



Royal College
of Nursing
Scotland

Key drivers of corridor care in Scotland





Executive summary

Ensuring patients in hospitals are treated in appropriate designated clinical areas is critical for delivering safe, high-quality care and to protect the health and wellbeing of both patients and nursing staff. However, growing demand for health and social care services, along with supply-side challenges related to limited resources and staffing, is putting the health care system under increasing strain, resulting in care increasingly being delivered in inappropriate places such as corridors, putting patient safety at risk and negatively impacting nursing staff.

Corridor care is no longer just a winter problem in the NHS in Scotland. It is widespread and has become increasingly normalised, with far reaching impacts for patients, nursing professionals, and the health system. Hospital overcrowding and use of continuous flow models have pushed corridor care beyond emergency departments, reaching wards and departments right across hospitals. Fundamentally, care delivered in corridors and other inappropriate places is unsafe for patients and those treating them – it increases risk of infection, robs patients of their dignity, and increases the likelihood of negative health outcomes. For nursing staff, delivering care in corridors can cause significant psychological strain, leading to stress and burnout – a leading contributory factor to nurses leaving the profession. Delivery of care in this way is reflective of deep systemic issues within the NHS and social care, and impacts on the safety culture across and between teams within hospitals and the wider health and care system, undermining trust, communication, and efficiency. Corridor care poses a significant risk for both patients and nursing staff, and over time has normalised unsafe practices. Whilst corridor care is the term commonly used, care delivered in corridors is not care and should never be regarded as such.

Powerful testimony from RCN Scotland members has shone a spotlight on the challenges they face every day from having to deliver care in inappropriate places, and there is a strong evidence base on the negative impact this has. And yet, despite this, the true scale of the corridor care crisis in Scotland is unknown, due to a lack of data and reporting. There is not currently a single agreed definition and measure of corridor care in Scotland and health boards are not required or mandated to record and report instances of it. This is despite a commitment from the Scottish government to ‘eliminate non-standard care areas.’

Without consistently measured and reported data, it is simply impossible to have an accurate picture of the true scale of corridor care in Scotland, and a lack of data collection and measurement risks it going unchecked and significantly reduces accountability for tackling it. What gets measured gets done, and not having a measurement and reporting mechanism in place risks inaction and demonstrates tackling corridor care is not being sufficiently prioritised politically.

In the absence of reported data on corridor care, and a single agreed definition, other data needs to be used to determine the key drivers of corridor care. To do this, we analysed a wide range of publicly available data sets to understand the true scale of corridor care in Scotland and identified a set of six key drivers from this data. The six key drivers identified are:

1. Ageing population with increasing multimorbidities
2. NHS waiting times and waiting lists for treatment
3. Availability and capacity of NHS beds
4. Nursing workforce crisis
5. Availability and supply of social care nursing services
6. Delayed discharges.

Across each of these drivers, a range of measures/indicators are used to show the extent of demand for and/or supply of health and social care services, and how these influence corridor care outcomes. The key drivers and associated indicators paint a picture that highlights the need for building capacity to be able to effectively meet growing demands and mitigate the impacts of future challenges. And it is our contention that this means sustained investment to build nursing capacity.

As the largest workforce in the NHS, nursing plays a critical role in action to eradicate corridor care in Scotland. Registered nurse staffing levels have a significant impact on patient and nurse outcomes, positively driving improvements in population health through management of acute illnesses and long-term conditions, prevention, and supporting people to manage their own health and stay well, keeping people out of hospital, and reducing demands on the system. Sustained investment in nursing is therefore essential for eradicating corridor care.

Based on the findings and evidence presented in the report, we have identified three core recommendations which are essential for eradicating corridor care in Scotland. These are focused on defining corridor care, reporting on corridor care, and investment to increase capacity to address the widespread challenges in the health and social care system. Our recommendations recognise the critical role of nursing in eradicating corridor care.

Our recommendations are:

Recommendation 1: For the Scottish government to create a single national definition of corridor care. This definition must include any and all areas of hospitals where waiting, assessment and treatment takes place that were not originally designated, planned, designed, equipped or staffed for appropriate safe and effective clinical patient care, including corridors, waiting rooms, chairs, unfunded and unplanned extra/temporary beds, and other inappropriate spaces.

Recommendation 2: For the Scottish government to commit to capturing, collating and reporting data on corridor care across NHS Scotland. This should include data on the number of patients being cared for in inappropriate places, where these inappropriate places are, what the places are, and details of the impacts on patients and nursing staff, alongside an accompanying list of actions to be taken forward by relevant authorities.

Recommendation 3: The Scottish government must deliver sustained investment in increasing capacity across the health and social care system, recognising the contribution of the whole health and social care system to corridor care outcomes, and the vital role that nursing staff in both acute and community settings play in eradicating corridor care. Actions must include building acute hospital capacity to improve availability and supply of services, and growing prevention and community focused activities to shift the balance of care away from hospital settings, to overcome the challenges of growing demand, with nursing at the heart of this activity.

The recommendations are principally aimed at the Scottish government (and health boards), calling on them to act, as the strategic actors who have the power to make the decisions needed to deliver the necessary changes to eradicate corridor care.

The recommendations are additionally summarised at the end of the report.

The report was written prior to the publication of the Scottish government's 'Health and Care Improving Flow Plan 2026-2031' ([Scottish government, 2026](#)). We acknowledge publication of the Flow Plan.

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1. Introduction

1.1. What is corridor care?

‘Corridor care’ refers to the unsafe and undignified practice of patients receiving treatment in spaces that were not originally, designated, designed or staffed for patient care. This is not limited to emergency departments. It includes corridors, waiting rooms, additional beds in wards or bays, chairs, wards designated for same day care and other inappropriate space.

Delivery of care in inappropriate places is widespread across hospitals in Scotland and the UK. The scale of the issue is considerable and has a significant impact on patients and the nursing profession.

1.2. Impact of corridor care

The impact of corridor care is far reaching, affecting patients, staff including nursing professionals, and the delivery of health and social care services. Hospital overcrowding means corridor care is experienced not just in emergency departments but right across hospitals (Box 1).

Box 1: Impact of corridor care

On patients:

- Care delivered in inappropriate places like corridors is unsafe and distressing for patients. It robs them of their dignity, and increases risks of negative health outcomes, including delayed and inappropriate treatment, incorrectly administered medication, and even increased risk of death.
- Patients are at increased risk of infection, due to inability to practice infection control procedures, have no access to call buttons and essential testing, experience a lack of confidentiality and privacy, and have an increased risk of falls. Patients also have limited access to toilet facilities, and lifesaving equipment such as suction and oxygen.
- Patients may be out of sight of clinical staff or be in a location that is difficult to access, making it more challenging for them to be checked on regularly and for an urgent response/intervention to be delivered if required.
- Waiting and receiving care and treatment in such locations can also make a patient’s condition worse. Trolleys and waiting room chairs, for example, are not designed for continuous use by a patient over a prolonged period of time and can be physically uncomfortable and painful. This can result in blood clots, muscle fatigue, and pressure ulcers, and can lead to longer hospital admissions, as patients who are immobile or not in optimal positions quickly become deconditioned.

On nursing staff and the profession:

- Delivering care in inappropriate areas places immense psychological strain on nursing staff, with increased stress, burnout, and disillusionment, leaving many feeling distressed that they were unable to provide the level of care they entered the profession to deliver. Such practices can be very difficult for nursing staff morally, with many feeling they are breaching the duty of care they have for patients.
- High levels of burnout and moral injury are among the main reasons given by nursing staff for leaving or considering leaving the profession.
- Evidence shows there is a strong correlation between the health and wellbeing of nursing professionals and safer, high-quality patient care ([Kirk, 2024](#)). Healthier and happier nursing professionals deliver safer, higher quality care.

On the NHS and health and social care services:

- Delivery of care in inappropriate places reflects deeper systemic issues within the NHS and social care, including funding constraints, staffing shortages, and inefficiencies in patient flow ([Patient Safety Learning, 2025](#)).
- Corridor care does not just impact on nursing staff in emergency departments. It is felt across acute hospital sites and far beyond. It impacts upon care delivered in the community, with ambulances stuck at A&E departments, unable to drop off patients, resulting in fewer ambulances being available to deliver essential emergency care in communities.
- Corridor care significantly affects safety culture among different health care teams, including ambulance staff, ward staff, and emergency department (ED) staff. These groups must collaborate in high-pressure, resource-limited environments where patient safety is already at risk. However, the dynamics created by corridor care can undermine trust, communication, and efficiency, all of which are critical components of a strong safety culture.

Corridor care poses a significant risk for both patients and nursing staff, and over time can normalise unsafe practices. With concerted action, these impacts can be mitigated and delivery of care in inappropriate places can be eradicated.

1.3. Understanding the context in Scotland

In January 2025, RCN published *On the frontline of the UK's Corridor Care crisis* ([RCN, 2025a](#)), a dossier of evidence from our members highlighting the exponential rise and increasingly normalised practice of treating patients in unsafe and undignified environments in hospitals right across the country, with serious risks to patient safety and nursing staff health, wellbeing and psychological safety. Asking nursing staff to deliver care in such locations is wholly inappropriate and risks moral injury, with many feeling they are breaching their duty of care to patients.

We know from evidence that nursing staff in Scotland are currently witnessing and experiencing unsafe care practices. Findings from a recent Nursing and Midwifery

Council (NMC) survey highlighted that 37% of registered nurses and midwives practising in Scotland have witnessed a patient safety incident in the last year, defined as a situation where they believed a person's safety or care was compromised. Pressure on workloads and inadequate staffing were the most frequently cited contributing factors to safety of care being compromised ([NMC, 2026](#)). This was the highest percentage in the survey of any of the four UK nations. Impacts of corridor care on patient safety are real and they are happening now.

Recent testimony from RCN members ([RCN, 2026a](#)) paints a harrowing picture of nursing staff feeling 'angry', 'ashamed' and 'embarrassed' at having to care for patients in unsafe and undignified conditions. Members expressed anger and frustration at the lack of action from the UK's governments, including the Scottish government, to tackle corridor care. In our manifesto for the recent Scottish parliament election ([RCN, 2026b](#)), we called for the Scottish government to commit to eradicating corridor care/care in inappropriate places across Scotland's hospitals, with accompanying actions. The actions included investment in the nursing workforce, to recognise the vital role of the profession in this regard, and for the Scottish government to commit to capturing and collating data on corridor care.

Nursing plays a critical role in action to address corridor care, and in supporting improvements to the health and social care system and general population health. There is substantial and growing evidence demonstrating that registered nurse staffing levels have a significant impact on both patient outcomes and staff wellbeing ([RCN, 2025a](#)). Low or insufficient levels of nurse staffing are associated with a range of adverse outcomes for patients, including more corridor care. Investment in nursing is therefore essential if corridor care is to be eliminated.

The Scottish government did make a commitment to 'eliminate non-standard care areas' ([Scottish government, 2025a](#)) and outlined a series of proposals to transform the health and care system. These include shifting the balance of care to the community with an increased focus on prevention ([Scottish government, 2025b](#)), strengthening workforce planning, more effective, transparent governance, and increasing capacity to alleviate pressure on hospitals including improving patient flows, removing barriers to discharge, and increased investment to tackle waiting lists ([Scottish government, 2025c](#)). Despite these commitments and proposed actions, RCN Scotland members have continued to report that corridor care has been allowed to persist. It is now normal practice and widespread all year round.

The true scale and impact of corridor care in Scotland is unknown, due to a lack of data and reporting. Our call in our manifesto for the Scottish government to collate, capture and report data on corridor care is vital in this regard, to deliver the evidence base needed, and forms a key recommendation of this report.

The Scottish government has stated that there is currently no requirement or ability for health boards in Scotland to record and submit data on corridor care, not least, they argue, because there is no agreed definition of what corridor care is. The Scottish government states that its focus is on addressing the underlying causes of corridor care, such as high hospital capacity and poor patient flow ([Scottish parliament, 2026a](#)). Yet, it is worth noting that the Scottish government simply cannot successfully address the underlying factors driving corridor care if they cannot define it. It is impossible to successfully address something that has not been clearly defined.

Evidence from our members suggests a lack of action on these commitments as the corridor care crisis continues to deepen.

The lack of data collection and measurement of corridor care risks it going unchecked, significantly reduces accountability for tackling it, and demonstrates it is not being sufficiently prioritised by the Scottish government. In response to a parliamentary question in March 2026, asking if there is a requirement for health boards to collate and report data on corridor care in Scotland, the then Cabinet Secretary for Health and Social Care, Neil Gray MSP, indicated a slight shift of position, suggesting the Scottish government was actively considering the feasibility of national data collection, citing issues around data complexity and operational challenges ([Scottish parliament, 2026b](#)). Whilst this represents a positive shift from the Scottish government, no time frame has been given, and it has continued to emphasise that its focus remains on addressing the underlying causes of high acute hospital occupancy. The answer to a more recent parliamentary question (July 2026) reaffirmed this commitment from the Scottish government to actively consider the feasibility of national data collection, with the same challenges to doing so cited ([Scottish parliament, 2026c](#)).

In the absence of a single measure of corridor care, using available data to determine what the key drivers of corridor care are helps to better understand the scale of corridor care in Scotland and to identify solutions for eradicating it.

Note on data used

The data used in this report is from publicly available, published data sets. The data covers different reporting periods across the various sources used, and therefore, each of the sources may not be directly comparable in terms of time period(s) covered. Where data is not publicly available, and has been gathered in other ways, such as via a Freedom of Information request, this is clearly indicated.

Across each metric in the report, data covering the period 2019-25 has been used, where available. Data for 2025 is not available in all instances. Where this is the case, data for the latest available year has been used (usually 2024). The aim of this is to provide detail of trends and patterns over time, covering the pre and post-pandemic period, and to enable changes to be tracked and measured over the applicable time period. Data for 2026 has been provided where available at the time of writing. The data in the report was collated and analysed between February and July 2026.

Notes providing further information and caveats regarding the data are provided in relevant places throughout. The report was written prior to the publication of the Scottish government's 'Health and Care Improving Flow Plan 2026-2031' ([Scottish government, 2026](#)). We acknowledge publication of the Flow Plan.

