for patients coming in who are acutely ill.

Inpatient wards and continuous flow models

Many hospitals have created extra bed spaces, or temporary bed spaces on wards to increase capacity. This places extra pressure on staff in these wards and worsens the experience and effectiveness of care for all patients on the ward.

The continuous flow model, first introduced in North America in the late 1990s and also known as the full capacity protocol, has been advocated by NHS England. It essentially mandates that patients are transferred to wards at timed intervals to meet predicted discharge or transfer rates from the ward, regardless of whether a bed is available. There is some evidence that this can reduce crowding in EDs, in units with low numbers of patients waiting for admission and robust governance systems in place to protect patient safety. If well operationalised with proactive ward discharges and effective use of discharge lounges, this can be a beneficial model. However, the continuous flow model has not been studied in the extreme situations of ED crowding that are now commonplace in the NHS.

The implementation of continuous flow models is often misinterpreted or inappropriately operationalised. For example, additional patients are transferred to wards irrespective of expected discharges, which can increase the burden particularly on ward nursing staff and exacerbating already-stretched patient : staff ratios. This may well be contributing to the NHS 2023 staff survey response, where only 26 % of the workforce felt that there were enough staff at their organisation. Rather than being a quick fix, the continuous flow model has been found to rapidly exhaust its usefulness, specifically in the face of chronic bed shortages. The RCP has also received reports of similar operational practices being applied to the discharge of patients into the community; the appropriateness, effectiveness or safety of this have not been studied.

Patient safety

There are numerous studies looking at patient safety and crowding in EDs, demonstrating worse outcomes and a poorer experience for patients and healthcare staff. A large observational study of more than 5 million NHS patients in England showed that delays to hospital inpatient admission beyond 5 hours from time of arrival at the ED is associated with an increase in all-cause 30-day mortality, adjusted for age, health conditions and a wide range of other factors. This quantified harm demonstrates that there was one excess death for every 72 patients who spent 8–12 hours in the ED. 40% of adult presentations were in those aged over 65 years; this is the group most likely to present with clinical complexity such as frailty, delirium and dementia. Crowding is also more common in areas of high social deprivation and will therefore widen health inequalities.

Other studies have shown that ED crowding increases time to receive vital treatment such as antibiotics and analgesia. There have been other examples of patient safety incidents caused by failure to deliver appropriate clinical care in temporary care environments, including failures to provide venous thromboembolic prophylaxis and treatment such as time-critical medication. However, the direct impact of delivering care in these circumstances, including on patient safety, has been less well studied.

Efforts to improve patient flow can result in other bed management practices associated with increased mortality or length of stay: multiple bed moves, moving patients at night, increased risk of infection outbreaks, and patients being placed under the care of the wrong team. Evidence suggests that it is older, frailer patients who are most likely to be subject to multiple bed moves and be in 'outlying' beds during their admission. This contributes to negative outcomes such as delirium and deconditioning, which can have lasting consequences for patients, carers, staff and healthcare services.

Patient experience

The General Medical Council recognises that avoidable delays and waiting for UEC services causes harm to patients and affects the morale of staff. Patients often have a poor experience of using UEC services, causing increased stress and anxiety for both themselves and their families, and delaying their recovery. There is also a risk that patients may delay or avoid presenting with significant illness because of previous or expected poor experience.

A recent systematic review demonstrated that the most commonly identified factors influencing patient experience in EDs included overcrowding and wait times, privacy and communication. Furthermore, it is known that patient experience is positively associated with both clinical effectiveness and patient safety, both of which are compromised in the delivery of care in temporary care environments.

A Health Services Safety Investigations Body report examining harm caused by delays in transferring patients to the right place of care revealed poor staff wellbeing due to stress, moral injury, incivility and burnout as a consequence of ED crowding. This was further validated by the 2024 RCN survey, in which nearly 54% of respondents reported considering leaving the NHS as a result of providing care in these circumstances.

There are some basic principles that should always be observed for patients and families experiencing care in temporary environments, although these principles can apply to all locations of care. Healthcare staff should prioritise moving the most unwell or vulnerable patients using evidence-based decision tools such as NEWS2, the Clinical Frailty Scale (CFS) and the four 'A's test (4AT) for delirium.

Patients and families:

> require explanation of why they are being cared for in these areas, and verbal consent should be obtained prior to patients being moved

> must be orientated to facilities, particularly to the availability of toileting facilities, food and drink, and how to alert staff to their needs

> should be reassured that they will receive the clinical care they need for their condition

> need regular updates on when they are likely to be transferred to the correct place

> require regular mobilisation when the patient is in a temporary care environment for more than a few hours, which is essential for patients well enough to mobilise

> should be enabled to debrief around their experience in the temporary care environment.

