The state of health care and adult social care in England

2024/25

State of Care

HC 1367

Care Quality Commission

The state of health care and adult social care in England 2024/25

Presented to Parliament pursuant to section 83(4)(a) of the Health and Social Care Act 2008.

Ordered by the House of Commons to be printed on
23 October 2025.

HC 1367

This publication is available at www.gov.uk/official-documents.

Any enquiries about this publication should be sent to us at enquiries@cqc.org.uk

ISBN 978-1-5286-5993-2

E03451258 10/25

Printed on paper containing 40% recycled fibre content minimum.

Printed in the UK by HH Associates Ltd. on behalf of the Controller of
His Majesty’s Stationery Office.

Contents

Foreword

The health and social care system is fragmented and under severe strain as it prepares for a major shift from hospital to neighbourhood care.

There is some encouraging evidence of innovation, but community services need significant investment in both capacity and capability to deliver the transformative shift called for in the government's 10 Year Health Plan for England.

Without increased support to help community services deliver the vision of the plan, there is a real risk of erosion of the quality of care, with the most vulnerable groups of people bearing the greatest burden through longer waits, reduced access to care, and poorer outcomes.

Demand for services continues to rise across the health and care system and many people are waiting too long to get the help they need. Our 2024 Community mental health survey found a third of respondents reported waiting 3 months or more and 14% reported waiting more than 6 months between their assessment and first appointment for treatment. The longer people waited, the more people reported that their mental health got worse.

After identifying concerns about systemic issues across community mental health care, including a shortage of staff and a lack of integration between services, we have started a comprehensive inspection programme of community mental health services for working-age adults, crisis services and health-based places of safety.

As part of this programme we have engaged with providers, who told us that a lack of investment in community mental health services made it difficult to attract and retain staff with the right skills and to deliver good, person-centred care. People who used community mental health services described the negative impact of moving between different services – sometimes with different criteria about who could access care – and of having many different care co-ordinators.

We have previously voiced concern that if people don't get the care they need when they need it, they can end up in crisis. Over the last year, the number of urgent and very urgent referrals to mental health crisis services has risen steeply.

Issues with getting access to care persist across the system.

Although work is underway to increase capacity and improve people's access to a GP, around 1 in 3 (35%) of the respondents to the 2025 GP Patient Survey who had tried to contact their GP by phone described it as difficult. The survey also found that access to GP services can be harder for some groups, including those living in the most deprived areas, autistic people and people with a learning disability, those with a mental health condition, a neurological condition or another long-term condition or illness.

If people can’t get an appointment it leads to pressure on other parts of the health and care system. For example, 1 in 15 respondents in the survey said they went to A&E if they could not contact their GP or did not know what the next step would be. This number was higher for people living in deprived areas.

We are especially concerned about the impact of this on certain groups of people – particularly older people. However, our inspectors have seen examples of GP practices working collaboratively with other services to improve people’s access to and experience of care.

In adult social care, the demand for support funded by a local authority continued to rise in 2023/24. Although staff vacancies in adult social care have fallen to pre-pandemic levels, they are still 3 times higher than in the wider job market – and vacancy rates in homecare services are more than double the rates in care homes. The ending of new care worker visas will likely put further pressure on recruitment, making it more important than ever that a sector-wide workforce strategy is agreed and that the recently announced fair pay agreement has an impact.

Through our local authority assurance work, we have seen the effects of a shortage of staff – both homecare staff and in the workforce delivering reablement packages. This results in people having to wait too long for a homecare service to enable them to live at home. Capacity within bed-based rehabilitation, reablement or recovery services is consistently the biggest cause of delayed hospital discharges nationally.

To help people stay in their own homes for longer, there is an urgent need to commission more community services – but we have identified factors that could limit the growth of the homecare sector. More providers are telling us that they are handing back contracts to local authorities due to rising costs – and an increasing proportion of the homecare market is made up of very small providers that may be less financially resilient.

For some years, we have been calling for a long-term sustainable funding solution for adult social care, with clear career development pathways and better pay, terms and conditions for staff. The Casey Commission will be an important milestone in reforming social care and the early focus on productivity, quality, digital services, workforce development and integration are all important. But this will not improve the core sustainability of adult social care, which will be looked at later in this parliament and will be crucial to the delivery of the 10-year plan.

In a previous State of Care report, we described the health and social care system as being ‘gridlocked’. While there have been some areas of improvement, there has been little improvement in the flow of patients out of hospitals to more appropriate care settings. On any given day in March 2025, nearly 6 in 10 patients who were ready to be discharged experienced a delay. This maintains pressure across the system, as hospital beds remain occupied, limiting capacity for incoming patients and creating knock-on effects in people’s care across the whole system, from how quickly they get seen in A&E to the length of time they wait for planned medical procedures.

Once people are discharged from hospital, the whole system needs to work together to keep them well or they risk being readmitted. Over the last 10 years, there has been a steady increase in the percentage of emergency readmissions – with older people and people living in more deprived areas more likely to be readmitted within 30 days of being discharged from hospital.

We commissioned research from National Voices into people's experience of the discharge process. This found that while the majority were happy with their discharge process, for others the negative impact was significant and could result in readmission. The research found one woman whose poor experience during her hospital stay and discharge process left her feeling dehumanised.

Once again, we are highlighting inequalities that risk increasing without targeted action. People living in the most deprived areas in England experience significantly poorer outcomes across multiple measures, with deprivation creating a cascade of disadvantage in access to healthcare. For example, children and young people in the most deprived communities are nearly 3.5 times more likely to need to have their teeth extracted in hospital because of decay, and the latest data from MBRRACE-UK shows that, compared with women from white ethnic groups, Black women were more than twice as likely to die during or up to 6 weeks after pregnancy, and Asian women were 1.3 times more likely to die during the same period.

The fragmented nature of the current system also means that more vulnerable groups of people are falling through gaps in care. For example, older people, people with dementia, autistic people and people with a learning disability, and people with complex mental health needs can struggle to navigate services, while their families and unpaid carers carry increasing burdens. Work on our dementia strategy highlights how badly a clear, accessible, easy-to-navigate pathway of care between social care, community care and other health services is needed.

In this year's report, we highlight examples of services working together to deliver person-centred, co-ordinated care. This includes neighbourhood health services receiving good results from patient satisfaction surveys and attendance rates, advances in artificial intelligence helping reduce administrative burdens for GPs, and examples such as a new integrated urgent community response service that's improved ambulance response times and is helping to keep people out of hospital if they can get the care they need nearer home.

However, we have also seen too many instances where poor co-ordination between health and social care, inadequate information sharing, and a lack of digital integration is creating barriers to good care.

The government's plan to rebalance the delivery of care from hospitals into communities is a crucial opportunity to act on making care less fragmented and halting the erosion of quality, but community services must be robust enough to support this shift.

Despite delivering comparative value for money compared with acute hospital alternatives, community services report struggling with funding and commissioning arrangements that prioritise hospital providers. These services also have fewer consistent national standards, targets or data to show evidence of their impact. In research we commissioned from the Nuffield Trust, integrated care system (ICS) leaders said that the concentration of limited resources in acute trusts and a national focus on acute sector metrics conflicted with attempts to move to community-focused, preventative approaches.

We are calling for more focus on community care and the necessary investment to make the shift away from hospital care successful – with particular attention to neighbourhoods in deprived areas – to avoid worsening existing inequalities.

We will play our part through our renewed focus and commitments, including listening to and acting on information from the public and taking action to protect people from poor care. This goes hand-in-hand with our work with providers and systems to drive improvement by identifying and promoting examples of innovation and person-centred care, and working with partners to develop solutions where we see barriers to delivering good care.

Mike Richards

Professor Sir Mike Richards
Chair

Julian Hartley

Sir Julian Hartley
Chief Executive

Summary

Demand for services is increasing across a health and social care system that is already under severe pressure – affecting how easily people can access care and the quality of care they receive. There is also unwarranted variation in people's experience of services across the country and inequality is particularly affecting people in the most deprived areas.