2. Key drivers of corridor care in Scotland

To understand the extent of corridor care in Scotland, we examined a range of data sources to ascertain the key drivers of corridor care, assessing the underlying contributing factors to it, and likely future challenges if these factors remain unchecked. From this analysis, we have developed a list of what we consider the key drivers, with each supported by a series of evidence-based indicators.

The six key drivers we have identified are:

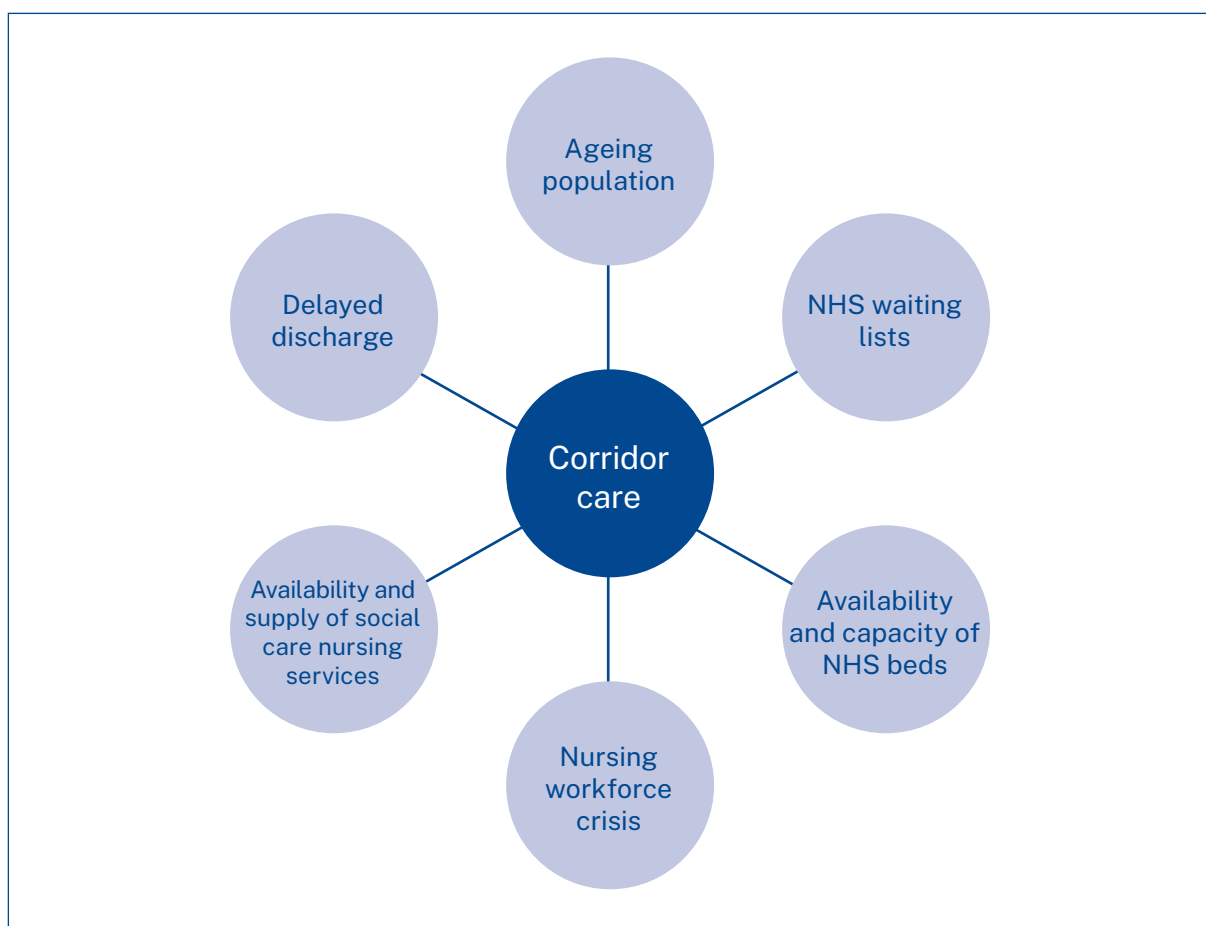
1. Ageing population with increasing multimorbidities
2. NHS waiting times and waiting lists for treatment
3. Availability and capacity of NHS beds
4. Nursing workforce crisis
5. Availability and supply of social care nursing services
6. Delayed discharges.

These drivers and their associated indicators paint a picture of a system in which corridor care *must inevitably occur*. We appreciate that we cannot draw an unequivocal distinction between these drivers and specific instances of corridor care. This is in part because corridor care is not yet being properly defined, captured and recorded in accordance with our recommendations. But nevertheless, the effect of these drivers is sufficiently well understood to mean that it is, in our view, inconceivable that they are not the key drivers of corridor care as we currently understand that term (in the absence of proper capturing and recording of data, and a nationally agreed definition). Therefore, we can contend that the data reported demonstrates and emphasises why corridor care is occurring and continuing and will continue to worsen if action is not taken to address the key drivers.

Critically, for each of the key drivers, there is clear evidence of the important and significant contribution that registered nurses and the nursing profession more widely makes to alleviating the impact of the drivers and to eradicating corridor care.

Our findings demonstrate that each key driver is interlinked, contributing to corridor care both individually and also in the collective context of the wider systems and processes in which they operate and function (Fig. 1).

Figure 1: Identified key drivers of corridor care in Scotland



Source: Graphic created by RCN Scotland

3. Key driver 1: ageing population with growing multimorbidities

Population demographics and overall population health drives demand for health and social care services, with older, sicker populations requiring more health care, at a higher intensity, for longer periods of time, resulting in exponential growth in demand for often finite, limited resources and services.

To assess the impact of an ageing population on corridor care, the following indicators have been identified. These indicators provide a comprehensive picture of the current age and health demographics of the Scottish population and how these influence demand for health care services. The indicators are:

- Population age profile
- Burden of disease
- Healthy life expectancy.

3.1. Population age profile

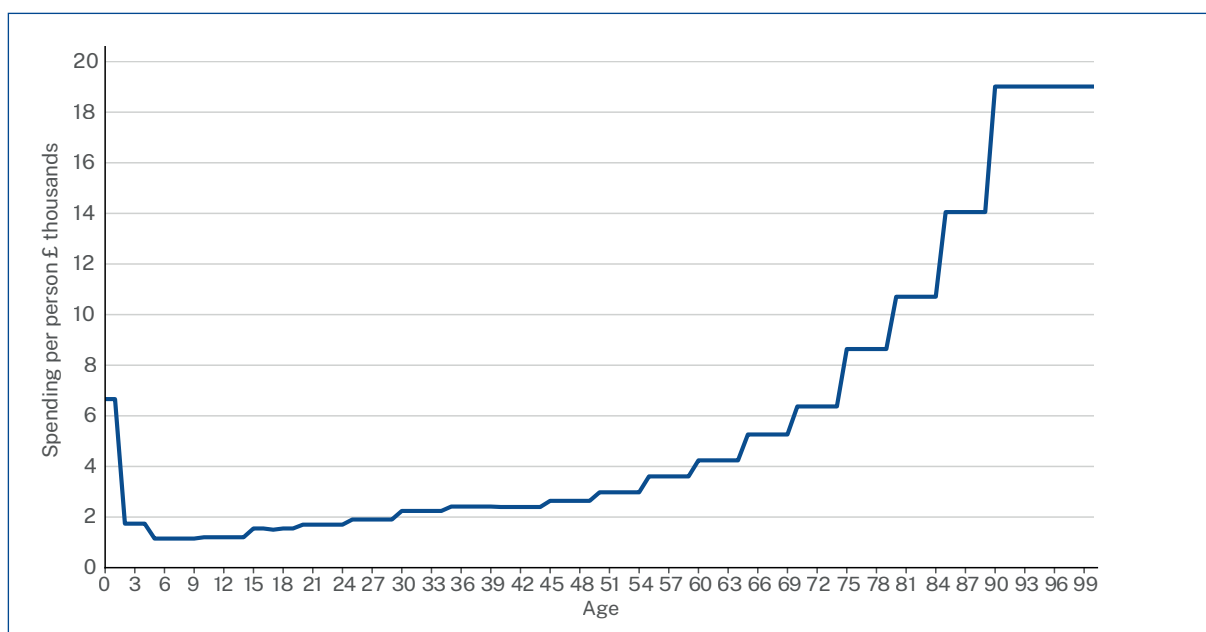
Scotland's population is ageing. More than a fifth (21%) of the population are now aged 65 and over, an increase of more than 16% (16.3%) over the last 20 years (since mid-2005). This is equivalent to an additional 332,400 people ([National Records of Scotland \(NRS\), 2026a](#)).

By contrast, over the same period, the number of young people aged 15 and under has fallen by 54,000 (5.8%). The proportion of people aged 16-64, the bulk of the population, has continued to increase but at a much lesser rate than the older population. Over the period, the 16-64 population cohort grew by only 4.7% (equivalent to 156,900 people) ([NRS, 2026a](#)).

This pattern of population ageing is projected to continue and further accelerate. The number of people aged 75 and over is projected to increase by over 341,000 by mid-2047, at the same time as the number of children (0-15) and young people (16-29) is projected to fall, by 79,900 and 57,300 respectively ([NRS, 2025](#)).

An ageing population not only has implications for health and social care service demand but also for the future workforce for these vital health and social care services. It also comes at a higher cost, as health spending increases with age. Data from a recently published Scottish Fiscal Commission report, which looks at predicted health care spending for 2029-30, highlights that from age 50 onwards, health care spending increases by larger amounts for each age group (the exception being spending for babies and children under 5 which is also higher than in some adult age groups) ([Scottish Fiscal Commission, 2025](#)) (Fig. 2).

Figure 2: Resource health spending by age in Scotland, 2029-30*

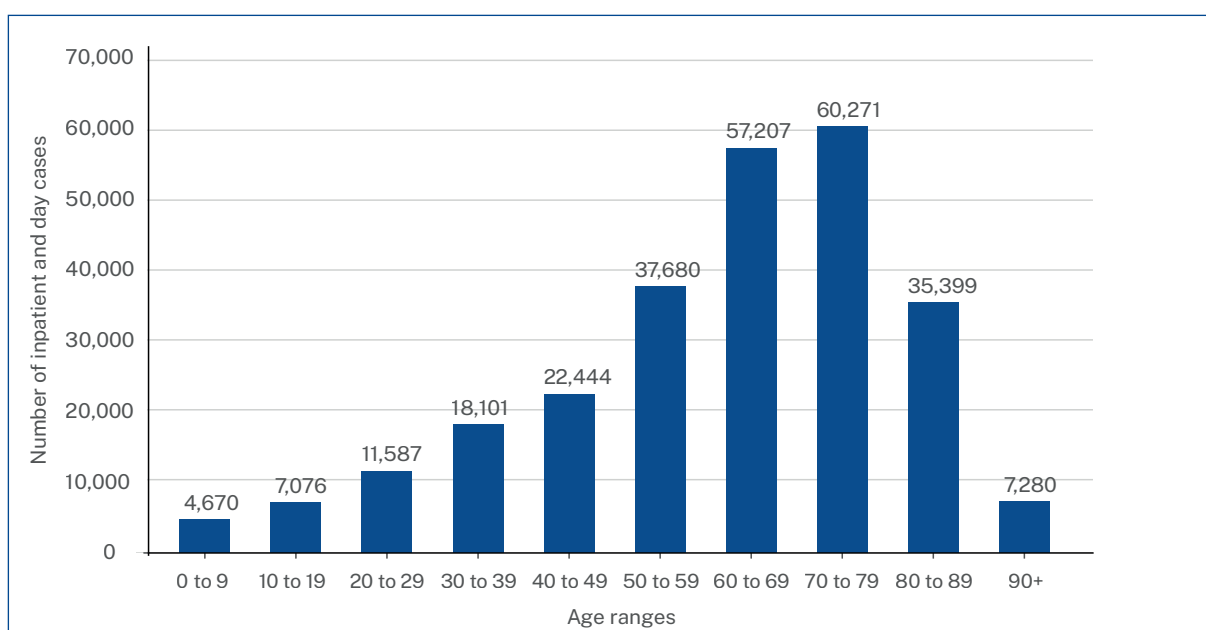


Source: graph created using data extracted from Scottish Fiscal Commission report ([2025](#))

*Data is an average of health spending between male and females, and is based on 2024-25 prices

Additionally, as well as higher cost, the number of inpatient cases is higher among older age groups. There is a close correlation between NHS bed use and capacity and corridor care. There has been a clear growth in need and demand for hospital beds among older adults as the population ages (Fig. 3).

Figure 3: Number of inpatient and day cases, by age, October to December 2025*



Source: Public Health Scotland (PHS) ([2026a](#))

*Data for October to December 2025 is the latest available (at time of writing)

The drop off in number of cases seen in the 80 to 89 and 90+ age groups is likely explained by a smaller proportion of people in those age groups as a whole relative to the 60 to 69 and 70 to 79 age groups.

The data clearly demonstrates the extent of the challenge facing Scotland's population. With a greater proportion of the population now over the age of 50, and with this projected to increase further in coming years, the cost of delivering health care will continue to increase, placing further strain on hospitals and health and social care services.

3.2. Burden of disease

As the population ages, so too does the burden of ill health/disease and demand on the health care system.

Projections indicate that Scotland's population is set to increase over the next two decades ([NRS, 2025](#)), and the corresponding annual disease burden is forecast to increase by more than a fifth (21%) to 2043. It is predicted to increase substantially for those aged 65 and over, with the biggest increases among those aged 65-84 ([Public Health Scotland \(PHS\), 2022](#)). Half of 65-74-year-olds and 63% of those aged 75 and over reported they have at least one long-term limiting condition, compared to only 30% of those aged 25-34 and 35-44 ([Scottish government, 2025d](#)).¹

This growing burden of disease indicates increased demand for limited health and social care services, as services and staff who work in them are pushed to the limit in terms of capacity and resources.

