Another brick in the wall: why 'corridor care' is an oxymoron and why it is important to understand it

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The Trainee Emergency Research Network (TERN)'s paper entitled "Understanding corridor and escalation area care in 165 UK emergency departments: a multicentre cross-sectional snapshot study", is an excellent example of pragmatic emergency medicine research focusing on a key issue facing emergency medicine services globally.[1] It is also a fantastic example of collaboration across participating sites. TERN is part of the Royal College of Emergency Medicine (RCEM) and is based on a network filtering through regions and hospitals in the UK. To bring together 165 sites in research of this nature is quite an achievement, and all participating sites deserve congratulations.

The authors of this paper have successfully quantified the extent to which crowding leads to patients being treated in inappropriate spaces. If anything, their findings will be an underestimate. For instance, patients who need a bed are often left sitting in a chair overnight, and patients are also commonly admitted to 'off-the-clock' areas to artificially improve performance, but are still not in the right place to receive the care they need.

In the UK the RCEM has been strongly advocating for both patients and staff around the seemingly endless problem of emergency department (ED) crowding. At the same time, emergency medicine researchers have progressively been adding to the scientific knowledge base. Most recently, the harm associated with crowding has been quantified, such that for every 72 patients who wait 8–12 hours before admission there is one excess death.[2] Furthermore, a crowded ED impairs the function of the ambulance service and bad patient experience discourages patients from seeking help appropriately. Meanwhile, policy makers have been focusing on 'solutions' for crowding that have no evidence base behind them, or for which the only evidence is a lack of effect. Approaches focusing on demand management and alternative access, while attractive in principle, will fail to address the root causes of ED crowding and largely fail to benefit the sickest patients. This paper provides further evidence that the cause of crowding is not the volume of patients coming in, but the flow out. Basically, if all the patients who required admission were taken out of the equation, the EDs in the study (remember that is most of the EDs in the UK) would not have been overcrowded. The issue is the exit block, and the policy focus needs to be on that.

One of the fundamental roles of an ED is to provide resuscitation for critically ill patients. In this study, 10.5% of patients had no available resuscitation bed at the time of the survey. This leads to what most emergency physicians and nurses regard as the familiar task of 'Trolley Tetris', with patients being swapped around and unenviable decisions around where to put the least critically ill patient or the least infectious patient with an infectious disease being taken daily. It also illustrates why so many department leads did not feel confident in their ability to mount a major incident response, another key role.[3]

This paper does not quantify the effect on humans of the use of escalation spaces, whether patients or staff. Despite NHS England's guidance on 'providing safe and good quality care in temporary escalation spaces',[4] it simply isn't possible to offer proper care in corridors and cupboards. Patients describe loss of autonomy, unmet expectations and feelings of increased vulnerability.[5] Many of these patients are elderly, frail and vulnerable. Many have visual or hearing impairment or are confused. Many have extensive nursing needs. The paper also highlights that patients with mental health presentations and children may also end up in this predicament. The disconnect between guidance from politically driven organisations such as NHS England and the real world is starkly exposed here.

So what next? ED crowding risks being seen as a wicked problem by politicians, other specialties and managers, while recent history shows that this is an entirely fixable problem provided the effort is directed into the right area. Focusing on demand management consumes effort and cost without any appreciable benefit. We would recommend that the lessons of the early part of this century—ruthless attention to flow out of the ED, within the hospital and at discharge—should not be forgotten.

There has been a drive to measure and report the use of treatment escalation spaces. This paper indicates the challenges associated with agreeing a definition and finding an automated method. The methodology here was labour-intensive and unsustainable as a repeatable tool. And while what is measured gets attention, this paper demonstrates that if a department is crowded, patients will be in escalation spaces. We can measure crowding directly and indirectly. What is important may already be being measured. The gap is in the courage of politicians and other health service leaders to acknowledge where the problem lies, and to take basic steps towards starting to think about long-term solutions. This paper provides another brick in the wall of knowledge around ED crowding, and the TERN network should be congratulated on its publication.

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REFERENCES

1 TERN. Understanding corridor and escalation area care in 165 UK emergency departments: a multicentre crosssectional snapshot study. *Emerg Med J* 2025.
2 Jones S, Moulton C, Swift S, *et al*. Association between delays to patient admission from the emergency department and all-cause 30-day mortality. *Emerg Med J* 2022;39:168–73.
3 James RH, Jones R, Kelly A, *et al*. Survey of major incident preparedness in English type 1 emergency departments. *Emerg Med J* 2025;42:418–9.
4 NHS England. Principles for providing safe and good quality care in temporary escalation spaces. 2024. Available: https://www.england.nhs.uk/long-read/principles-for-providing-safe-and-good-quality-care-in-temporary-escalation-spaces [Accessed 25 Oct 2025].
5 Craston AIP, Scott-Murfitt H, Omar MT, *et al*. Being a patient in a crowded emergency department: a qualitative service evaluation. *Emerg Med J* 2025;42:148–53.