In some places, there are promising signs. We see examples of innovation, excellent care and improvements in quality that are making a difference for people. Although there are many challenges in shifting the focus and resources to deliver services in the community, we have seen positive examples of pilot schemes and new initiatives that appear to support this change.

But our work also exposes issues about the readiness of the system for a shift to delivering neighbourhood care, as well as concerns for how some people experience care – such as for older people, people with dementia and people using maternity services.

Access and demand for care

Demand for services is growing. People cannot always access the care and treatment they need when they need it, and the system often fails to deliver effective, joined-up care, resulting in long waits and unmet needs.

Demand for GP services is still growing, resulting in more pressure on services. Over 700,000 more patients were registered with a GP on average in 2024/25 compared with 2023/24, and the number of appointments has risen by nearly 10% over the last 2 years. In the 2025 GP Patient Survey, only half (53%) of the respondents who had tried to contact their GP by phone reported that it was easy.

Access to NHS dental care remains a challenge. The number of units of dental activity completed in England increased marginally in 2024/25, but still remains 8% lower than pre-pandemic levels. And there is variation in how much contracted dental activity is delivered: data from 2023/24 shows that dental practices in the top-performing integrated care system (ICS) area completed 97% of their contracted dental activity, compared with 48% in the lowest-performing ICS area.

In community health services, there has been a 26% increase in the number of children and young people waiting to access care between January 2023 and December 2024, compared with a 19% increase for adult services. But most notably, the number of children and young people waiting for over a year for these services increased almost threefold in this period.

In adult social care, the demand for support funded by a local authority continued to rise – new requests for care were 4% higher in 2023/24 than in the previous year, and 8% higher than in 2019/20. For adults of working age, there has been a large growth in demand for support, with requests per 100,000 people 14% higher than 4 years earlier. But, over the last 20 years, the proportion of older people who receive local authority-funded long-term social care has fallen from 8.2% to 3.6%.

Pressures in one part of the system affect other parts. This is true for hospitals, which are affected when there is a lack of access to preventative and community-based support.

For example, delays in access to rehabilitation, reablement or recovery services were the biggest cause of delayed discharge for people who had been in an acute hospital for 14 days or longer (26%). And the 2025 GP Patient Survey found that 6.6% of people went to A&E when they could not contact their GP practice or did not know what the next step would be – this was 4 percentage points higher for people in the most deprived areas.

In 2024/25, people were still waiting too long for mental health care and were unable to access the care they need when they needed it. During the year, there was an average of 453,930 new referrals to secondary mental health services every month – an increase of 15% from 2022/23. Furthermore, a third of the respondents (33%) to our Community mental health survey reported waiting 3 months or more.

Demand for urgent and emergency care services remains high, but the way in which people are accessing this care is changing. While there was a drop in the volume of calls to NHS 111 in 2024/25, calls to ambulance services have continued to increase, with the volume of ‘hear and treat’ responses also rising. The number of attendances at all types of urgent and emergency care services has also risen, with the biggest increases at single service facilities for specific conditions (type 2 services) and minor injury units (type 3 services).

And patients are still waiting too long in A&E: in 2024/25, 1,809,000 people waited over 12 hours from the time of their arrival until they were either admitted, transferred or discharged, which is 169,000 (10%) more people than in 2023/24.

Workforce and capacity

Issues with recruitment, retention and understaffing in some areas are affecting people’s care.

Vacancy and turnover rates in adult social care have continued to fall but, at the same time, international recruitment has declined rapidly, and ending new work visas for care workers is a cause for concern. Vacancy levels for adult social care staff are currently 3 times higher than those of the wider job market.

Rising financial pressures continue to be a risk for the sustainability of some adult social care services, including in the homecare sector. Despite an 11% growth in the sector during the last year, we are concerned that some homecare providers have said they are handing back local authority contracts due to rising costs. We are also concerned about the burden on unpaid carers.

District nursing services are an important part of shifting care from hospital settings into the community, but the number of qualified district nurses per 10,000 people aged 65 and over has dropped by 50% in the last 14 years. A shortage of qualified staff in district nursing is contributing to a shift away from providing holistic care to delivering services in a task-based way.

Regardless of changes in the way GP appointments are being delivered, we still hear that people struggle to get appointments. While there are more full-time equivalent (FTE) GPs in training per 100,000 patients, the number of FTE fully-qualified GPs per 100,000 patients has reduced.

Mental health services continue to face systemic recruitment and retention challenges as staff feel burnt out and overworked. Hospitals are also facing workforce challenges. We continue to hear how persistent understaffing and a poor mix of skills, along with pressure to admit patients to hospital despite a lack of capacity, affects the wellbeing of staff and therefore the care that people receive.

People’s experiences

The health and care system remains fragmented and pressure in the system has an impact on people’s experiences of care.

We analysed a wide range of experiences for this report, which consistently shows a need for more person-centred care, with an emphasis on better communication, co-ordination, and collaboration with other services.

Holistic care that addresses both physical and mental health needs is essential – especially for people with multiple conditions. But too often, information is not shared properly, and services are not joined up.

There are significant challenges around funding and system working, as poor communication and collaboration between services, and problems with shared care protocols can have a negative impact on people’s experience of care, the co-ordination of their care and transitions between care pathways.

While there has been some improvement, people are still facing long waits for elective care, and the length of time people must wait varies across the country. This has an impact on the quality of care people receive – our 2024 Adult inpatient survey found that 43% of elective patients said their health deteriorated while waiting to be admitted to hospital. Findings from the community mental health survey also highlighted the impact of long waits for people with mental health needs, with results showing that the longer people waited, the more people said their mental health got worse.

Navigating the care system remains challenging, especially for people with needs that are more complex to meet or who have limited advocacy – this includes people living with dementia, autistic people and people with a learning disability and people living in more deprived areas.

The 2025 GP Patient Survey found that people aged 85 and over were most likely to not do anything when unable to contact their GP or when they were unsure what the next step would be. This is particularly worrying because of the risk of poor outcomes for this population group, such as falls or being admitted to hospital as an emergency.

Inequalities and concerns for specific groups of people

We continue to see significant unwarranted variation and inequalities in care. This persists in how people access and experience care, and their outcomes from it.

In the report, we have highlighted how deprivation affects people's access to, and experience of, health and social care. For example, the 2025 GP Patient Survey highlights that people living in the most deprived areas can find it harder to access GP appointments. Furthermore, older people and people living in more deprived areas are more likely to be readmitted within 30 days of being discharged from hospital.

Variation at both a regional and ICS level is leading to inconsistent quality across the country. For example, in 2024/25, the average ambulance handover time at the ICS level ranged from 16 minutes 8 seconds to 1 hour 50 minutes 39 seconds. And in 2023/24, the rate of children and young people who were admitted to hospital for tooth extractions due to decay ranged from 994 per 100,000 young people under 19 years in one ICS to 17 per 100,000 young people in another ICS.

In this 2024/25 report, we focus on some specific concerns for particular groups of people. The concerns involve issues around safety, quality, workforce, and inequalities:

- Our research with people aged over 65 showed that most had a positive experience when it came to being discharged from hospital and receiving follow-up care in the community. However, some said they didn't feel ready to be discharged, and follow-up care didn't meet their emotional needs. Others did not receive the care they felt they needed, leading to a deterioration in their health or mental wellbeing. Some family and friends also took on unpaid caring responsibilities due to these gaps in care.
- Some systems are using data to proactively identify older and frail people who are at risk of falls and hospitalisation, and are providing targeted interventions to reduce this risk. However, system leaders report that workforce challenges are limiting their ability to increase support of older and frail people.