3.3. Healthy life expectancy

Given this growing burden of disease in the Scottish population, it is not surprising that healthy life expectancy – that is the number of years people live in good health – has been steadily falling, from 60 in 2021-2023 for females, to 59.4 years in 2022-2024, with a similar decrease for males during this period ([NRS, 2025b](#)). What this tells us is not only is the age at which people are getting sick, and thus requiring health care and services, getting younger but also that ill health is occurring more readily in the under 65s. This means a significant proportion of people are already in poor health by the time they reach 65 and will therefore likely need health and social care services sooner and for a longer period of time, placing further strain on health systems and services.

These three indicators paint a stark picture of an ageing population with worsening health outcomes, creating more demand on already struggling health and social care systems and services. Increasing demand with limited capacity within systems and services to effectively respond will inevitably lead to more health care being delivered in inappropriate places in hospitals, as services battle to treat ever growing numbers of older, sicker, and more complex patients.

¹ The Scottish Health Survey is self-reported data and so will likely contain some responder bias as a result

The contribution of nursing

The Scottish government has committed to shifting the balance of care away from acute hospital settings towards more community-based services, and a focus on prevention is identified as a key facilitator of this shift ([Scottish government, 2025e](#)). Prioritising prevention and health promotion is essential to improve the health of the population and reduce the impact of the ageing population on health and social care services. Nursing has a vital role to play in supporting and delivering this change. At all stages of life, nurses working in community settings in particular play a critical role in prevention, managing acute illness and long-term conditions, supporting people to manage their own health and stay well, helping to keep people out of hospital, and thus reducing demands on acute hospital services. Therefore, addressing this growing demand and eradicating corridor care requires investment in these vital nursing roles and frontline services.

Whilst an increased focus on prevention is essential to mitigate some of the challenges posed by an ageing population for the health and social care system, it should be noted that many of the positive impacts of prevention will be most readily seen in the medium to longer term. This means a shift in focus towards a more preventative approach cannot be relied upon as the only solution to achieve improved outcomes on corridor care in the immediate to short term. Immediate, significant investment in the nursing workforce and acute health and care services is required now if the growing and currently live corridor care crisis is to be addressed.

4. Key driver 2: NHS waiting lists and waiting times for treatment

Long waiting lists and waiting times for NHS services are a clear indication of growing demand for NHS services. According to Public Health Scotland, this is in large part driven by our ageing population, highlighting this demographic change and increasing prevalence of multimorbidity will increase demand among the population over the age of 65, and is expected to place further strain on NHS and health services ([PHS, 2025a](#)).

As demand increases, the likelihood of care being delivered in inappropriate places also increases, especially when this is not matched with an increase in capacity.

The following indicators have been chosen as they strongly illustrate the current challenge faced by the NHS in Scotland, specifically assessing its ability to respond to growing demand whilst also continuing to deliver safe, effective, high-quality care. The indicators are:

- NHS Scotland waiting times for treatment
- NHS Scotland A&E waiting times
- Unplanned attendances at A&E

In the absence of published data on corridor care, lengthy waits for treatment at A&E are a strong indicator of capacity challenges facing hospitals in Scotland.

The Scottish government has a series of targets for delivery of care across the NHS. These include targets for waiting times in A&E departments, and for access to treatment for cancer and planned care, which, the Scottish government argues, are adequate measures of corridor care. The government states that existing data on acute occupancy, four-hour performance and long A&E delays gives a strong sense of pressure, delays and patient care, and helps to inform understanding of flow challenges.

To understand the extent to which demand is increasing and waiting times targets are not being met, we analysed the various data sets on the delivery of care against these targets in NHS Scotland. Our analysis draws on these data sets, using the data from 2025, and comparing this to data from 2019 (pre-Covid-19), to serve as a comparison of changes over a longer time period. In some instances, data for early 2026 is included to provide an indication of the current situation in the NHS.

4.1 NHS Scotland waiting times for treatment

Table 1 shows the proportion of people receiving treatment within the timeframe indicated by the target, comparing 2019 to 2025, to show a trend for each target. Every measure/target has worsened since 2019, demonstrating that pressures on NHS Scotland have increased and continue to increase. Significantly, not only is performance against each of the targets worsening, but none of the targets have in the fact been met since at least 2019.

Table 1: NHS Scotland treatment waiting time targets 2019 to 2025 comparison – percentage of people receiving treatment within the timeframe indicated by the target

Target	Percentage treated within target time: 2019	Percentage treated within target time: 2025	Percentage treated within target time – worsening or improving
95% of people attending A&E should be admitted, discharged, or transferred within 4 hours	89%	69%	Worsening
95% of people referred urgently with a suspicion of cancer should begin treatment within 62 days (i)	83.7%	72.6%	Worsening
100% of people should begin inpatient/day case treatment within 12 weeks of the decision to treat (ii)	71.5%	57.9%	Worsening
90% of people referred for planned care should begin treatment within 18 weeks (iii)	79%	67%	Worsening

Source: NHS Scotland data, published by Public Health Scotland ([2025b](#), [2026b](#), [2026c](#), [2026d](#))

- (i) Data covers the period October to December in each year.
- (ii) Data for each year is the figure at December of the corresponding year.
- (iii) Data presented here is 2024 instead of 2025, as 2024 is the last full year of data reported. The average for each year calculated using the reported data for each month.

As the data shows, long waits are not restricted to A&E departments and are experienced across the whole of the health service. Whilst it is long waits in A&E departments that have a more direct or immediate impact on corridor care, long waits in other areas are indicative of growing demand, with reduced patient flow through the system. This frequently results in more people presenting at A&E when their condition has worsened due to their needs not being met often because of long waits in other areas to access treatment and services, further increasing demand on A&E.

Since July 2022, the Scottish government has committed to eliminating long waits and to ensuring that no one is required to wait more than a year for a new outpatient appointment and/or an inpatient or day-case procedure, with a target date for this to be achieved by March 2026. In a report published at the end of 2025, Audit Scotland highlighted that it remained unclear whether the commitment could be achieved within the stated target timeframe, given that long waits remain so high ([Audit Scotland, 2025](#)). The target timeframe/deadline has now passed and the commitment remains unmet, with waiting times remaining consistently high and well above target.

4.2 NHS Scotland A&E waiting times

Looking specifically at A&E waiting times, Table 2 shows the number of people receiving treatment and attendances, including within various timescales, comparing the 2025 data to 2019, and also to 2024 to provide a clearer picture of recent trends in demand.

Table 2: Number of people receiving treatment against key NHS Scotland measures – changes since 2019

Measure	2019	2024	2025	Percentage change 2019-2025	Percentage change 2024-2025
Emergency department attendances wait more than 4 hours (i)	182,174	495,663	493,446	+171%	-<1%
A&E attendances wait more than 4 hours (ii)	190,115	517,116	513,268	+170%	-<1%
A&E attendances wait more than 12 hours (ii)	5,562	81,148	77,878	+1300%	-4%
A&E attendances – total	1,740,759	1,637,888	1,652,248	-5%	+<1%

Source: NHS Scotland data, reported by Public Health Scotland ([2026b](#))

(i) This refers to type 1 emergency departments.

(ii) This refers to type 1 and type 3 sites. Type 3 admissions include all A&E site visits, including non-emergency visits.

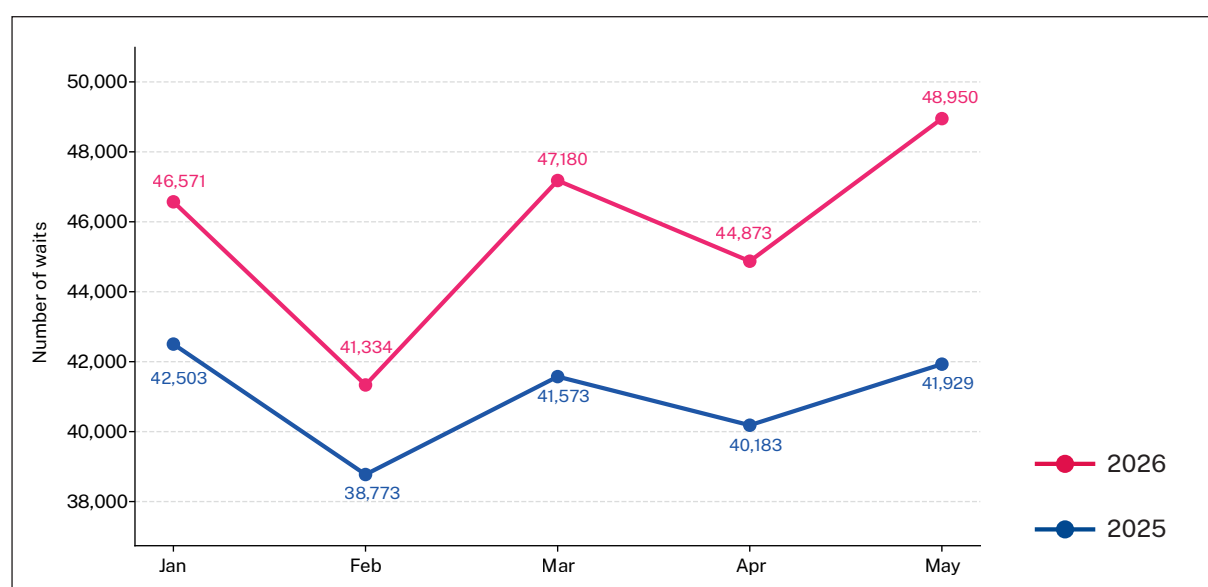
These measures clearly show a significant long-term worsening of trends, with increasing numbers of people facing increasingly lengthy waits in A&E departments for treatment and are indicative of the very high level of demand on the health system in Scotland.

The largest increase is in the number of people waiting for more than 12 hours in A&E, rising by a staggering 1300% since 2019. Indeed, the number of people waiting for more than 12 hours in December 2025 (7,451) exceeded that for the whole of 2019 (5,562), illustrating the extent of the challenges faced. This is particularly concerning as evidence shows that individuals who spent 12 hours or more in A&E are twice as likely to die within 30 days of those treated, admitted, or discharged within two hours ([ONS, 2025](#)). Waits of 12 hours or more are also far more likely to result in care being delivered in corridors and other inappropriate places. A recent RCN article ([RCN, 2025b](#)) stated: “In the absence of published data on corridor care, waits of 12 hours or more are the clearest indicator of corridor care taking place in hospitals, with staff unable to move people to a ward despite them being unwell enough to be admitted.” Longer waits quite simply put patients at increased risk.

There has been some improvement in A&E attendances of more than 12 hours, as well as for waits of more than four hours and eight hours, although to a lesser extent, between 2024 and 2025, which is welcome. Actions taken to deliver this improvement must be continued to ensure the improvement can be maintained over the longer term. However, these improvements are minimal compared to the longer-term deterioration in waiting times. It is also arguably too early to tell if these minor improvements can be sustained going forward, as pressures on the health service continue to mount.

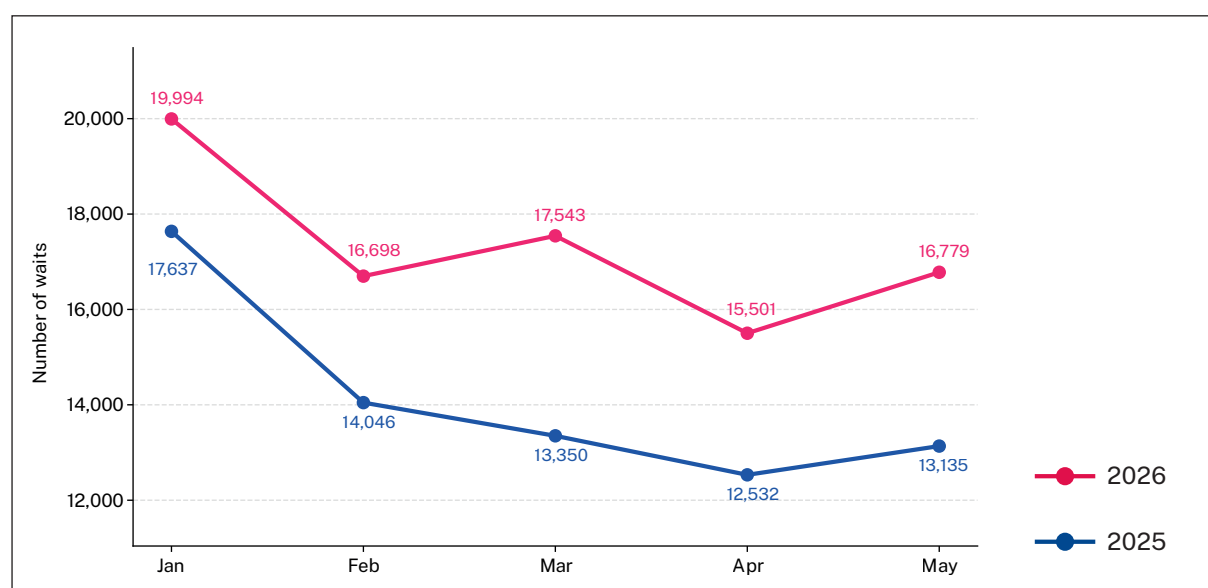
The latest available data (at the time of writing) to May 2026 indicate this improvement has not been maintained. The early months of 2026 have seen a worsening performance compared to the same months the previous year. Figures 4 to 6 present the number of waits against each of the three main A&E performance measures for January to May 2025 and 2026.