Staff experience

Delivering care in temporary care environments can be physically and emotionally challenging for staff. Each element of clinical care is likely to take longer because the environment is not planned for clinical care. Staffing for these patients must include dedicated medical, nursing, pharmacy and therapy staff at agreed staffing levels for inpatient care and the acuity of condition. These staff should work as a team in line with RCP, RCN, Royal Pharmaceutical Society and RCP Patient and Carer Network guidance on _Modern ward rounds: Good practice for multidisciplinary inpatient review_. Staffing levels are likely to need to be higher than for permanently established beds, given the inefficiencies and increased risks.

Additional support for teamworking should be given, as these staff may not regularly work together. Team approaches to the shift such as the _Start well, end well_ approach should be instituted. There are some basic principles that should always be observed:

> staff should not continually work in these environments

> induction to the facilities in a temporary care environment for new staff in that area is essential

> permanent rather than temporary employees should be deployed to temporary care environments

> regular debriefing for staff and emotional support are essential.

Core standards for inpatient care

In summary, the RCP expects patients being cared for in temporary care environments to have access to the same standard of care that is offered to all patients admitted to hospital. All patients must have a named consultant and an identified responsible clinical team.

The RCP recommends the following basic core standards, whether in a permanent or temporary escalation space.

Patient safety	Privacy and dignity	Governance
☐ Regular physiological measurement of vital signs and calculation of NEWS2 and response in line with national guidance for acutely admitted patients.	☐ Privacy and dignity must be maintained at all times. This includes when requested or required via screens around the individual's 'bed' area and access to a fully private area for confidential discussions or certain examinations.	☐ Immediately accessible patient information for clinical staff, eg observation charts available at the 'bedside', and full access to patient records and electronic systems.
☐ Call systems for the patient to alert staff.		☐ Appropriate access to electronic systems, including safety incident management systems.
☐ Rapid availability of oxygen and suction, and resuscitation equipment.	☐ Accessible nutrition and hydration with regular meal and snack provision, and water and drinks available at the 'bedside'.	☐ Regular debriefing, and Freedom to Speak Up champions.
☐ Safe medicines management.		
☐ Easy access to clinical equipment for patient assessment.	☐ Toileting facilities at, or a short distance away from, the 'bedside'.	
☐ Regular multidisciplinary review in line with the acuity of their condition.	☐ 'Bedside' or nearby washing and dressing facilities.	

Minimising and eliminating care in temporary care environments

Care in temporary care environments is due to a mismatch between capacity and demand, with inadequate patient flow caused by a lack of timely discharge and transfer of patients. The NHS and the Department of Health and Social Care must formally measure and nationally report all year round on the prevalence of care being delivered in temporary care environments. Only when this is done will the true scale of the problem be recognised and understood, so that appropriate action can be taken to eliminate care being provided in temporary care environments.

Until this is achieved, the RCP makes the following recommendations.

Hospitals and local healthcare systems should:

> regularly review demand and capacity for inpatient care and assessment

> develop robust plans to expand inpatient capacity when that capacity is required, using appropriate facilities designed and staffed for inpatient care. If this includes identifying temporary care environments, there must be plans for how they can meet the standards for inpatient assessment and care, and have clear criteria for when these would be used, staffed and de-escalated

> work with system partners and patients to ensure timely discharge or transfer from the acute hospital when patients are well enough to be cared for in other environments

> provide operational support to clinicians to ensure timely interventions that maximise patient flow, with a focus on the most vulnerable or unstable patients.

Clinicians should:

> work as multiprofessional teams to ensure timely assessment, management and transfer of patients, identifying those most in need of care in a different care environment to enable timely transfer

> work with other clinical departments to ensure timely assessment and patient flow, including response to referrals and clinical in-reach to other departments including acute medical units and EDs

> prioritise the sickest patients, followed by those who might be discharged and transferred in their regular assessments

> ensure that temporary care environments support patient privacy and dignity if medical photography is required, to support rapid virtual review by other clinical departments

> ensure timely discharge and flow in line with expected discharge and admission times and rates.

A variety of resources are available to help clinical and operational management teams to improve patient flow and reduce the delivery of care in temporary care environments. These include:

> RCP Urgent and emergency care winter planning

> Getting It Right First Time (GIRFT) and Society for Acute Medicine Six to help fix: Acute medicine guidance for improving in-hospital flow

> GIRFT and RCP Principles for acute patient care

> GIRFT Further faster: Urgent and emergency care handbook (FutureNHS login required)

> Emergency Care Improvement Support Team (ECIST) resources at https://future.nhs.uk/connect.ti/ECISTnetwork/groupHome (FutureNHS login required)

> Royal College of Emergency Medicine Service design delivery toolkit

> British Geriatrics Society Joining the dots: A blueprint for preventing and managing frailty in older people

> GIRFT / NHS England indicator tables:

– Summary Emergency Department Indicator Table (SEDIT)

– Summary Acute Medicine Indicator Table (SAMIT) and SAMIT 75+ for frailty

This position statement has been developed in consultation with members of the Patient Safety Committee, which comprises representatives from the RCP as well as from specialist societies, other royal colleges, the Patient and Carer Network and external stakeholders.

The document was approved by RCP Council.

www.rcp.ac.uk
policy@rcp.ac.uk

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