- Although more people in England are being diagnosed with dementia, staff in health and social care do not always understand the specific care needs of these people and providers do not always have the necessary knowledge of person-centred approaches and dementia-friendly environments.
- Despite the same issues being reported over the last 10 years, efforts to address the underlying causes of poor maternity care have continued to fall short. Too many women are still not receiving the high-quality maternity care they deserve, and some women with protected characteristics under the Equality Act 2010 remain at greater risk of harm. The national maternity review, announced in the government's 10 year plan, presents a real opportunity for change.
- Autistic people and people with a learning disability can find it challenging to get an appointment with their GP, because booking systems may not offer the flexibility and choice that they need. Our research also suggests that there are not always the right reasonable adjustments to make primary care a positive experience.
- In 2024/25, we delivered a series of Independent Care (Education) and Treatment Reviews (IC(E)TRs) into the care and treatment of autistic people and people with a learning disability who are in long-term segregation. Reviews for some people noted there was no discharge plan in place, or even that they had not had discussions about being discharged or leaving long-term segregation.
- Longstanding inequalities in mental health care for Black men continue. Staff must be properly trained to fight racism and support Black men with respect and understanding, and services need to be held accountable when they fail to do the right thing.
- Our joint targeted area inspections with Ofsted, His Majesty's Inspectorate of Constabulary, Fire and Rescue Services, and His Majesty's Inspectorate of Probation looked at serious youth violence. They showed that children with special educational needs or disabilities are waiting too long to have their needs assessed, which makes them more vulnerable to the consequences of serious youth violence.

Signs of improvement and innovation

Although the system is under serious pressure, we have seen evidence of innovation and improvement making a difference for people. In our assessments, we continue to see how good leadership can promote a culture of openness and learning.

The government's 10 Year Health Plan aspires to a new model of care where a neighbourhood health service is designed around the individual – and science and technology will be key players. This year, we have seen examples of neighbourhood health services receiving good results in patient satisfaction surveys and attendance rates, and there is evidence of technological advancement.

Harnessing the advances in artificial intelligence (AI) is seen as one of the core elements of shifting care from analogue to digital in the government's plan. We know some GPs are using AI, mainly to reduce administrative burden. And in our work, we support initiatives to drive positive change by using technology.

Deprivation of Liberty Safeguards

The number of applications to authorise the deprivation of a person's liberty have continued to increase significantly over the last decade – far beyond the levels expected when the safeguards were designed, which often results in lengthy delays.

Issues with the Deprivation of Liberty Safeguards (DoLS) system continue to disproportionately affect certain groups of people. Our survey of Mental Capacity Act leads in hospitals highlighted particular concerns around older people, including those with dementia.

We are still seeing wide variation in how local authorities are managing DoLS applications – while some report not having any backlogs, others are still struggling to meet demand.

The wider policy landscape in health and social care is changing - the introduction of the Mental Health Bill in Parliament and the government's recent announcement that it intends to take forward the consultation on Liberty Protection Safeguards are likely to have implications for the DoLS system.

Health and social care systems

It's vital that the health and adult social care sectors work effectively as a system and that they prioritise improvements in areas of concern.

This year's State of care report draws on findings from our assessments of how local authorities are meeting their duties under the Care Act and new research that we commissioned Nuffield Trust to carry out with ICSs on the progress made against inequalities and their readiness for the 3 shifts set out in the government's 10 Year Health Plan for England.

While systems demonstrate strong leadership foundations and are piloting innovative approaches, they report systemic barriers to large-scale and enduring change.

Efforts are hampered by the concentration of limited resources in acute hospital trusts and a national focus on acute sector metrics, which is in conflict with attempts to move towards community-focused, equity-centred, preventative approaches. There is some progress on moving hospital-based expertise into the community, but systems report disagreements on how to shift resources to prioritise community services.

Systems report good progress on using data-driven approaches to understanding the needs of local populations and targeting interventions. However, data-sharing across organisations remains a problem, and the quality and completeness of data is variable. Systems are making most progress in supporting older and frail people in activities focused on prevention, assessment and planning, and multi-disciplinary working – but workforce challenges are hampering these efforts.

Local authorities are working to provide targeted interventions, often using public health data, to prevent future care needs and avoid hospital admissions. We have seen proactive approaches, often involving community and voluntary sectors, and examples of community-based early intervention and other work to help keep people well in their own homes.

Partnership working is evident in efforts to make sure people are safely discharged from hospital and back home. Reablement services were working well when there were strong partnership working networks between hospital staff and local authority social work teams. But again, barriers to success included staff shortages and recruitment problems.

Although local authorities have worked to increase and improve their homecare capacity through reviews and new approaches to commissioning, insufficient homecare capacity often affects the ability of hospitals to discharge people safely, which affects the flow of the system and leads to long delays for care and waiting lists, and then affects people’s health and wellbeing.

Evidence used in this report

This report sets out the Care Quality Commission's (CQC's) assessment of the state of health care and adult social care in England in 2024/25.

To inform our view of the quality of care in this report, we use evidence from our inspection and registration activities and the experiences of people who use services, their families and carers, as well as evidence from our regulatory and strategic projects.

This report is also based on our wider horizon scanning and analytical activity. We have reviewed reports published by our stakeholders, drawn on findings from national surveys, and analysed publicly available datasets to inform our understanding of the challenges facing health and social care today and the experiences of people using services. We also analyse unpublished cuts of health and care datasets to allow further interrogation of key issues and trends. Where we have used data from other sources, these are referenced within the report. For better readability we have rounded many of these figures, so they may not match exactly with the published source.

To ensure that the report represents what we are seeing in our regulatory activity, analytical findings have been corroborated, and in some cases supplemented, with expert input from our Chief Inspectors, colleagues in our Regulatory Leadership directorate, specialist advisors, analysts and subject matter experts. Our analysis is also supplemented with expert input from our Clinical Fellows and National Professional Advisors.

Here, we provide further detail relating to the evidence used in this report.

People's experiences and what they have told us

Our view of quality and safety has been informed by information that people have shared with us through our online Give feedback on care service (GFOC). People's experiences and comments submitted in this way were analysed to inform our understanding of the following areas:

- **Secondary and specialist care services:** a thematic analysis of 866 comments from April 2024, July 2024, and January 2025. We extracted a total sample of 2,185 comments and analysed the data until no new and significant information emerged.
- **GP services:** a thematic analysis of a sample of 293 comments from 1 April 2024 to 31 March 2025. We initially analysed a sample of 240 comments to update our view of themes identified in previous analyses (such as those conducted for State of Care 2023/24) and then extracted a further sample of 53 comments based on keywords to focus on experiences of frail and/or older people.

- **Dental services:** a thematic analysis of comments from 1 April 2024 to 31 March 2025. We initially analysed a sample of 216 comments and extracted a further sample of 133 comments based on keywords to focus on experiences of those entitled to free NHS dental care. We used the analysis of the keyword sample to provide an updated view of themes identified in analyses conducted for our previous State of Care report.

We also conducted 3 focus groups with 28 Experts by Experience to understand people's experiences of community adult social care services for older people. These Experts by Experience had recent experience of supporting our homecare inspections as well as lived experience of using or caring for someone using these services.

As in previous years, we have also used findings from our published surveys to understand what people think about the NHS services they use. This includes the:

- Adult inpatient survey 2024
- Community mental health survey 2024
- Children and young people's survey 2024
- Urgent and emergency care survey 2024.

As well as using published findings, we conducted a thematic analysis of free text responses to the 2024 NHS Urgent and emergency care survey. This analysis was based on a sample of 651 respondents of people aged 66 and older who were also classified as being frail.

Providers of health and care services

We conducted targeted analyses of:

- information collected through our surveys
- data from statutory notifications received
- information from adult social care provider information returns.

We have also drawn on findings from our published inspection reports of registered providers during 2024/25 and used the data and insight gained through our routine engagement with them. This included 28 maternity inspection reports published between January 2024 and June 2025 and 21 inspection reports for hospice services for adults published in 2024/25.

This report also provides an analysis of data submitted to us by providers in our Market Oversight scheme, as well as information and insight gained from our engagement with providers that participate in the scheme. The scheme covers providers with a large local or regional presence which, if they were to fail, could disrupt continuity of care in a local authority area.