Figure 4: Number of 4 hour+ waits, January to May 2025 compared to January to May 2026 (includes all A&E attendances)



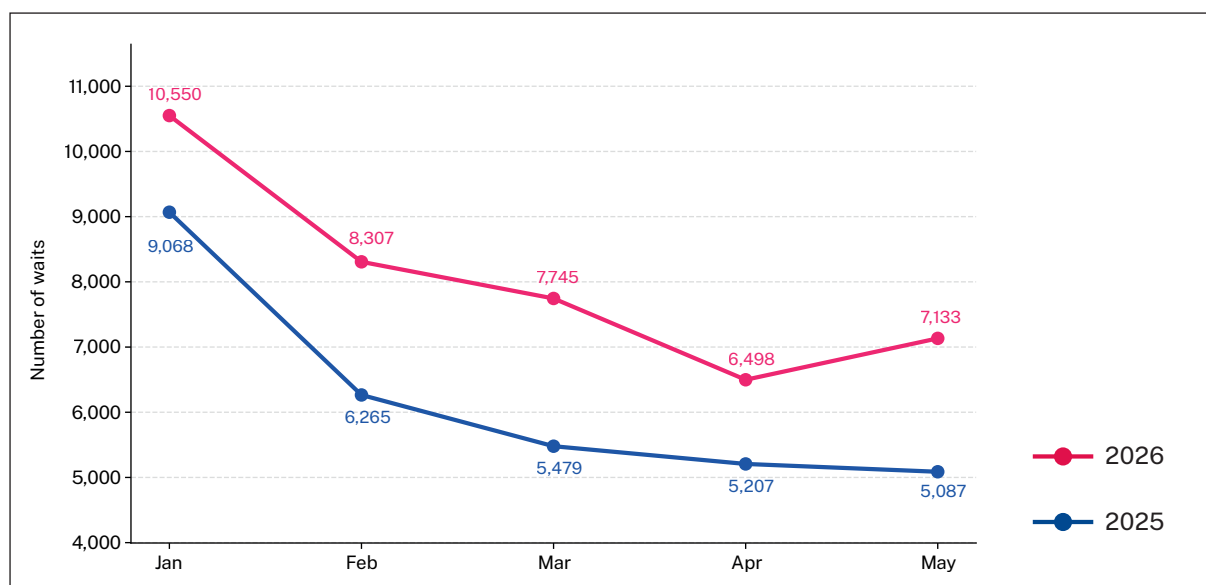
Source: NHS Scotland data, reported by Public Health Scotland ([2026b](#))

Figure 5: Number of 8 hour+ waits, January to May 2025 compared to January to May 2026 (includes all A&E attendances)



Source: NHS Scotland data, reported by Public Health Scotland ([2026b](#))

Figure 6: Number of 12 hour+ waits, January to May 2025 compared to January to May 2026 (includes all A&E attendances)



Source: NHS Scotland data, reported by Public Health Scotland ([2026b](#))

Across all three measures, the number of waits in each of the first five months of 2026 are higher than in the same month in 2025, demonstrating a clear worsening of performance. The figures for May 2026 show not only a higher number of waits compared to 2025 but waits of more than four hours were the highest recorded in 2026 so far, indicating emergency departments are facing increasing pressures. Furthermore, although it needs to be considered that A&E attendances are usually higher over the winter months than at other times of the year, these figures for May 2026 show pressures are now being felt well beyond the traditional winter period.

The figures indicate the slight improvements seen between 2024 and 2025 are not being sustained, with worse outcomes experienced in the early months of 2026 compared to 2025.

Longer waiting times paint a picture of a health service under increasing strain, with growing demand and services unable to cope, resulting in poor outcomes for patients. Findings from the Royal College of Emergency Medicine (RCEM) ([2025a](#)) highlight that there were more than 800 excess deaths in Scotland in 2025 associated with long A&E waits before admission, an increase of more than a third from the previous year. More patients waiting in A&E departments for increasingly lengthy periods of time inevitably results in more treatment/care being delivered in corridors and other inappropriate places, as hospitals are required to make space to accommodate these additional patients wherever they can. The use of continuous flow models means that these issues are being experienced far beyond emergency departments. Overcrowding is experienced across wards with extra beds being added to bays and nursing staff doing their best to care for patients in bathrooms, offices, cupboards, and bereavement rooms not designed for delivering care.

Continued failure to drive down waiting times and to deliver on waiting list targets is unsustainable and risks undermining the stability and sustainability of the NHS.

4.3 Unplanned attendances and admissions

The data on A&E attendances can be disaggregated further to identify unplanned or unscheduled attendance. Such attendances particularly matter as the ability of a health care system to respond to unplanned or unscheduled health care needs is indicative of its agility and ability to adapt. Rising unscheduled attendances (and subsequent admissions) indicate a health system at crisis point, with a weakening ability to deliver safe, high-quality health care to everyone who needs it when they need it.

Table 3 outlines unplanned emergency attendances, across the various reported timescales of waiting times, comparing 2025 to 2019, and also to 2024 to provide a clearer picture of recent trends in demand.

Table 3: Number of unplanned attendances at A&E against key NHS Scotland measures – changes 2019-2025

Measure	2019	2024	2025	Percentage change 2019-2025	Percentage change 2024-2025
Unplanned A&E attendances* – wait more than 4 hours	189,601	511,822	507,893	+168%	-<1%
Unplanned A&E attendances* – wait more than 8 hours	22,701	181,352	177,306	+681%	-2.2%
Unplanned A&E attendances* – wait more than 12 hours	5,562	80,593	77,262	+1289%	-4.1%

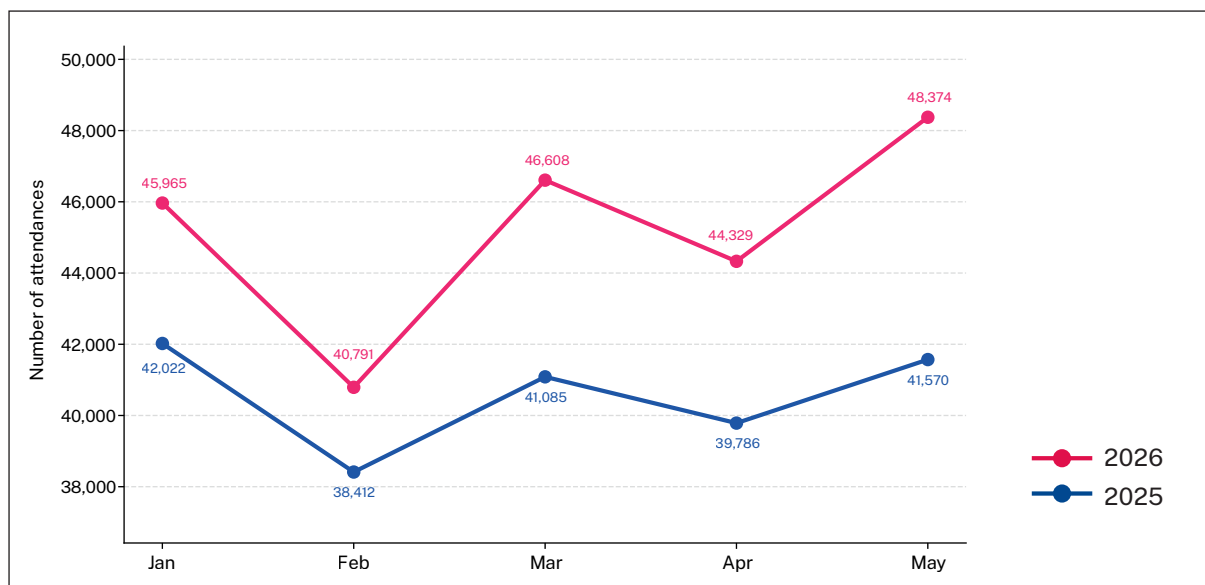
Source: NHS Scotland data, published by Public Health Scotland ([2026b](#))

*All unplanned attendances (Type 1 and Type 3)

These measures clearly show continuing pressure on A&E departments, with a long-term trend of increased numbers of unplanned attendances. There have been some recent positive improvements with the number of unplanned A&E attendances falling slightly between 2024 and 2025.

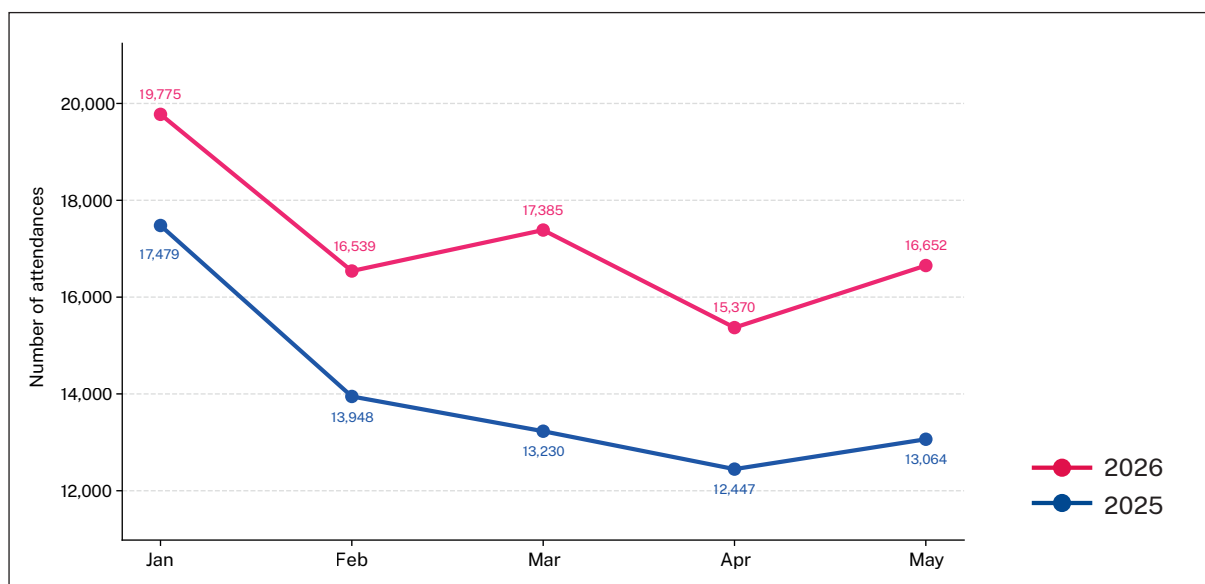
As with overall A&E attendances and waits, looking at the data for the early months of 2026 indicates that the slight improvement seen between 2024 and 2025 has not been sustained. Across all three of the measures (waits of more than four, eight and 12 hours), performance was worse in January to May 2026 than in the corresponding months in 2025. As with all A&E attendances, May 2026 was the worst month on record for the highest number of unplanned attendances with a wait of more than four hours in 2026 so far. This is shown in Figures 7 to 9, indicating a reversal of the slight improvement in performance seen between 2024 and 2025.

Figure 7: Number of unplanned A&E attendances of 4 hour+ waits, January to May 2025 compared to January to May 2026



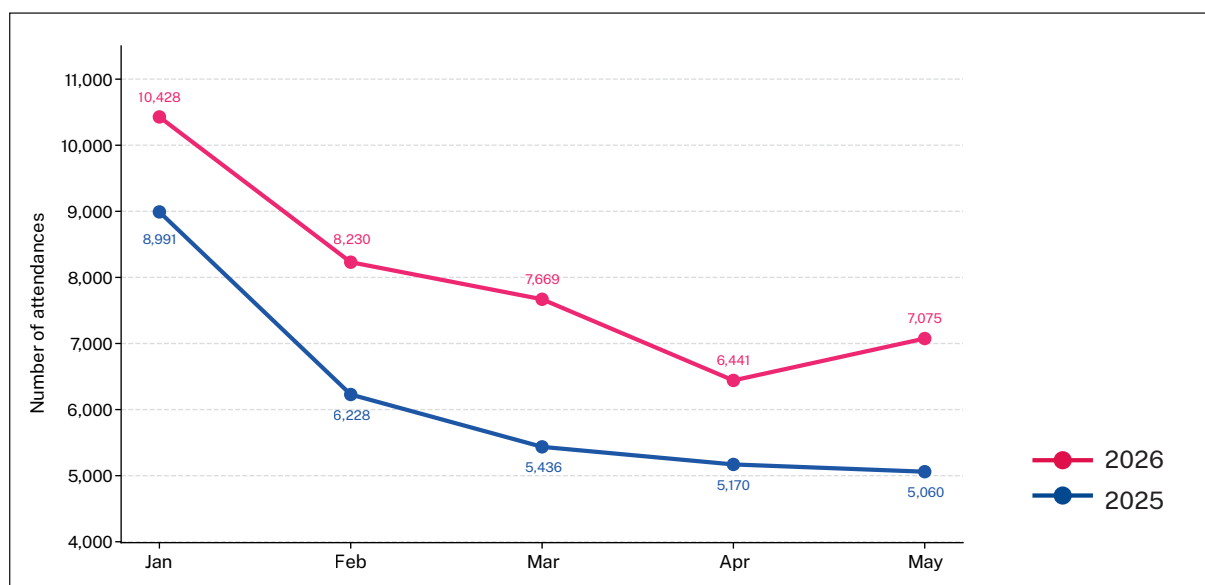
Source: NHS Scotland data, reported by Public Health Scotland ([2026b](#))

Figure 8: Number of unplanned A&E attendances of 8 hour+ waits, January to May 2025 compared to January to May 2026



Source: Public Health Scotland ([2026b](#))

Figure 9: Number of unplanned A&E attendances of 12 hour+ waits, January to May 2025 compared to January to May 2026



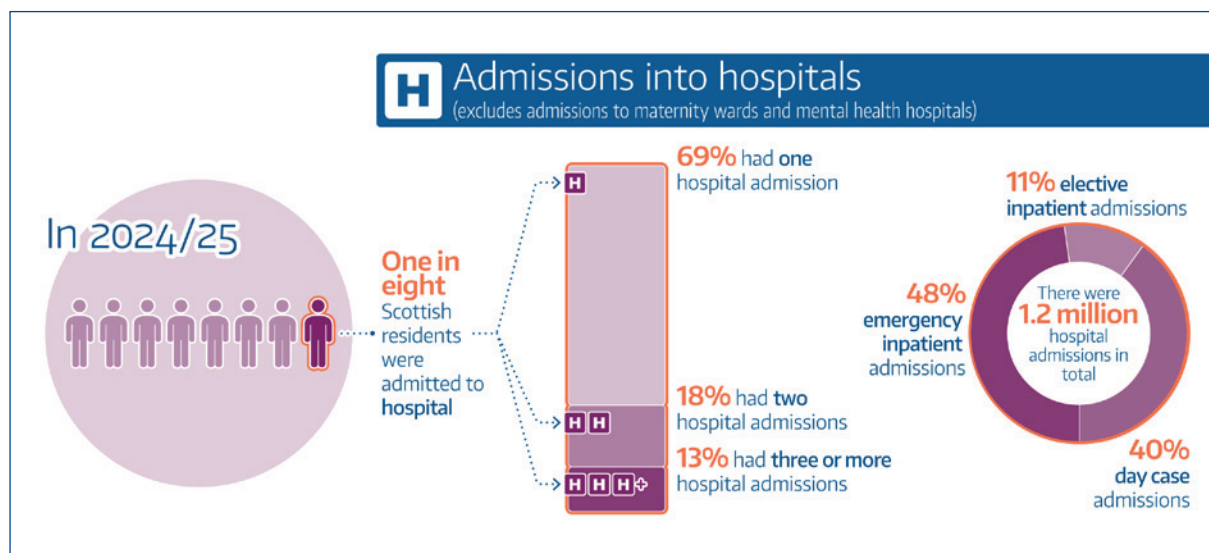
Source: NHS Scotland data, reported by Public Health Scotland ([2026b](#))

These unplanned attendances place increasing pressure on the limited capacity and resources of A&E departments, creating conditions where care is consequently much more likely to be delivered in corridors and other inappropriate places. The use of continuous flow models, designed to get patients out of A&E and into other areas of a hospital as quickly as possible, are contributing to this trend. In the models wards are forced to find spaces to locate increasing numbers of patients, inevitably resulting in increased likelihood and incidences of corridor care.