Aggregated ratings for the main sectors and services we regulate are provided in the data appendix of this report. The ratings data are from inspection reports published under our single assessment framework, as at 1 August 2025. We began implementing the single assessment framework in January 2024 so these ratings, comprising more than 3,900 services and providers, are our growing picture of the quality of care under this new framework from that point in time.

The rating charts presented in this report are not directly comparable to previous years because:

- Our assessment activity during this time has been based on risk to people using these services so it is unlikely to be representative of all services in a sector. This means that we have prioritised assessing services where our data indicated there may be greater risk to quality and safety for people.
- For some services, the numbers of assessments completed using the single assessment framework are still too low to be representative of all services in that sector.
- Alongside the introduction of the single assessment framework, we also made changes to some aspects of our assessment methodology. One of these changes was differences in the levels at which we rate providers. Read the full detail of the different levels of ratings on our website.

Statutory responsibilities for Deprivation of Liberty Safeguards

Evidence in this report, alongside our annual report and accounts, enables us to fulfil our legal duties to report on equality issues and on the operation of Deprivation of Liberty Safeguards (DoLS). Our DoLS monitoring activity is also an important part of our role as a National Preventive Mechanism.

We report on our data from notifications received between 1 April 2024 and 31 March 2025 on the outcome of an application to deprive a person of their liberty under DoLS. This excludes applications through the Court of Protection and notifications from primary medical services, but due to changes in our systems, we cannot exclude Court of Protection from other DoLS notifications. This number may include duplicate submissions from providers for an individual DoLS application or where the DoLS applies to a dual registered care home.

To supplement this evidence, in May 2025, we conducted a qualitative analysis of 30 notifications to explore people's experiences of DoLS. We also conducted 2 surveys of CQC inspectors in October 2024 and May 2025, which received 20 responses. We asked inspectors what they considered to be the main challenges affecting providers when managing DoLS and to provide examples of how DoLS (including a lack of a DoLS authorisation) has changed people's experiences of care. In addition, we asked inspectors to comment on how some groups of people may be disproportionately affected by the DoLS system, based on what they had seen during inspection activity.

As well as the 2 surveys, we conducted a small online internal focus group with 3 adult social care and secondary and specialist care inspectors in June 2025. Topics included the outcomes of delays for DoLS assessments, staff understanding of DoLS and the outcomes for people who use services.

In May and June 2025, we ran a survey among Mental Capacity Act (MCA) leads working in hospitals. We worked with national NHS leads to share the survey with MCA leads in NHS and independent hospitals and members of the independent provider safeguarding network. We conducted a thematic analysis of comments from 45 respondents to understand their experiences of managing DoLS and the challenges they face. We also reviewed 30 reports from our local authority assurance assessments, focusing on findings on how local authorities managed safeguarding risks in their local area in relation to DoLS.

To help illustrate the impact of DoLS on people, their family members and/or carers, we include 2 case studies from interviews with members of the public, which reflect their personal experiences and perspectives. They were collected to understand how people can experience a DoLS, rather than as part of our assessments of services and of what constitutes good practice.

Regulatory and strategic projects

During 2024/25, we conducted focused regulatory work on:

- urgent and emergency care services
- adult community mental health services
- dementia care
- Independent Care (Education) and Treatment Reviews (IC(E)TRs)
- Black men’s experiences of mental health services.

We also published our National review of maternity services in England 2022 to 2024. We have undertaken strategic projects, including work on inequalities in health for autistic people and people with a learning disability, and the use of artificial intelligence in general practice. For this State of Care 2024/2025 report, we also specifically commissioned primary research with National Voices and Nuffield Trust. Over the year, we have also continued our programme of assessing all 153 local authorities in England. Insight gathered through these projects has informed our reporting in 2024/25.

Local authority assurance

In 2022, CQC was given new responsibilities to assess how local authorities meet their duties under the Care Act (2014). In December 2023, we started an assessment programme for all 153 local authorities in England with adult social care responsibilities, to be assessed within a 2-year period.

This year, we have analysed 32 reports from our programme of local authority assurance assessments with a focus on how local authorities are working with partners on prevention, hospital discharges and reablement services. We wanted to understand how reablement and homecare services are being used to support avoidable admission to hospital and support people to live independently for longer.

Urgent and emergency care

During the winter of 2024/25 we carried out inspections in 8 hospitals looking at the emergency departments and medical wards within these providers. This was to gather information to understand the performance of systems across the urgent and emergency care pathways for the population they serve, share innovative practices, and identify blockers and barriers facing providers and systems. We analysed patient pathway tracking records from these providers as well as 7 of the 8 inspection reports. We also conducted 3 focus groups with inspectors involved in this work. From these, we were able to draw out themes about the quality and safety of care in these providers.

Community mental health care

Last year, our rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) highlighted particular concerns about the systemic issues within community mental health care. This year, we started a comprehensive programme of inspections of community mental health services for working-age adults, crisis services, and health-based places of safety (HBPoS). We have gathered a range of evidence to support us in shaping this programme of work, including:

- **An information request** sent to all 51 NHS providers of community mental health services to ask trusts about their self-assessments of issues raised in our rapid review of NHFT and their actions following the publication of the review (August 2024). Analysis completed on responses from 45 trusts.
- **A literature review** commissioned from the University of Birmingham focusing on what is currently known about community mental health services, which was developed with peer reviewers with lived experience and clinical expertise (December 2024).
- **3 provider engagement sessions** about our inspection programme and what good care looks like in the community mental health sector. Representatives from 45 providers of community mental health services and crisis care (including health-based places of safety) for adults of working age participated (November and December 2024).
- **Focus groups with Experts by Experience** including 17 Experts by Experience with a range of experiences of using and/or supporting those they cared for to use community mental health and/or crisis services. The sessions focused on the challenges for people using these services and improvements that could be made (January 2025).

- **Research on optimisation of psychotropic medicines in the community.** We commissioned Ipsos to explore what good care looks like in this area from the perspective of a range of professions and organisations that support prescribing in the community. The research combined 314 survey responses with 13 in-depth interviews (January to April 2025).
- **Two focus groups with inspectors** involved in the first 4 inspections of adult community mental health trusts. These focused on testing our insights around community mental health services for this report (June 2025). We have continued to work closely with these inspectors as we develop this report.

Black men's mental health

In last year's State of Care report, we highlighted the longstanding health inequalities faced by Black or Black British people, and our specific concerns around Black men's mental health. To develop our understanding of how Black men experience mental health care, we commissioned Queen Mary University (QMU) and University College London (UCL) to carry out a rapid review of what 'good' looks like in relation to access, experience and outcomes for Black men. The work included a rapid evidence review and semi-structured interviews with 23 participants, including Black men who use mental health services and their carers and family, providers, mental health advocates and people working in charities. The interviews explored Black men's experiences of accessing and receiving mental health services, as well as the experiences of participants delivering and/or planning care. In addition, the research team worked with a community engagement group – the Black Men's Health Taskforce – throughout.

Independent Care (Education) and Treatment Reviews (IC(E)TRs) programme

CQC was commissioned by the Department of Health and Social Care to undertake a series of Independent Care (Education) and Treatment Reviews (IC(E)TRs). The IC(E)TR programme undertakes reviews for autistic people and people with a learning disability who have been detained in long-term segregation in hospital. To inform early findings around the programme, we undertook thematic analysis of:

- A sample of 16 early reports of reviews dated May to November 2024. These reports look at different areas of people's care in long-term segregation such as quality of life, future planning, and recommendations for providers and stakeholders involved in a person's care to improve their care and help them to move out of long-term segregation.
- A focus group with 5 IC(E)TR Panel Chairs (May 2025). Panel chairs are responsible for reviewing people's care through the IC(E)TR process. This was undertaken to increase understanding and confidence

in themes identified in the analysis of the reports and included discussion points such as drivers and barriers to leaving long-term segregation, and adjustments and adaptations for people.

Inequalities in health for autistic people and people with a learning disability

In last year's State of Care report, following compelling feedback from our expert advisory group, we introduced our priority area of exploring the challenges and barriers experienced by autistic people and people with a learning disability when accessing their GP practice. We held 4 online focus groups with 12 people with a learning disability and autistic people (recruited by Choice Support) between September and November 2024 to hear about their experiences of accessing and receiving primary care.