Following this, it is therefore logical to expect that the pattern of unplanned attendances seen at A&E departments will be replicated in patterns of unplanned (emergency) inpatient admissions to hospitals.

In 2024-25, there were 1.2 million hospital admissions in Scotland, with one in eight Scottish residents admitted to hospital on one or more occasion (Fig. 10).

Figure 10: Number of people admitted to Scottish hospitals, 2024-25



Source: Graphic from Public Health Scotland ([2025c](#))

Of these, almost half (48%) were emergency inpatient admissions, compared to only 11% of admissions being elective. This is equivalent to 390,860 patients, which is a slight drop from 2023-24. The emergency hospital admission data for recent years is shown in Table 4.

Table 4: Emergency hospital admissions – number of patients, by financial year

Reporting year	Number of patients	Percentage of total admissions
2024-2025	390,860	48%
2023-2024	407,323	51%
2022-2023	393,515	51%
2021-2022	396,265	54%
2020-2021	352,886	59%

Source: NHS Scotland data, published by Public Health Scotland ([2025c](#))

Whilst the figure for 2024-25 represents a small decrease on the previous year and a continuation of a downward trend seen in recent years, it is nevertheless a significant proportion of total admissions. Unplanned or emergency inpatient admissions usually result in a longer average length of stay compared to elective admissions. In 2024-25, the average length of stay for emergency inpatients was 7.4 days, more than double the average of 3.1 days for elective inpatients ([PHS, 2025c](#)). This places significant demand on hospital beds, particularly in the context of reduced NHS bed availability and capacity.

Average length of stay for an emergency admission is also higher among older age groups. For those aged 75 and older, average length of stay was 13 days compared to around five days for those aged 45-49. Given Scotland's ageing population, it is projected that by 2034, there will be a 12% increase in annual unplanned acute inpatient hospital admissions, further increasing demand on the health service and its agility to respond. Such a pattern is also replicated for all inpatient hospital admissions (not just emergency admissions). Those aged 75 and older had an average stay length of 12.1 days compared to 4.4 days for those aged 45-49. This clearly illustrates a changing profile of acute hospital treatment, with much more treatment being delivered as emergency/unplanned care with lengthier stays in hospital ([PHS, 2025c](#)), creating challenges for hospitals and the health service more broadly, to ensure care can continue to be delivered safely and effectively.

More emergency, unplanned care and admissions mean hospitals are less able to plan and schedule care, having instead to respond to situations and care needs as they arise. Without the appropriate agility and resources in the system to facilitate this, hospitals can become overwhelmed, and care is more likely to be delivered in corridors and inappropriate places as a result.

The contribution of nursing

Across each of the three indicators outlined, there is a common theme of increased demand and a health care system unable to cope. Having the correct number of nursing staff in the correct place at the correct time is critical for dealing with such increases in demand. As the single largest workforce in the NHS, nursing has a critical role to play in driving the adaptation towards more emergency, unplanned care. This must be supported to do so through increased investment. The nursing workforce plays a vital role in reducing waiting times by improving and streamlining patient flow through hospitals, enabling more patients to be seen in a safe and timely manner, reducing both the need for and likelihood of patients being forced to wait and be treated in corridors and other inappropriate places. Nursing staff are also critical for monitoring, assessing and treating patients, anticipating and preventing deterioration, and are essential to proactive, effective, and safe early discharge planning, helping to free up beds, and reducing the need for patients to wait in the first place. All these activities are essential for eradicating corridor care.

5. Key driver 3: NHS hospital capacity – availability and occupancy of beds

Availability and capacity of beds in the NHS is another key driver of corridor care. Having a constant high availability of staffed beds is critical to facilitate an effective response to growing demand on acute services, particularly for unplanned or unscheduled care. Sufficient bed capacity and availability of beds is essential for both responding to immediate shocks and fluctuations in demand, and also for longer term planning. Ensuring good bed capacity is one way in which the impact of the previously discussed key drivers can be mitigated, whilst declining bed capacity and availability will in turn increase the likelihood of adverse outcomes, like corridor care, occurring.

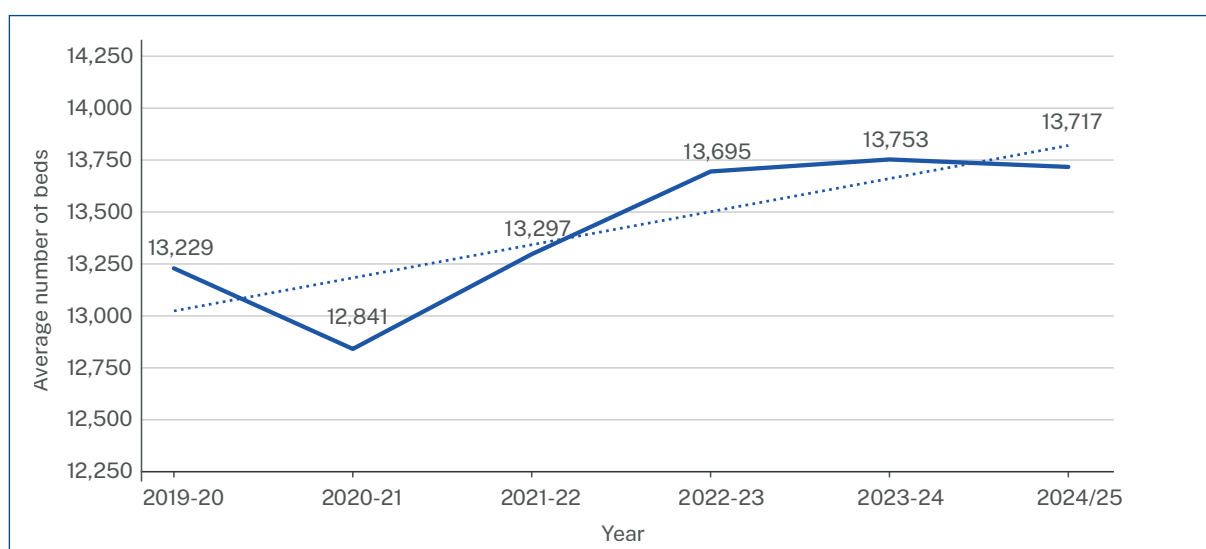
To demonstrate the impact of the availability and occupancy rates of beds in the NHS on corridor care outcomes, the following indicators have been chosen. They illustrate the growing pressure on NHS bed capacity and highlight the need for investment to ensure bed capacity, availability and ease of access can be maintained at all times. The indicators are:

- Bed availability – number of available staffed NHS acute beds
- Bed occupancy rates.

5.1 Bed availability – number of available staffed NHS acute beds

Bed availability in Scotland's NHS has fluctuated, with more stability in recent years (Fig. 11). Data is reported as average available staffed beds². In 2024-25, there was an average of 13,717 staffed beds available, a slight decrease of 0.26% from the previous year. The staff associated with these beds are predominantly likely to be registered nurses and nursing support workers.

Figure 11: Average available staffed beds in the NHS in Scotland, 2019-20 to 2024-25



Source: Public Health Scotland ([2025c](#)) The dotted line in the graph indicates the overall trend in the data.

² An available staffed bed is a bed which is resourced for inpatient or day case care. It is a daily average number of beds that are staffed and are available. The data source defines 'All available staff beds' as the sum of allocated beds + borrowed beds – lent beds + temporary beds.

Despite significant rising pressures on the NHS, availability of beds in the NHS in Scotland has remained largely static in recent years, excluding of course the significant dip resulting from the Covid-19 pandemic, with Public Health Scotland and Audit Scotland observing that this reduction in availability arose due to cancelled elective procedures and staffing shortages ([Audit Scotland, 2023](#)). Average available staffed bed capacity has increased by less than 4% (3.68%) since 2019-20 ([PHS, 2025c](#)). Following years of increasing bed capacity, 2024-25 represented the first year of decline (since 2020-21). This shift towards a decline in bed availability is concerning but it is too early to tell if the decline seen in 2024-25 is a temporary fluctuation. It is imperative action is taken to ensure this decline does not represent the start of a downward trend in bed availability which would have a significant impact on the prevalence and incidence of corridor care if allowed to persist.

Significantly, it should be noted that the data includes what it calls ‘temporary beds’ as part of the measurement of available staffed beds ([PHS, 2025c](#)). In hospitals, some temporary beds are planned to cover periods of higher demand or ‘surges’ and are funded and staffed. These are distinct from unplanned temporary beds placed in inappropriate non-clinical areas. Based on the definition provided by Public Health Scotland (as detailed in footnote 2 on the previous page), we have been unable to determine whether ‘temporary beds’ here is simply referring to planned funded and staffed temporary surge beds or unplanned temporary beds in inappropriate and non-standard clinical areas. Upon seeking clarification, Public Health Scotland confirmed³ that their definition of temporary beds applies to any temporary bed (i.e., a bed that is additional to the bed complement on the ward and includes both planned and unplanned temporary beds).

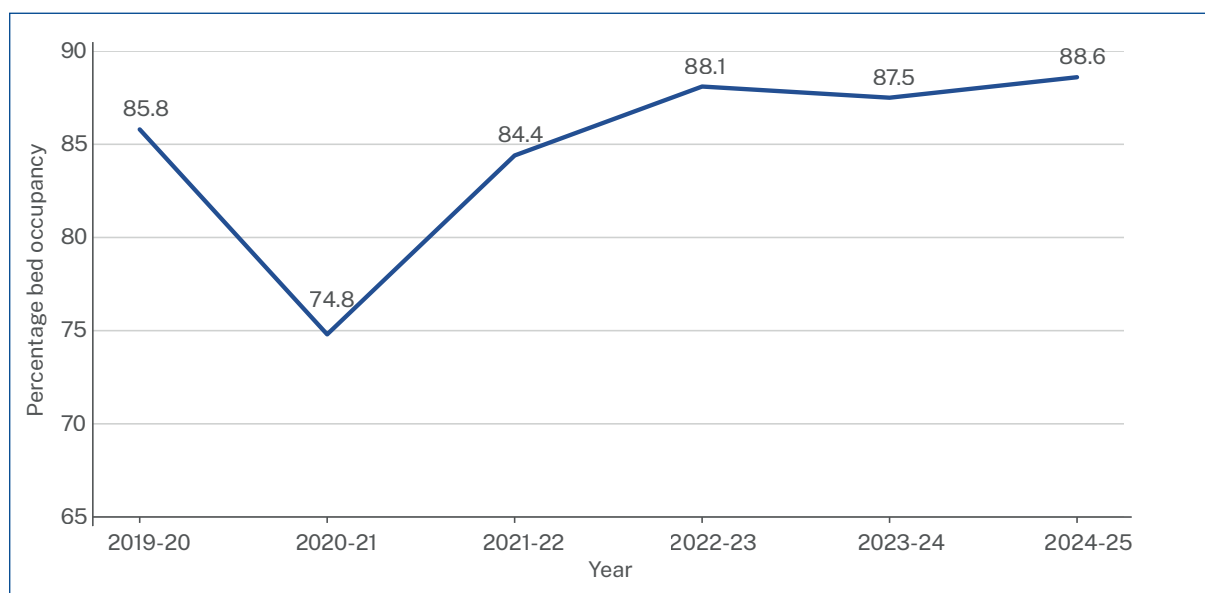
Unplanned temporary bed spaces in inappropriate and non-standard clinical areas should not be considered as available bed space and must be reported separately, as they are not intended or indeed designed for clinical care, and therefore risk patient safety. Increased use of unplanned temporary beds suggests that planned and funded bed capacity is not keeping pace with demand and there continues to be a reliance on temporary, inappropriate beds and spaces to meet current demand, which is only likely to increase further as demand continues to rise.

5.2 Bed occupancy

Alongside bed availability, levels of bed occupancy provide a strong indication of demand on hospitals and their ability or otherwise to respond to this demand.

Acute bed occupancy levels are high in Scotland. In 2024-25 (the latest data available at the time of writing), NHS bed occupancy was 88.6%, the highest level recorded in a decade (87% in 2015-16). This is an increase from the previous 12 months (2023-24) which saw occupancy levels of 87.5%, which in turn was a slight reduction from the 12 months before that (2022-23) (Fig. 12).

³ Clarification sought from the Data Management Team in Public Health Scotland on 16th July 2026, who confirmed the parameters of ‘temporary beds’ in [their definition](#)

Figure 12: Bed Occupancy NHS Scotland 2019-20 – 2024-25

Source: Graph created using data from Public Health Scotland ([2025b](#))

It is widely recognised that bed occupancy rates higher than 85% are considered to be dangerous, as this is when risks to patient safety and patient flow are likely to occur ([RCEM, 2025b](#)). Maintaining an occupancy rate below 85%, and not reaching full occupancy, is essential to ensure hospitals have capacity to be able to respond and accommodate patients arising from unexpected emergencies and other unprecedented situations. Without this, hospitals risk becoming overwhelmed and being unable to effectively and safely treat patients.