To understand the wider context of the barriers to accessing primary care for these people, we analysed 552 provider information returns from adult social care services from a 6-month period (December 2023 to May 2024). The analysis focused on 2 questions: barriers to providing good quality care and working in partnership with other specialist services.

Experiences of follow-up care after discharge from hospital

To understand people's experience of care following their discharge from hospital we commissioned research from National Voices. This centred on 4 key areas:

- transitions from hospital to the community
- support mechanisms for staying well at home
- barriers to accessing quality health and social care in the community
- the impacts of unmet care needs.

A questionnaire was sent to 704 people who had responded to the 2023 Adult inpatient survey and who had agreed to be re-contacted. In total, 144 people responded and 17 people were identified for follow-up interviews to gain a more in-depth understanding of their experiences, including 8 people at risk of experiencing health inequalities.

Integrated care systems

For the second year running, we worked with the Nuffield Trust to survey integrated care systems (ICSs) to understand how they are trying to help people who need care, and the barriers and enablers to this work. In 2025 we asked systems for their own views of their progress against 3 priority areas: reducing health inequalities, shifting services into the community, and supporting older and frail populations.

The Nuffield Trust survey was for people with a strategic role in developing community-based care or in leading health inequalities work in an ICS or local partnership. Specific groups invited to respond included staff with a responsibility for population or public health, transformation or strategy, adult social services, place-based partnerships, primary care or community care, and patient and public involvement. Analysis was based on 49 responses from 30 unique ICSs (71% of all 42 ICSs in England). In some cases, multiple people from the same ICS submitted responses, which will have skewed results. All NHS regions were represented in the responses, although some were more represented than others – partly due to differences in response rates and the number of ICSs within a region.

While more than two-thirds of ICSs are represented, not all ICSs are included, and a small number of responses were received overall, so the results may not represent the whole picture and small changes in the answers will have significantly changed the proportions. It should also be noted that response rates varied across questions (denominator range: 34 to 49 respondents) as some respondents indicated that certain questions were not applicable to their role or system.

The Nuffield Trust also carried out 8 semi-structured qualitative interviews with director-level roles across integrated care boards (ICBs). Interviews examined how strategic decisions were made, detailed descriptions of activities and initiatives in the 3 key areas, and enablers and barriers to progress in last 12 months. Interviewees represented 6 of the 7 NHS regions.

Use of artificial intelligence (AI) in general practice

We have drawn on work that was carried out to inform our regulatory approach to the use of AI in general practice. In April 2025, we surveyed GPs to find out their views and experiences of using AI, which received 156 responses. This sample provides some indicative insights but due to the small numbers involved, it is difficult to tell whether these answers represent a broader picture. As such, the results should be interpreted with caution.

To understand people’s views on the use of AI in GP practices, we commissioned an online survey by the market research company OnePoll of 2,000 people in March 2025. Analysis of responses focused on key themes around people’s knowledge of and feelings towards AI, confidence in the use of AI by GPs and perceptions around the potential benefits.

Chapter 1

Access and quality in health and social care services

Primary and community care

Key findings

- The demand for GP services is still growing, resulting in more pressure on services. Over 700,000 more patients were registered with a GP, on average, in 2024/25 compared with 2023/24, and the number of appointments has risen by nearly 10% over the last 2 years.
- The number of full-time equivalent fully-qualified GPs per 100,000 patients dropped by 0.7%, on average, in 2024/25 compared with 2022/23. In the same period, the number of full-time equivalent GPs in training grade per 100,000 patients rose by 10%.
- In the 2025 GP Patient Survey, 75% of respondents stated that their overall experience was ‘good’ or ‘fairly good’. However, the survey also found that only around half (53%) of people who had tried to contact their GP by phone said it was easy. It also found that access to GP services can be harder for some groups than others, including those living in the most deprived areas, autistic people and people with a learning disability, those with a mental health condition, a neurological condition and/or another long-term condition or illness.
- When a GP service is unable to meet people’s needs, it can lead to pressure on other parts of the health and care system. For example, the 2025 GP Patient Survey found that 6.6% of people went to A&E when they could not contact their GP practice, or did not know what the next step would be. This proportion was higher for people living in the most deprived areas (8%), compared with people in the least deprived areas (4%).
- Access to NHS dental care remains a challenge, and the amount of NHS dental activity completed in 2024/25 was 8% lower than in 2019/20. In 2023/24, dental practices in the top-performing integrated care system (ICS) area completed 97% of their contracted units of dental activity compared with 48% in the lowest-performing ICS area.
- There is geographical variation in the rate of children and young people being admitted to hospital for decay-related tooth extractions. This rate was nearly 3.5 times higher in the most deprived communities compared with the least deprived communities.
- Although district nursing services are an important part of shifting care from hospital settings into the community, the number of qualified district nurses per 10,000 people aged 65 and over has dropped by 50% in the last 14 years. A shortage of qualified district nursing staff is contributing to a shift away from providing holistic care to delivering services in a task-based way.
- Although over four-fifths of GPs we surveyed thought that artificial intelligence (AI) will have a positive impact on general practice in the next 5 years, less than half (42%) were using it. Although the public thought it could improve access to a GP, just over a quarter (27%) thought the use of AI by GPs could make their care better.

Demand and capacity in GP services

Demand for GP services is continuing to grow, which in turn increases pressure on services.

NHS England figures show that the number of patients registered with GP practices continues to increase, with over 700,000 more patients on average in 2024/25 compared with 2023/24. This has resulted in bigger GP list sizes, with the average number of patients per practice reaching 10,172 in 2024/25 – an increase of 2.6% on the previous year, and 5.7% over 2 years.[1]

An increase in the number of appointments recorded in GP systems also reflects this growing pressure, with figures for 2024/25 up by 9.8% over 2 years. The number of appointments attended also increased by 8% over the same period.

At the same time, our analysis of NHS England's General Practice Workforce data shows that between 2022/23 and 2024/25, the average number of full-time equivalent (FTE) fully qualified GPs per 100,000 patients in England dropped by 0.7%.

There is still variation across integrated care system (ICS) areas, with an uneven distribution of fully qualified GPs – as at March 2025, figures ranged from 34 to 54 FTE fully qualified GPs per 100,000 patients.

Nevertheless, it is encouraging that the number of full-time equivalent (FTE) GPs in training per 100,000 patients in England has risen between 2022/23 and 2024/25 by 10%, and the government has committed to "training thousands more GPs" in its 10 Year Health Plan.[2]

NHS England data suggests that the way GP appointments are being delivered in response to demand is changing. There has been a fall in the proportion of appointments carried out by GPs (down 3 percentage points to 44% in 2024/25 compared with 2022/23) and an increase in the proportion delivered by other direct patient care staff (to 25%, up 4 percentage points over the same period).

While most appointments continue to be carried out face-to-face (65% in 2024/25), the proportion of video and online appointments has grown (5.5% in 2024/25 compared with 0.6% in 2022/23). Such initiatives to improve access to appointments are positive, but it is important to ensure that systems to do this are accessible for all people. As outlined in our section on health and care for autistic people and people with a learning disability, these groups of people, as well as others, can face difficulties in using the technology to book appointments, therefore choice and flexibility is key. And, in a survey commissioned by the Royal National Institute for Deaf People, many people commented on the fact that they cannot use the phone because they are deaf or have hearing loss, which leads to difficulties, particularly for accessing GP appointments.[3]

Access to GP services

While most patients report good experiences at their local GP practice, there are enduring access issues at the 'front door of the NHS'.

The 2025 GP Patient Survey received responses in the first 3 months of 2025 from just over 700,000 people about their experience of local NHS GP practice services. The survey found that, of those who had tried, just over half of respondents reported that it was easy to contact their GP practice by phone (53%) in 2025. While this is a 3 percentage point improvement on last year (50%), around 1 in 3 (35%) respondents said it was difficult, and 1 in 7 (14%) said it was 'very difficult'.