Not including the impact of the pandemic (years 2020-21 and 2021-22), hospital bed occupancy rates have exceeded the 85% threshold every year since 2019-20, posing significant risks to patients and nursing staff, and significantly increasing the likelihood of care being delivered in corridors. High bed occupancy rates reduce flow through the system and leave little room for flexibility to respond to emergencies or unexpected surges in demand.

Other countries' experiences demonstrate that the bed availability challenges and high occupancy rates experienced in Scotland, whilst not unique, are certainly worse by comparison, highlighting the particular challenges faced in Scotland. Acute hospital bed occupancy across the UK is higher than in the majority of other countries. In the international data examined from the Organisation for Economic Co-operation and Development (OECD), the data is only reported for the UK as a whole and cannot be disaggregated to Scotland-only data, so UK data is used here. Figures from the OECD highlight that the average occupancy rate for acute care (curative) beds in the OECD30 countries was 71% compared to 81% in the UK (based on 2023 data, which is the latest available from the OECD). The individually reported figures for Scotland outlined previously are indeed higher than this UK average. The OECD figures presented offer a useful comparison to highlight the position of the UK (and Scotland) relative to others internationally. This pattern is also replicated when looking at bed availability figures, with the UK experiencing much lower bed availability. In the UK, hospital bed availability is 2.4 beds per 1,000 population, compared to an OECD average of 4.2 beds per 1,000 population (based on 2023 data) ([OECD, 2025](#)).

The contribution of nursing

To overcome this challenge and limit the likelihood of corridor care arising, the Scottish government must commit to sustained long-term funding of hospital bed places to ensure there is sufficient capacity to meet population needs both now and in future. This must be based on a comprehensive assessment of likely future challenges, considering changing population demographics, namely our ageing population, and associated demands for health care. More beds and increased bed capacity also induces a requirement for more registered nurses and nursing staff. Provision of more bed availability is critical, but on its own will not deliver improvements and reduce the impact of corridor care unless supported by a corresponding increase in the nursing workforce. Under current circumstances, there will simply not be enough registered nurses and nursing staff to safely accommodate and treat additional patients arising from increased bed availability and capacity, without corresponding investment in growing the number of registered nurses and other nursing staff.

6. Key driver 4: the nursing workforce crisis

Safe and effective nurse staffing levels are critical for safe and effective patient care. The evidence is clear that registered nurse staffing levels have a significant impact on both patient and staff outcomes. Inadequate staffing increases risks of patient harm, including preventable complications and in-hospital mortality, as well as an increased risk of care being delivered in inappropriate places ([Ball and Griffiths, 2022](#); [RCN, 2025c](#)). A combination of registered nurse shortages and higher numbers of patients per registered nurse are associated with an increased risk of death during a hospital admission. In hospital settings, when fewer nurses are on shift, patients have an increased chance of missed care, longer stays, and in-hospital deaths ([Zaranko et al, 2022](#)), with staff more likely to report poor quality care and vital care not being given. There are also significant harms to nursing staff, including burnout, occupational injury and lower job satisfaction. Put simply, lower nurse staffing levels are associated with worse outcomes. Evidence shows that for every 10% increase in the number of degree-educated registered nurses, there is a 7% decrease in risk of death ([Aitken et al, 2014](#)). It is therefore vital to ensure safe and effective levels of nurse staffing in all hospital settings.

In 2019, the Scottish Parliament passed the Health and Care (Staffing) (Scotland) Act, which was implemented in 2024. The purpose of the Act is to provide a statutory basis for the provision of appropriate staffing levels in health and care services, ensuring safe and high-quality care and improved outcomes for patients and other service users ([Scottish government, 2024](#)). Under the provisions of the Act, NHS health boards are statutorily obligated to ensure they always have appropriate levels of health care staff to ensure safe and effective care can be delivered. Evidence from the evaluation of the first year of operation of the Act, however, indicates this is not happening in practice, with many health boards reporting that they have not been able to comply with all the duties set out in the Act ([Scottish government, 2025f](#)). These findings are supported by testimony from RCN members, who speak of ongoing and worsening challenges with staffing and the impact this has both on them, as essential providers of care, and on patients, including increased safety risks and care increasingly being delivered in inappropriate places like corridors.

Despite legislation, it is clear that safe staffing levels are not being delivered in Scotland, and therefore further action is required to deliver safe staffing and to ensure there is the right number of nursing staff, in the right places, at the right times, with the right skills and knowledge to keep people safe. To achieve this, mandatory nurse-to-patient ratios are required to protect both patients and nursing staff, and to ensure consistent delivery of safe, effective care in all health and care settings. The RCN has been campaigning for the introduction of safety-critical nurse-to-patient ratios across the UK ([RCN, 2024](#)). We outlined this as a core ask in our manifesto for the 2026 Scottish Parliament election ([RCN, 2026b](#)).

In this section, the following indicators have been chosen as they effectively illustrate Scotland's growing nursing workforce crisis and critically highlight the need for investment in the nursing workforce to ensure safe staffing levels can be maintained at all times. The indicators are:

- Nursing supply – joiners and leavers
- NHS nursing vacancies.

We have chosen to focus on registered nurses and nursing support workers working in the NHS in Scotland, reflecting that corridor care is most readily experienced in acute hospital settings. We fully acknowledge, however, that the nursing workforce crisis in Scotland is experienced across health and social care and not just in the NHS.

Before exploring the indicators further, it is important to first understand the context of the nursing workforce in Scotland. Sections 6.1 and 6.2 provide information on the current NHS nursing workforce in Scotland both overall and specifically spotlighting district nursing, recognising the contribution of community nursing care in reducing pressure and demand on acute hospital services and systems.

6.1 NHS nursing workforce in Scotland

Recent data shows that there has been slight growth in the NHS nursing workforce in Scotland (Tab. 5).

Table 5: Whole Time Equivalent (WTE) Registered nurses and Nursing Support Workers in post in the NHS in Scotland, 2019-2026

	2019	2024	2025	2026*	% Change 2019-2026	WTE change 2019-2026	WTE change 2025-2026
Registered nurses – all	41,626.2	45,253.8	46,620.9	47,580.9	+14.3%	+5,954.7	+960.0
Nursing Support Workers – all	15,473.0	18,573.1	17,794.3	17,835.4	+15.3%	+2,361.6	+41.1

Source: NHS Education for Scotland (NES) [\(2026\)](#)

*At 31st March each year

Overall, there were over 960 more WTE registered nurses in post in March 2026 compared to March 2025, a 2.1% increase. However, this increase has slowed compared to previous years. By March 2026, the number of registered nurses had fallen slightly from the high in December 2025 (47,642.2 WTE), however, despite this, at no point has the planned establishment (i.e., full complement) been achieved. This continues to demonstrate an ongoing gap between planned and actual staffing levels.

Nursing support workers are another vital part of the nursing workforce. The number of nursing support workers has increased slightly between 2025 and 2026, increasing by just 41.1 WTE, although the overall number has increased by just over 15% since 2019 (see Tab. 7).

In April 2024, a reduction in the working week for nursing staff of 30 minutes to 37 hours was introduced in Scotland meaning more staff are needed to ensure the same level of care is maintained. A further one-hour reduction to the working week, taking it to 36 hours, was introduced in April 2026. It is currently too early to fully assess the impact of this change. RCN lobbied for this change on the basis of now unequivocal evidence that the health and wellbeing of staff has a direct effect on wellbeing of patients. Overworked and burnt-out staff pose a significant safety risk.

6.2 District nursing workforce

The contribution of nursing

It is important to look more broadly at the role of community nursing in eradicating corridor care. Community nursing spans a wide range of roles including district nursing, general practice nursing, and health visitors.

We have chosen to focus specifically on district nurses here. District nursing teams are fundamental to the Scottish government's plans to shift the balance of care from hospital to the community, caring for patients with complex health needs in their own home as well as delivering preventative care and supporting long-term conditions and palliative patients, reducing demand for hospital services, and positively contributing to reducing corridor care. We fully acknowledge that the community nursing workforce in Scotland is comprised of more than just district nursing and recognise the vital contribution that the whole of the community nursing workforce in Scotland makes to driving forward increased care in the community, supporting prevention and public health, and reducing pressures and demands on hospitals.

The data in Scotland shows a trend of increasing numbers of district nursing staff (Tab 6).

Table 6: Whole time equivalent (WTE) registered nurses and nursing support workers recorded as working in district nursing roles in Scotland, 2019-2026*

	2019	2024	2025	2026	% Change 2019-2026	WTE change 2019-2026	WTE change 2025-2026
Registered nurses	2,812.8	3,338.7	3,341.1	3,363.8	+19.6%	+551	+22.7
Nursing support workers (non-registered)	662.5	994.8	978.6	946.1	+42.8%	+283.6	-32.5

Source: NES [\(2026\)](#)

*Figures reported at 31st March each year

The data shows an increase in the WTE number of registered nurses working in district nursing roles of just under 20% since 2019, however, this increase has slowed in recent years. In contrast, the number of non-registered nursing support staff working in district nursing roles has increased at a much higher rate, increasing by 42.8% since 2019. There was a slight drop in the number of these roles between 2025 and 2026.

A closer look at the data highlights that this increase in the district nursing workforce has been achieved by introducing a significant number of band 5 registered nurses (community staff nurses) and nursing support workers at band 3. Since 2010, there has been a significant drop in the proportion of NHS district nursing teams who are registered nurses. In 2010, they accounted for 93.3% of the workforce, compared to only 77.8% in 2025, whilst at the same time, the number of nursing support workers has grown from 6.7% to over a fifth of the workforce (22.2%).

The NMC recognises that community nurses, including district nurses, require advanced knowledge and skills to manage increasingly complex care, high-risk situations, and independent caseloads in the community. While registered nurses possess foundational skills, the Specialist Practitioner Qualification (SPQ) District Nursing is essential for giving registered nurses the necessary knowledge and skills to support shifting care from hospitals to the home, ensuring safety, and leading interdisciplinary teams. Data obtained via Freedom of Information requests to health boards indicates that two-thirds (64.4%) of registered nurses recorded as working in district nursing roles are Agenda for Change band 5 with analysis of the data supplied by NHS boards indicating that only 24.4% of registered nurses within district nursing teams hold the SPQ qualification (spread across band 5 to band 8), designed to equip them with the additional knowledge and skills to manage complex caseloads ([RCN, 2026c](#)).

Having fewer registered nurses in the overall district nursing workforce, and less than a quarter holding the SPQ qualification, reduces the number of registered nurses available with the enhanced skills which make a critical contribution to relieving pressures on hospitals by reducing demand, reducing hospital overcrowding and incidences of corridor care as a result. As clinical needs rise, as has been indicated by increased demand on the health care system and Scotland's ageing population, so too does the need for the vital role of the registered nurse in district nursing teams.

6.3 Nursing supply – NHS joiners and leavers

A strong indicator of the strength or weakness of the overall nursing workforce in the NHS in Scotland is an assessment of the numbers joining and leaving. Recruitment of new nurses and retention of the current workforce is vital to establish safe nurse staffing levels and for delivery of safe and effective care to patients, including avoidance of unsafe practices like corridor care.

Recent data shows that there have been fluctuations in the numbers of registered nurses joining and leaving the profession (Tab. 7).

Table 7: NHS Scotland registered nurse joiners and leavers 2019-2026 (headcount)*

	2019	2024	2025	2026	Change 2019-2026	Change 2025-2026
Joiners	3,355	5,215	4,972	4,085	+730	-887
Leavers	3,133	3,199	3,054	2,923	-210	-131
Turnover rate	6.7%	6.5%	5.9%	5.5%	-1.2%	-0.4%

Source: NES ([2026](#))

*Figures reported at 31st March each year

In recent years, there have been some positive trends with more nurses joining the NHS, although this has dropped off in 2026. After March 2023 which saw the highest annual number of nursing leavers in a decade (over 4,800) the number of registered nurses leaving NHS Scotland remained at similar levels, with a positive reduction in the number of leavers seen in 2026.

A more detailed look at the data indicates that the vast majority of nurses who left their job role left NHS Scotland altogether – in 2026, of the 2,923 registered nurses who left, 2,499 left NHS Scotland. It is not clear from the data if those who left the NHS remain working as registered nurses in another non-NHS capacity. This represents a significant loss to NHS Scotland’s registered nurse workforce, putting further pressure on the remaining workforce.

The data also shows a clear trend towards registered nurses leaving the profession at a younger age. In 2025, there were more registered nurse leavers in their twenties, thirties and forties (1,589) than those aged 50-60+ (1,329). Leavers aged 20-49 made up more than half of total registered nurse leavers in 2025 (54.5%), with nearly one-fifth (16.9%) in their twenties ([RCN, 2026c](#)). Whilst the data does not provide a clear indication of what the main underlying reasons for those choosing to leave are, more people leaving at a younger age is indicative of significant underlying issues and challenges in the NHS.

Indeed, these figures do not tell the whole story. Evidence from RCN Scotland’s recent Employment Survey paints a worrying picture of a workforce in crisis. In our survey of nearly 1,900 members working in nursing roles across Scotland, more than a third (37%) stated that they are actively planning on leaving or thinking about leaving their job, citing significant levels of workforce instability as a primary motivation. Of those, almost three-quarters (74%) stated they were considering or planning to leave due to feeling undervalued. Perhaps most concerning, just under half of respondents (48%) stated that if they were to leave their current job, they would prefer to transition into a completely different job away from nursing ([RCN, 2025d](#)). This represents a significant level of discontent among the current nursing workforce, and indicates possible future challenges of nursing workforce supply, at a time when demand for services is increasing, further compounding already significant challenges.

6.4 NHS registered nurse vacancies – gaps in workforce capacity

Nursing vacancy levels are another strong indicator of pressures in the health care system. High levels of nursing vacancies reduce available capacity, profoundly impacting on the care that can be delivered.

There has been some variance in registered nurse vacancies over the period examined (Tab. 8), but nevertheless vacancy levels have remained high.

Table 8: NHS Scotland registered nurse vacancies, by WTE and rate, 2019-2026*

	2019	2024	2025	2026
Registered nurse vacancies – WTE	2,398.1	2,403.5	1,696.4	1,567.2
Registered nurse vacancy rate	5.4%	5.0%	3.5%	3.2%

Source: NES ([2026](#))

*Figures reported at 31st March each year,

Although there has been a downward trend in registered nurse vacancies in recent years, the level of vacancies remains unsustainable, and persistent vacancies indicate the nursing establishment has never been met.

A persistent level of registered nurse vacancies indicates that significant workforce pressures remain in NHS Scotland. This increases risks for both registered nurses and patients, with fewer nurses to care for more patients, and increases the likelihood of adverse outcomes occurring.

Where there are consistent vacancies in the nursing workforce, health boards will often resort to using bank and agency staff to plug staffing gaps in the short term. The latest data shows consistently high use of bank and agency nursing and midwifery staff⁴ in recent years peaking in 2023-24. Compared to 2019, there has been a 46.0% increase in the number of WTE bank nursing and midwifery staff used in the NHS in Scotland, rising from 4,697 WTE in 2019 to 6,856 in 2026, and a 58.9% increase in agency staff – 292 WTE in 2019 rising to 464 WTE in 2026.

High reliance on bank and agency nursing staff matters not only in terms of cost. Indeed, total nursing and midwifery bank staff usage in 2025-26 in NHS Scotland cost £391 million, and agency staff cost £34.5 million ([NES, 2026](#)). But aside from the cost, it also increases potential risks to patients through a lack of continuity of care and increased likelihood of adverse outcomes occurring, and also to nursing staff, who may be working in clinical areas they are unfamiliar with. High reliance on such staff is indicative of a health care system in crisis, utilising short-term, costly responses to a much wider systemic workforce crisis.

The contribution of nursing

To safeguard current and future nursing workforce supply, and to protect patients from adverse outcomes like care being delivered in corridors and other inappropriate places, investment in long-term workforce planning and action to attract more people into the profession are vital and need to be prioritised. Workforce planning must also be focused on retention of the current workforce as well as recruitment of new nursing staff. Safeguarding the nursing workforce protects both patients and nursing staff from adverse outcomes associated with unsafe staffing. Implementing the recommendations from the Nursing and Midwifery Taskforce will help to deliver this workforce planning and ensure safe staffing levels.

Having an appropriately staffed nursing workforce in Scotland's NHS, with the right numbers of staff, in the right places at the right times, is essential for eradicating corridor care.

⁴ Data reported as nursing and midwifery staff collectively, so not able to separate out figures for only nursing. All figures reported at 31st March each year.

7. Key driver 5: availability and supply of social care services

Corridor care is influenced not only by what happens in emergency departments and hospital wards but also by what goes on in the wider health and social care system. Well-resourced social care and care home services, with a strong, well-staffed nursing workforce, play a critical role in ensuring people are able to receive care in the most appropriate place for them. This helps reduce demands on hospitals, both by easing pressure on A&E departments, as fewer people will require to use them, and by freeing-up hospital beds, as those who have to be admitted to hospital can be discharged back into the community quickly and safely.

However, social care is continually overlooked compared to the NHS in Scotland – around seven to eight times more is spent on the NHS in Scotland than social care ([Scottish Care, 2026](#)), despite the close links between the two and the crucial role of social care in alleviating pressures faced by the NHS. This is problematic because, as the population continues to age, demands placed on social care and care home services will continue to increase. Research suggests that demand for social care services among those aged 65 and over in Scotland will increase by 70% by 2045 (from 2019 levels), and within this age group, the number of older adults aged 85 and over who are supported by social care services is expected to more than double ([Fraser of Allander Institute, 2022](#)). These figures suggest even greater challenges for social care moving forward with exponentially rising demand threatening to completely overwhelm the system.

To assess the impact of pressures in the social care sector on corridor care outcomes, the following indicators were chosen. They illustrate the need for sustained long-term investment in social care and its workforce, to reduce demands on hospital A&E departments and improve patient flow. The indicators are:

- Number of care homes
- Number of registered care home places
- Care home occupancy
- Care home nursing staff turnover
- Need for nursing care within care homes (acuity of need)
- Individuals waiting on a social care assessment.

7.1 Number of care homes

In recent years, there has been a steady decline in the number of care homes in Scotland (Tab. 9).

Table 9: Number of care homes in Scotland overall and by sector, 2019-2025

	2019	2024	2025	% change 2019-2025	Change in number 2019-2025
Number of care homes (Total)	1,102	1,019	1,003	- 8.98%	-99
Private sector	689	658	660	- 4.21%	-29
Local authority (public sector)	146	135	125	- 14.3%	-21
Voluntary/not for profit	267	226	218	- 18.35%	-49

Source: Public Health Scotland ([2025c](#))

An overall decline in the number of care homes indicates reduced capacity, which is problematic given Scotland's ageing population and projected increase in demand for social care services. Indeed, since 2019, there has been a 9% reduction in the number of care homes in Scotland ([PHS, 2025c](#)). Decreased supply of care home services will put pressure on acute hospital settings, in particular A&E departments, as more people turn to such services to address unmet care needs, further increasing demands on acute hospitals.

This decline has not been experienced equally across the different sectors, with the decrease much more pronounced in the public and voluntary/not for profit sectors. The private sector continues to be the largest provider of care homes in Scotland by a significant margin.

7.2 Number of registered care home places

As well as the number of care homes, another important metric is the number of registered care home places available.

Again, there has been a steady decrease in the number of registered care home places in Scotland (Tab. 10).

Table 10: Number of registered care home places in Scotland overall and by sector, 2019-2025

	2019	2024	2025	% change 2019-2025	Change in number 2019-2025
Number of registered care home places	41,032	40,055	39,919	- 0.3%	-113
Private sector	31,868	31,777	32,037	0.5%	+169
Local authority (public sector)	4,160	4,188	3,941	- 5.2%	-219
Voluntary/not for profit	5,004	4,090	3,941	- 21.2%	-1,063

Source: Public Health Scotland ([2025c](#))

The data shows a continuing decline in care home bed capacity. Whilst the proportionate decline in registered places is smaller than the decline in the number of care homes, it still nevertheless points to ongoing reductions in capacity.

The most marked decline in registered places has been in the voluntary/not for profit sector, followed by the local authority sector, with the private sector actually experiencing a small increase in registered places between 2024 and 2025. The private sector has by far the largest share of market provision.

7.3 Care home occupancy

The occupancy rate of care homes is another important indicator. As with bed occupancy in the NHS, a high rate of occupancy indicates a system under strain, with less flexibility to adapt to changing conditions and reduced ability to support acute hospital settings to alleviate some of the pressures driving corridor care outcomes. A high occupancy rate can also put significant strain on staff, resources, and resident wellbeing.

The data shows there has been slight variance in recent years in levels of care home occupancy, but that occupancy nevertheless remains high (Tab. 11).

Table 11: Care home occupancy rate Scotland overall and by sector, 2019-2025

	2019	2024	2025	Percentage point change 2019-2025
Care home occupancy rate	87%	85%	86%	-1%
Private sector	87%	86%	86%	-1%
Local authority (public sector)	83%	80%	80%	-3%
Voluntary/not for profit	92%	87%	89%	-3%

Source: Public Health Scotland ([2025d](#))

Taken in the context of falling numbers of care homes, occupancy rates remaining fairly steady over the period examined, suggests an overall reduction in care home service availability and that the system continues to be under strain.

Continued high capacity reduces the ability of the care home sector to accommodate patients who are clinically ready to leave hospital, when a care home or social care support service may often be best placed to accommodate their care needs. This results in an individual's discharge from hospital being delayed and creates backlogs within acute hospital settings which increases the likelihood of patients being subjected to corridor care. Sustained, long-term investment in increasing capacity in social care is required to overcome this. Investing in social care capacity would ensure that patients are able to receive care in the most appropriate place for them and leave hospital when they are ready to do so. This would free up hospital beds and ease pressure on A&E departments.

Care homes are a significant discharge route for patients in hospitals. Therefore, if there are fewer care home places available to discharge to, this will result in more patients being

stuck in hospital for longer, increasing the likelihood of incoming patients being treated in corridors and other inappropriate locations as there is simply nowhere else for them to go.

7.4 Social care and care home nursing staff

As well as good care home availability, an appropriately staffed nursing workforce is essential to ensure care can be delivered safely and effectively in social care services and care homes.

The contribution of nursing

Registered nurses and nursing staff play a critical role in the health and wellbeing of care home residents. They are central to the workforce, ensuring care home residents are cared for with dignity and compassion, and provide highly skilled care, promoting independence, detecting deterioration, and reducing the need for individuals to receive hospital care.

As the majority of care homes are operated by non-NHS providers, nursing staff working in these environments are not covered by the same terms and conditions as their counterparts working in the NHS, and this can lead to significant variance in levels of pay, terms and conditions both across the social care/care home sector and also between the social care/care home sector and the NHS. This can impact on the attractiveness of the sector for nursing staff.

Unlike with NHS Scotland nursing workforce data, access to robust nursing workforce data for the social care/care home sector is limited. The Scottish Social Services Council (SSSC) uses a job function classification to identify registered nurses working in the sector, then estimates the annual workforce due to incomplete responses or missing data. On this basis, the SSSC continues to state that these figures and trends should be viewed with some caution. Mandatory data reporting requirements would alleviate this issue ([SSSC, 2025](#)).

A snapshot of workforce data is collected in December each year by the SSSC. However, there continues to be a time lag between the collection and publication of data, therefore, the most recently available data (at the time of writing) is for 2024 (Tab. 12).

Table 12: Estimated total social care, care home, and nurse agency workforce, 2019-2024

	2019	2023	2024	% change 2019-2024	% change 2023-2024	Change in number 2019-2024
Total social care sector registered nurses	7,390	8,930	8,250	+11.6%	-7.6%	+860
Adult care home registered nurses	4,550	3,660	3,960	-13.0%	+8.2%	-590
Nurse agency	2,490	5,000	4,010	+61%	-19.8%	+1,520

Source: SSSC ([2020](#), [2024](#), [2025](#))

Of the estimated 8,250 registered nurses working in the social care sector in 2024, nearly half (48.0%) were directly employed in care homes for adults. Nearly all the remaining half (48.6%) were employed by nursing agencies. Nursing agencies supply significant numbers of nursing staff to NHS, independent and social care settings.

Of the approximately 3,960 registered nurses understood to be working in care homes for adults in 2024, the majority were employed by the private sector⁵ (92.2%). There was an 8.2% increase between 2023 and 2024, with an additional 300 registered nurses employed in care homes for adults, which SSSC report as the first notable increase in a number of years ([SSSC, 2025](#)). It is too early to tell if the increased number of registered nurses working in care homes in 2024 represents a trend towards increased nurse staffing in the sector overall and will need to be monitored to assess if a trend develops, specifically on the impact this may have in terms of supporting care delivery in the sector and for alleviating pressures on hospitals and A&E departments.

Nevertheless, overall, there has been a declining trend with 590 fewer registered nurses working in care homes for adults since 2019, which represents a 13.0% decrease. This only serves to exacerbate the prevalence and problem of corridor care in Scottish hospitals. Evidence shows that insufficient nurse staffing levels can negatively impact all residents in care homes. Conversely, higher nurse staffing levels, have resulted in reductions in A&E use and reduced re-hospitalisation rates from care homes ([Harrington et al, 2020](#)). Therefore, as clinical needs rise, as has been indicated by increased demand on the system and Scotland's ageing population, so too does the need for the vital role of the registered nurse in care homes and social care, as a critical driver for eradicating corridor care.

5 The Scottish Social Services Council (SSSC) state that private sector care home operators are those operated by private companies on a for-profit basis. This does not include voluntary/third sector providers. The report referenced differentiates between private, public and voluntary.

7.5 Need for nursing care within care homes (acuity of need)

The contribution of nursing

Not all stays within care homes require nursing care. Therefore, a good indicator of pressures within the system with regards to nursing and subsequent impacts on the system, is to better understand what proportion of individuals in care homes require nursing care (Tab. 13).

Table 13: Percentage and number of adults supported in Care Homes in Scotland who need nursing care, 2019-20 – 2023-24

	% of adult care home residents requiring nursing care	Number of care home residents requiring nursing care
2019-20	64.4%	28,355
2022-23	66.8%	28,875
2023-24	67.0%	30,170
2024-25	67.7%	29,655

Source: Public Health Scotland ([2026e](#))

The data clearly shows a trend of increased need for nursing care among care home residents and indicates that care home residents now increasingly have more complex and challenging health care needs. Taken in the context of a declining nursing workforce in care homes, and an overall reduction in the number of care homes and registered places, this indicates a care home system under increasing stress, with additional demands increasingly placed upon it, at the same time as resources, investment, and capacity are declining.

Without more investment in the nursing workforce within care homes, such services will simply no longer be able to cope with the growing demands placed upon them, further compounding the pressures being experienced in acute hospital settings. Investment in social care, and the nursing workforce to deliver such care, is vital if patients are to receive the right care in the right place at the right time, and support government ambitions of shifting the balance of care. A strong sustainable nursing workforce is essential to meet the needs of the population receiving social care and to ensure social care services are able to alleviate pressures on hospitals and contribute to eradicating corridor care.

7.6 Individuals waiting on a social care assessment

The figures presented to date have focused on those who already access and utilise care home and social care services, and they already show growing demand on services. Another important measure is to also look at those waiting to access services, as they are the pipeline of future service users, providing a strong indication of likely future demand on services, and of current levels of unmet need.

When looking at the data on individuals waiting on a social care assessment, there is a clear upward trajectory over the last three years (Tab. 14).

Table 14: Number of individuals waiting on a social care assessment, 2024-2026

	Number
May 2026*	6,825
May 2025	6,439
May 2024	6,342

Source: Public Health Scotland [\(2026f\)](#)

*Data is reported monthly. May 2026 is the latest month available (at the time of writing). Data for the same month in each year shown for comparison. Data only available from November 2022 onwards.

The figure for May 2026 is an increase of just under 6% from the number of people waiting in May 2025 and just under 8% from May 2024 indicating increasing growth in current unmet need for social care services. This increasing level of unmet need will place further demand on acute hospital services, as individuals who are not currently getting the social care services/support they need are more likely to turn up at A&E departments, requiring urgent medical care, due to their unmet social care needs.