In 2025, more respondents had used online methods the last time they contacted their GP practice, including the practice website and the NHS App, than in 2024 (up 3.1 percentage points and 2.2 percentage points respectively). Of those who said that they had tried these methods, there was a small increase in the proportion saying they found it easy:

- 51% said that it was easy to contact their GP practice using the practice website, compared with 48% in 2024
- a slightly lower proportion (49%) said that it was easy to contact their GP practice using the NHS App (45% in 2024).

However, significant numbers of people continue to report challenges, with just over 1 in 3 saying that contacting their GP using the NHS App (36%) and using the practice website (34%) is difficult.

These survey findings are echoed in the feedback we have received from people using services through our Give feedback on care service. People told us about early morning calls, long waits in call queues and for call backs, and frustrating policies and procedures that make them feel like there are not enough appointments available to meet demand.

Getting an appointment can be particularly difficult in the morning if the booking period clashes with commitments such as commuting or the school run:

> *"Working people are unable to get an appointment unless calling at 8am. Can't call at that time as that is the time for getting ready for work and school."*

Access issues highlighted on inspection – examples of practices rated as inadequate and good

Practice rated as inadequate

In October 2024, we rated a GP service as inadequate overall and placed it in special measures. We found that patients could not always access appointments soon enough. Patient feedback continued to highlight difficulties in accessing services and this was reflected in the results of the GP Patient Survey. People we spoke with during our on-site inspection also talked about difficulties in getting an appointment.

Staff told us that, during holidays and sickness leave, they struggled to cope with the demand for appointments, and this was the case on the day of our visit.

People could book appointments by telephone and online. On the day of our visit, the telephone monitoring system showed that people were waiting 30 minutes or more for a call to be answered.

The practice leadership team told us that people could also book if they visited the practice in person. However, when we visited, we found people who had tried to do this but were told it was no longer available, and they would need to book appointments by telephone.

We re-inspected this practice in April 2025 and found improvements to enable people to access services when they needed to, without physical or digital barriers, including out of normal hours and in an emergency. As a result of these improvements, the average call wait time had dropped to just over 2 minutes. The rating improved at this inspection.

(Taken from CQC inspection report)

Practice rated as good

By contrast, we rated a GP practice as good overall and outstanding for being caring in January 2025. We found that the service was exceptional at responding to people's immediate needs. Patients reported a very quick turnaround when contacting the service, and said how quickly their needs were met, with one person saying there was, "a very rapid response to triage online requests and also telephone communications". The vast majority of people were seen on the day of contact with the service. The remaining patients were booked in for a more routine appointment in line with their needs.

(Taken from CQC inspection report)

We know that experiences of seeking care can also be shaped, positively or negatively, by interactions with non-clinical staff, as the following highlights:

> *“Went to see the doctor but could not get an appointment. Been aggressively turned away from the [receptionist]. Had to almost insist we need to see the GP as it’s an emergency.”*

> *“[The receptionists] are very helpful and welcoming, they can help you sort out any problems with my doctor and get any problems you have sorted out.”*

Where online booking systems have been implemented well, we hear that this can support access. But practices must ensure that, as in NHS England’s guidance, the “introduction of these systems is balanced against the nature of the local population to avoid introducing additional inequalities”.

Feedback from autistic people and people with concerns about their mental health show that GP practices do not always offer the reasonable adjustments needed to support them to make appointments online or by telephone. These barriers can also affect other groups, such as older or frail people:

> *“Telephone appointments are completely inaccessible to me … It often takes 1-2 months of near-daily emails to make an appointment … or receive an answer to a question. This does not feel like equal access to healthcare.”*

As the government commits to going ‘digital by default’ in attempts to end the 8am scramble, practices will need to consider how to implement change in ways that minimise digital exclusion and consider the impact of health inequalities. (See more on this in our section on Health and care for autistic people and people with a learning disability.)

The 2025 GP Patient Survey also points to some marked inequalities in people’s experiences of accessing a GP. Among the groups least likely to describe their experiences of contacting their GP practice by phone as easy were autistic people, those reporting a mental health condition, a neurological condition or a learning disability, or another long-term condition or illness.

The 2025 survey also found that the ease of contacting a GP practice by phone varied by:

- socio-economic characteristics of the area where respondents lived – with those in the most deprived areas less likely to describe their experience as easy (50% compared with 54% from the least deprived areas)
- ethnicity – Black and Black British people were most likely to say it was easy to contact their GP by phone (63%), whereas Asian and Asian British people were least likely to find it easy to do this (48%).

It can be particularly difficult for prisoners to access GP appointments, as we have found through our joint inspections with His Majesty's Inspectorate of Prisons. For example, at one prison, there was a wait of up to 2 months for a nurse triage appointment, with a further 10 days' waiting time to see the GP, which was too long. The report for this inspection cited "insufficient capacity in GP clinics", and also noted that "Primary care and GP provision was under pressure because of the high number of arrivals." We report on these issues in prisons and can take enforcement action to support better outcomes for prisoner healthcare.

Improving equity of access to primary care for people experiencing homelessness

NHS England's Core20PLUS5 approach to reducing health inequalities identifies people in inclusion health groups, who are often socially excluded and face barriers in access to healthcare, and have extremely poor health outcomes. North Central London ICS has taken action to improve access to primary care for people experiencing homelessness through establishing 2 community-based hub clinics. These clinics provide flexible access to appointments, including drop-ins, pop-up clinics, and outreach into hostels, as well as pre-bookable appointments that key workers and professionals can access.

In 2024/25, 178 people were seen at these clinics. Appointments resulted in 32 care plans being established and 80% of patients in the area were offered a seasonal vaccination. Through this work it is estimated that 8 admissions to hospital were avoided.

Source: Nuffield Trust

People's experience of GP services

Most people who responded to the 2025 GP Patient Survey reported a positive experience, as 75% of respondents stated that their overall experience was 'very good' or 'fairly good', compared with 74% in 2024. But there is a substantial minority who did not have a good experience of GP services, with almost 12% reporting a 'fairly' or 'very' poor experience (13% in 2024).

Through our Give feedback on care service, we hear of positive experiences of GP services. Care and treatment by clinical staff is perceived as kind, and people tell us that they show a willingness to listen and offer excellent advice and help.

When people have negative things to report on their experiences of staff, these concerns are often around interactions between the doctor and patient and communication. People report not feeling listened to, or say that the GP is being dismissive of their concerns.

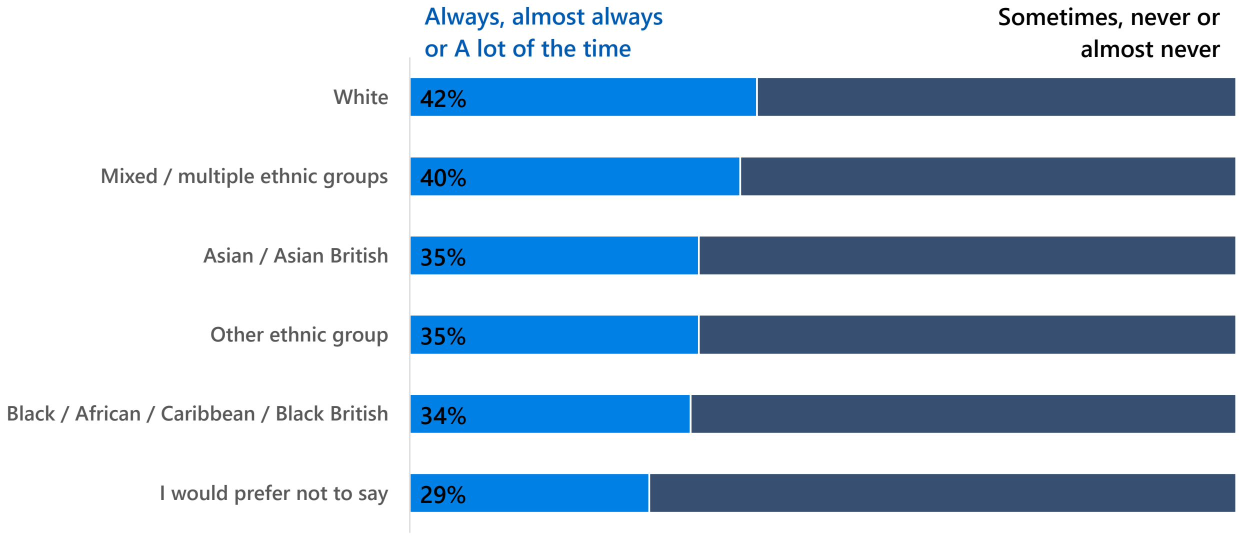
As recognised by the Royal College of General Practitioners, "Continuity of care is a critical element of general practice, particularly, continuity of the personal relationship between patients and their general practitioner."[4] 'Bringing back the family doctor' is also part of the government's GP reforms.

Continuity of care

Unfortunately, continuity of care is not yet widely reflected in people's experiences. In the 2025 GP Patient Survey, of the people who said they had a preferred healthcare professional, 43% said they only got to speak with them 'sometimes'. Nearly a fifth of respondents (18%) said that they 'never' or 'almost never' got to speak with their preferred healthcare professional.

Access to a preferred healthcare professional is unevenly distributed. According to the GP Patient Survey, only 34% of respondents from Black/African/Caribbean/Black British, and 35% of Asian/Asian British respondents got to see their preferred healthcare professional 'always', 'almost always', or 'a lot of the time', compared with 42% of White respondents (figure 1). There is also a socio-economic difference, with 43% of those living in the least deprived areas being able to see their preferred professional 'always', 'almost always', or 'a lot of the time', compared with 36% of respondents in the most deprived areas.

Figure 1: **How often do you get to see or speak to your preferred healthcare professional when you ask to? (by ethnic group)**



Source: 2025 GP Patient Survey

These discrepancies are more concerning given the results of a survey carried out by the NHS Race and Health Observatory. This found "a worrying lack of trust amongst people of certain ethnic minority groups of the service or care that they receive", with 51% of participants reporting some form of discrimination. This included alarming rates of racial or ethnic discrimination, with 38% of Asian participants and 49% of Black participants reporting that primary care providers treat them differently due to their ethnicity. The report also showed that, compared with White British patients, people in ethnic minority groups reported worse experiences in their communication with their GP practice and felt they were taken less seriously.[5]

Communication

There are also issues in the co-ordination between GP practices and other healthcare services. People have shared their experiences of problems when accessing other health and care services through their local GP, for example issues with referrals, incomplete or inaccurate information, or delays in actioning recommendations. This disconnection may represent a particular risk for some people, as those who are most vulnerable may fall between the cracks or experience additional delays in getting the care they need.

Managing conditions and assessing needs

We have seen through our inspections that GP practices do not always manage long-term conditions in line with guidance. For example, we served a Warning Notice to a practice in 2024, as we were not assured that the service was operating an effective system to ensure that patients received necessary and timely monitoring, blood tests, and medication reviews across a range of medical conditions.

Assessing needs – a good GP practice

We rated a GP practice as good overall and outstanding for our assessment of the caring aspect of its service. Staff worked with other healthcare professionals to assess people's needs and deliver co-ordinated packages of care. The practice also worked with specialist services to review patients with long-term conditions, to improve their care and treatment and increase learning among the clinical team.

Staff and leaders in the practice were aware of the needs of the local community. They used registers to identify people with specific needs (for example, people with a learning disability, mental health condition, long-term condition, palliative care needs, and carers), enabling them to assess and manage people's care requirements appropriately. For example, to support patients with a learning disability, small group sessions were held to provide tailored information about breast screening. The service also worked with the LGBTQ+ community, asylum seekers, travellers, carers and young carers to identify and meet their individual needs.

By working both collaboratively with other services and independently, the practice set up and ran a heart failure clinic, and in 2023/24, 602 patients were assessed. This localised service helped to reduce the impact on secondary care.

(Taken from CQC inspection report)

How does access to a GP affect other parts of the system?

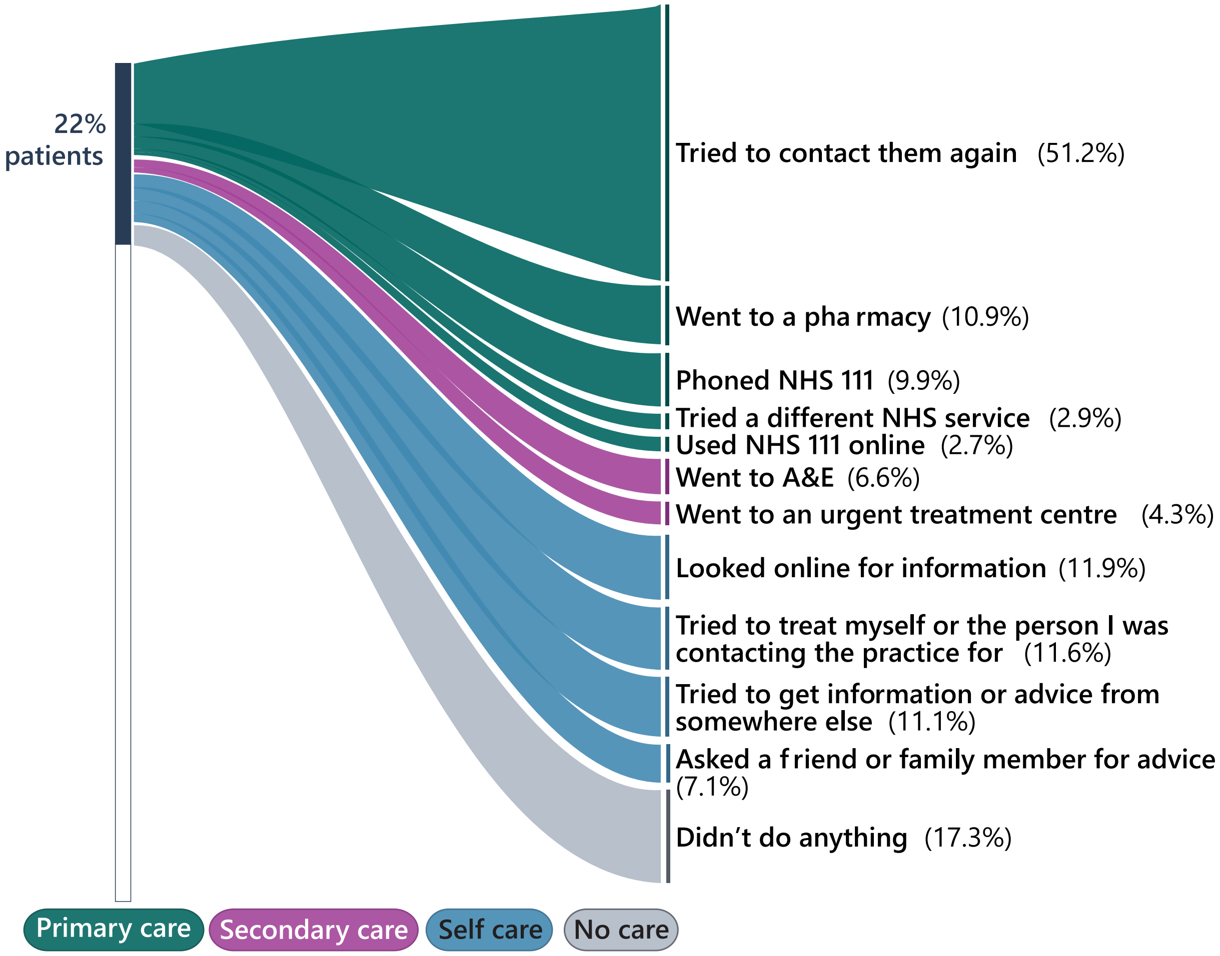
Primary care is a vital element of the government's 10-year plan to transform the NHS, which includes shifting care from hospital to the community. But rising demand and access challenges, together with pressure on the workforce, raises questions as to whether the sector is sufficiently equipped to support the delivery of care closer to home.