8. Key driver 6: delayed discharge

The rate at which patients flow through hospital from arrival, admission and to discharge is a key driver of corridor care. Too often, patients who are medically fit to be discharged are stuck in beds in hospitals as there is nowhere safe for them to be discharged to. This is often driven by the crisis in social care and community nursing provision, as well as system inefficiencies, the system struggling to manage complex needs, and staffing issues.

This matters for a number of reasons. Firstly, for patients, staying in hospital longer than is required significantly impacts their health. A prolonged hospital stay can lead to deconditioning, increased risk of infection, and reduced mobility, particularly for older and more frail patients. We know from evidence that for every 24-hour period a person spends in bed and not walking, muscle mass declines between 2 and 5% ([Brennan, 2024](#)), and by as much as 10% after a week for older adults. The decline is accelerated in more frail, older adults, and in those who are acutely unwell.

Secondly, such delays also put significant strain on health care systems. As has been explored already, there is currently a lack of beds in the NHS in Scotland and delayed discharges place additional pressures on already limited supplies of beds for incoming patients, both planned and emergency. This adds to existing pressures, makes admitting patients more challenging, contributes to overcrowding, and increases waiting times for treatment. This ultimately leads to more patients being treated in corridors and other inappropriate places within hospitals as there is simply nowhere else for them to go. It also exacerbates pressure on other services, including the ambulance service, and has a significantly negative impact on nursing staff, causing stress and burnout.

All of this comes at a financial cost to the NHS. A recent Audit Scotland report highlighted that there has been no published information on the cost of delayed discharge in Scotland since 2019-20 due to the challenges experienced by Public Health Scotland in getting health boards to report patient level costs since the pandemic. Nevertheless, despite the absence of such data, Audit Scotland, using NHS information on the approximate cost of providing the type of hospital care a person experiencing delayed discharge is likely to receive, calculate the cost of hospital days in Scotland to be over £440 million, equivalent to an average cost of £618 per day per hospital bed. This is much higher than the cost per day in both a publicly funded care home with nursing and publicly funded residential care home – £144.72 and £126 respectively ([Audit Scotland, 2026](#)).

To understand the true extent of the impact of delayed discharge in driving corridor care in Scotland, the following indicators were chosen, as they are currently the best available measures of delayed discharge in Scotland. The indicators are:

- Number and daily average of delayed bed days occupied
- Number of hospital discharges following a period of delay.

8.1 Number and average of delayed bed days occupied

The number of bed days occupied because of delayed discharges in 2025-26 is almost a third more than in 2019-20 (Tab. 15).

Table 15: Number and daily average delayed bed days occupied, NHS Scotland, 2019-20 – 2025-26*

	2019-20	2023-24	2024-25	2025-26
Number of delayed bed days occupied**	542,204	666,190	720,119	705,952
Average daily number of delayed bed days occupied***	17,782	21,841	23,672	23,211

Source: Public Health Scotland ([2026g](#))

*Reporting period is 1st April to 31st March each year

** Figures calculated by totalling reported monthly figures

*** Figures calculated by totalling reported monthly average figures

The latest data shows that year 2025-26 saw a slight improvement in delayed discharge figures. Nevertheless, there has still been a pronounced increase in both the number of beds occupied as a result of a delayed discharge and the average number of daily beds occupied since 2019-20. Actions taken to deliver the recent improvements must be continued to ensure the improvement can be maintained over the longer term. However, these improvements are minimal compared to the longer-term deterioration in performance and it is not yet clear what is causing such improvements and if they can be maintained.

For example, examining the monthly delayed discharge figures shows that for the early months of 2026, the number of delayed beds occupied increased in March compared to February – rising to 59,618 from 55,547. February 2026 had seen an improvement from January, but this now appears to have not been sustained in the March 2026 figures. Looking at the latest figures for April and May 2026, which are the first months of data available for reporting year 2026-27, April saw a slight improvement from March 2026 with the number of delayed beds occupied falling to 57,067 but concerningly, the figures for May 2026 show the number of delayed beds has again risen to 59,429, which is 4% (over 2,000) more than the number of delayed beds occupied in May 2025 (57,399) ([PHS, 2026h](#)).

Such figures paint a picture of a hospital system under significant strain, with reduced capacity to admit patients at a time when demands are rising, significantly increasing risks for both patients and staff.

Indeed, looking at the primary causes for delayed discharges in 2025-26 across Scotland paints a picture of growing demands for limited resources. The latest data from Public Health Scotland identifies awaiting completion of care arrangements as the joint-leading cause of delayed discharges in Scotland, alongside complex delays, applicable in 28% of cases. This is closely followed by 24% of delays due to awaiting place availability, and 15% awaiting a community care assessment ([PHS, 2026g](#)). This indicates availability of beds and social care services, as discussed earlier, are critical to significantly reducing delayed discharges, and thus significantly reducing the likelihood of corridor care occurring.

Taking a closer look at the figures, they show that older people aged 75 and over are much more likely to experience a delayed discharge than younger people (Tab 16).

Table 16: Number of delayed bed days occupied by age group, NHS Scotland, 2019-20 – 2025-26*

	2019-20	2023-24	2024-25	2025-26
Age 18-74	181,471	234,743	245,966	245,483
Age 75+	360,733	431,447	474,153	460,469

Source: Public Health Scotland ([2026h](#))

*Figures calculated by totalling reported monthly figures

In 2025-26, just under two-thirds (65.2%) of bed days occupied by people delayed in their discharge from hospital were occupied by people aged 75 and over. This pattern has been replicated across previous years, with patients aged 75 and over accounting for the majority of bed days occupied due to delayed discharge.

This distribution of the age profile of those experiencing delayed discharges is not surprising. As discussed, the challenges faced by the social care system, with reduced care home availability and increased demand for social care assessments, and the nursing workforce challenges experienced by the sector, is driving this trend, with older adults forced to remain in hospital as there is simply nowhere else for them to go. This subsequently impacts patient flow through the hospital, reducing availability of beds for new patients to be admitted, which consequently leads to patients being treated in corridors and other inappropriate places.

This sits within the context of significant demographic shifts in the population. As the population ages, demand for health care and the complexity of care and treatment required increases, as older people experience more multimorbidities and are spending more years of their lives in ill health. This places significant pressure on health and social care services now, but this pressure will continually increase as the full effect of these demographic changes filter down into health and social care services in the coming years and decades.

8.2 Number of hospital discharges following a period of delay

As well as number of bed days occupied due to delayed discharges, data is reported on the number of discharges from hospital following a period of delay (i.e., the number of individuals who have experienced a delayed discharge). Increasing numbers of discharges from hospital following a period of delay indicates continued and ongoing pressures in acute hospital settings, increasing the likelihood of incidences of corridor care.

Currently, around 3% of discharges from hospital are delayed discharges ([PHS, 2026h](#)).

Table 17 shows the number of discharges following a period of delay, across the reference years. The numbers in the table below are the totals of the monthly census point delayed discharges for each year reported.

Table 17: Number of discharges following a period of delay at the monthly census point, 2019-20 to 2025-26

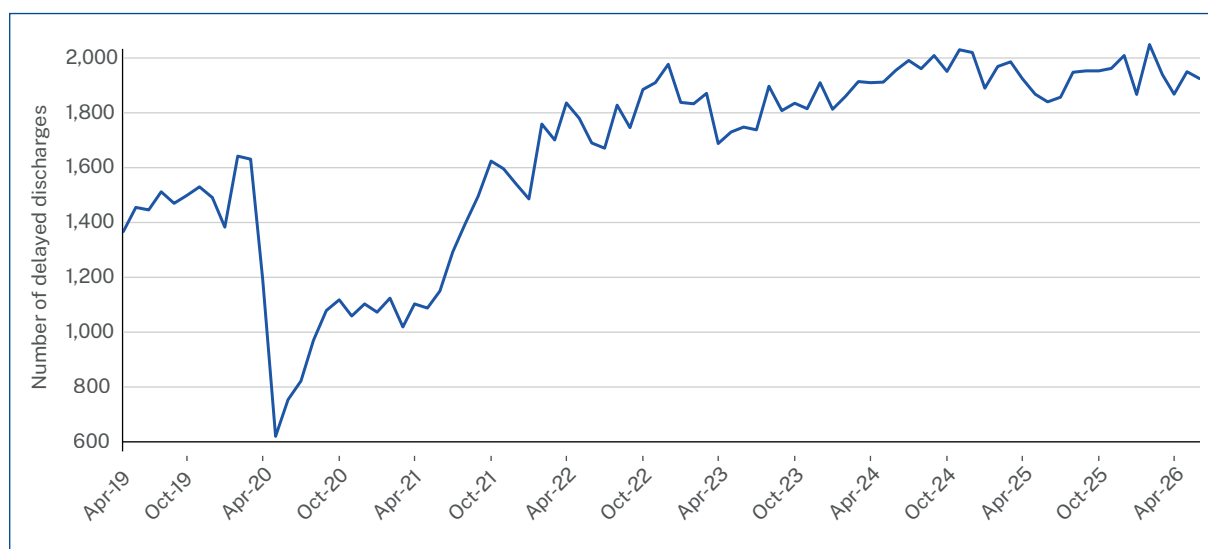
	2019-20	2023-24	2024-25	2025-26
Number of delayed discharges at the monthly census point	17,619	21,978	23,599	23,113

Source: Public Health Scotland ([2026h](#))

The figures show that there has been a steady upward increase over the period in the number of delayed discharges. The figures have dropped slightly in 2025-26 compared to the previous year but still remain significantly higher than pre-pandemic.

Looking at the month-to-month figures from April 2019 onwards provides an indication of the medium-to-long term trend on the number of delayed discharges experienced (Fig. 13).

Figure 13: Number of delayed discharges at monthly census point, NHS Scotland, April 2019 to May 2026



Source: Created using data from Public Health Scotland ([2026h](#))

Note: The large drop seen in early 2020 was a result of the impact of measures taken due to the Covid-19 pandemic which did not represent 'business as usual' for the NHS

The graph clearly shows, notwithstanding the drop during the period of Covid-19 pandemic special measures, that there has been a steady increase in the number of delayed discharges. Brief periods of decline seen in 2024 and 2025 have not been sustained.

Delayed discharges in January 2026, where there was a total of 2,049 at the monthly census point, were at a record high – they were higher than in any month recorded since April 2019. The numbers recorded in February, March, April and May 2026 has fallen slightly to 1,939, 1,868, 1,950, and 1,925 respectively but nevertheless remain high ([PHS, 2026h](#)). High numbers of delayed discharges inevitably have an impact on corridor care, as acute hospital services continue to come under immense pressure, with reduced patient flow and reduced capacity for new patients.

From this evidence, it is clear that delayed discharges from hospital are a key driver of corridor care in Scotland. Delayed discharge restricts patient flow through hospitals, limiting capacity for hospitals to admit new patients, with knock on impacts not just for the hospitals in terms of increased incidences of corridor care, but also for other areas of the health and social care system which face backlogs and increased demands as a result.

The contribution of nursing

Delayed discharge is a symptom of a system that is not working properly, and which does not have the right resources in the right places at the right times. Delayed discharge therefore cannot be addressed in hospitals alone without increasing capacity and the number of registered nurses working in the community and in care homes, alongside delivering preventative interventions to prevent some admissions from happening in the first place.

There is now widespread agreement in Scotland about the urgent need to shift the balance of care into the community, to future-proof services against a backdrop of growing demand and increasing needs, which is leading to unsatisfactory and unsafe outcomes like corridor care. Against this backdrop, registered nurses and nursing staff in community settings play a vital role in eradicating corridor care. Through activities such as managing chronic conditions and provision of urgent care at home, community nurses can reduce pressure on hospitals, by preventing hospital admissions and facilitating faster discharges when admissions do occur. There is a wide body of evidence which shows that systems with strong community nursing services tend to produce better outcomes for people, improved management of illness and disability, and have a lower and more proportionate use of resources ([Yata et al, 2025](#)).

Delivering more nurses in the community is critical to ensure care is delivered closer to where people need it, reducing demand and pressure on acute hospitals. Corridor care cannot be eliminated without investment in community nurses and nursing. Yet we know community nursing is under immense pressure and lacks capacity to lead this shift towards increased community provision without significant investment in the nursing workforce and infrastructure to support staff. The gap between capacity and patient demand in many community services is growing, which can and does impact on quality of care. Investment in growing the nursing workforce in community settings is therefore essential.

Of course, as has been highlighted, hospitals continue to remain under immense pressure, and this cannot be ignored. Therefore, any shift in priority or focus to community settings and services cannot be done at the cost of simply moving resources from acute hospitals in the short-term into community settings. Delivering real change and meaningful progress means increasing capacity in the places where it is needed, and this will require additional funding. Eradicating corridor care requires both immediate investment, capacity, and resources in hospitals to enable them to deal with the situations they face right now, whilst also recognising the importance of investing in community services to drive a longer-term shift to reduce pressure on acute hospitals.

Report recommendations

Recommendation 1: For the Scottish government to create a single national definition of corridor care. This definition must include any and all areas where waiting, assessment and treatment takes place that were not originally designated, planned, designed, equipped or staffed for appropriate safe and effective clinical patient care, including corridors, waiting rooms, chairs, unfunded and unplanned extra/temporary beds, and other inappropriate spaces.

Recommendation 2: For the Scottish government to commit to capturing, collating and reporting data on corridor care across NHS Scotland. This should include data on the number of patients being cared for in inappropriate places, where these inappropriate places are, what the places are, and details of the impacts on patients and nursing staff, alongside an accompanying list of actions to be taken forward by relevant authorities.

Recommendation 3: The Scottish government must deliver sustained investment in increasing capacity across the health and social care system, recognising the contribution of the whole health and social care system to corridor care outcomes, and the vital role that nursing staff in both acute and community settings play in eradicating corridor care. Actions must include building acute hospital capacity to improve availability and supply of services, and growing prevention and community focused activities to shift the balance of care away from hospital settings, to overcome the challenges of growing demand, with nursing at the heart of this activity.

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