When people's needs are not being met by their GP practice (such as those who face barriers to accessing GP services, as outlined above) it can lead to pressure on other parts of the health and care system, as people might seek care or treatment elsewhere.

Findings from the 2025 GP Patient Survey show that around 1 in 5 patients (22%) said they could not contact their GP practice or did not know what the next step would be at their last GP contact. While most of these patients went on to seek further care or treatment from primary care, just over 1 in 15 went to A&E (6.6%) and just under 1 in 20 (4%) went to an urgent treatment centre (figure 2).

Looking at this from a socio-economic perspective, the proportion of people who went to A&E because they could not contact their GP or did not know what the next step would be was 4 percentage points higher for people living in deprived areas (8%), compared with people in the least deprived areas (4%).

Figure 2: **A breakdown of the 22% of patients who couldn't contact their GP practice or did not know what the next step would be after contact, showing their actions**



Source: 2025 GP Patient Survey. Please note this is a multiple choice question so percentages may not add up to 100.

Variation in patterns of access and demand reinforces the need for local systems to understand and engage with local communities to develop solutions that deliver proactive and person-centred community-based care. This could help local systems ensure that people receive appropriate advice and support on where to go and how to navigate access to primary and secondary services. It could also reduce the risk that some people might simply stop trying to get the care they need, which would therefore reduce health inequalities.

Community-focused health and wellbeing services with a focus on prevention

In line with the aim of the NHS 10 Year Health Plan to expand neighbourhood health services, a community hub has been established in the Cambridgeshire & Peterborough Integrated Care System. The hub aims to provide community-focused health and wellbeing services with a focus on prevention, enabling GP practices to deliver more appointments and new services in an accessible, less clinical setting. Medical services include blood tests, physiotherapy, pharmacy consultations, asthma checks, cervical screening, and psychiatric assessments.

Non-clinical services include dementia support, sexual violence counselling and relationship breakdown support. The hub also provides financial advice and social events, as well as a community library and café. The service has received a high level of patient satisfaction, with 85% of respondents rating services as ‘very good’. The service also has a 1% ‘did not attend’ rate, which is considerably lower than the national average (4.5%).

Source: Nuffield Trust

Dental care – access and experiences

Adults

In last year’s State of Care report, we highlighted how people were struggling to access NHS dentistry. These struggles appear to have persisted, and we continue to see variation in people’s access to services and their experience of dental care.

The 2025 GP Patient Survey also asks questions about dental care. It found that just under half (49%) of respondents had not tried to get an NHS dental appointment in the last 2 years or had never tried to get an NHS dental appointment. When asked why, of those that had tried to get an appointment, just over a quarter (26%) said that they did not think they could get an NHS dental appointment, suggesting a lack of confidence in accessing these services.

Similarly, a Healthwatch England poll from September 2024 found that, of those unable to get an NHS dental appointment in the last 2 years, just under a quarter (24%) said this was because they were not on an NHS dentist list and could not find an NHS dentist that was accepting new patients.[6]

When we consider data on NHS dental provision we see that, as at November 2024, only 2 in 5 (39%) adults had seen an NHS dentist in the last 24 months and, in some integrated care system (ICS) areas, figures were as low as 1 in 3 (27%).

The dental activity delivery rate is a key measure of performance and delivery of NHS dental services. This shows more notable geographic variation – varying by more than double when we look at extremes of performance. This indicator enables us to see how much of the commissioned NHS dental work that dentists in a geographic area have delivered.

Dental practices in the top-performing ICS delivered 97% of their contracted units of dental activity in 2023/24, compared with 48% in the lowest-performing ICS.

At a national level, NHS Dental Statistics published August 2025 show that there was a 4% increase in courses of dental treatment delivered in 2024/25 (compared with 2023/24). Additionally, the total units of dental activity completed in 2024/25 showed a marginal increase (up 1% compared with the previous year). However, this still remains 8% lower than the total units completed in 2019/20, which shows that the dental sector has not recovered to pre-COVID pandemic rates of completed dental activity.

Our analysis of data on dental provision and activity also indicated a link between performance and whether an area can be classified as urban or rural. We saw that ICS areas with the highest proportion of contracted units of dental activity completed and those with the highest proportion of adults who have seen an NHS dentist tended to have a more urban composition than those with the lowest, which tended to be more rural.

Efforts to improve equity in dental access for those in rural areas were reflected in the NHS dentistry recovery plan, which was introduced in 2024 and ended in March 2025. As well as initiatives to address workforce issues, the plan introduced incentives to dentists to practise in areas where NHS dental provision was particularly low (often referred to as ‘dental deserts’).[7]

Inequalities in access to dental care are reflected in people’s experiences, as shared with us through our Give feedback on care service. When looking specifically at feedback from people who are entitled to free NHS dental care, we see people reporting difficulties in registering for NHS care in their local area and being unable to access timely appointments for routine NHS care. For example:

> *“I am currently pregnant and now left without a dentist. There are no dentists in my region or even the next which are taking on new NHS patients.”*

Access to NHS emergency care also emerged as a concern. People told us about issues they experienced when contacting NHS 111 for dental problems. This included being directed to dental practices with no available NHS appointments.

> *"I am living daily in pain, as NHS 111 service gives you numbers to dentists who don't have appointments or don't have NHS dentists either."*

We also saw descriptions of appointment 'gatekeeping' when accessing emergency care. For example, being told they could access urgent care sooner on a private basis than through the NHS.

A personal story – difficulties in finding the right dentist

Richard looks after his uncle Ray who has chronic anxiety about visiting a dentist. Richard books the appointment and attends with Ray.

Ray has been in discomfort and pain, has had difficulty eating and has not wanted to smile. This means he wants to be seen quickly, as waiting is "traumatic" and "frustrating".

Richard has struggled to find a good dentist with short waiting times, which has left Ray in pain for months. Richard has tried lots of different NHS dentists and has considered using private dentists. He feels that there's a lack of information on dental provision, which means he's had to rely on user reviews and word of mouth to find dentists. Then when they arrive at the service, they are often disappointed. There is nothing there to make Ray feel relaxed, staff show no empathy or make an effort to help him with his fear. This makes him feel judged and not cared for.

(Interview with a member of the public)

ICS areas are tackling healthcare inequalities in response to issues with access to dental care. For example, Suffolk and North East Essex Integrated Care Board has shared how it has approached making routine and urgent NHS dental care available to all through its dental commissioning strategy. This included establishing recruitment and retention packages to improve workforce availability, establishing a mobile dental clinic to target areas of greatest need, prioritising access for groups of people who are more vulnerable (including those in the Core20PLUS5 groups), and commissioning additional services to allow more NHS appointments to be made in the evenings, at weekends and on bank holidays.[8]

Once they can access dental care, many people are positive about their experience of dental services.

The 2025 GP Patient Survey found that almost 3 in 4 people had a good experience of NHS dental services (71%). Similarly, Healthwatch data for September 2024 suggests that over 4 in 5 people seen by an NHS dentist felt that their dentist put them at ease (82%) and treated them with respect (85%).

This satisfaction is also reflected in much of what we hear about dental services from people sharing positive experiences of care and treatment through Give feedback on care. Our analysis of a sample of feedback highlighted some key characteristics of good patient-reported experience, such as:

- ease of booking appointments, particularly timely access to emergency care and flexibility around appointment times
- positive interactions with kind, professional and reassuring staff, with a focus on the patient feeling informed and at ease
- clear and concise communication around treatment options, including information about costs, the risks and benefits of treatment and the nature of the procedure
- adequate time to ask questions and interact with clinical staff
- good pain management when undergoing treatment, including good communication and an empathetic approach from staff.

Feeling informed and at ease was highlighted as particularly important for those with complex needs, older or frail people, and children and young people. There was evidence to suggest that positive interactions with welcoming and empathetic staff can support people to overcome anxieties around dental treatment.

> *"I am so lucky to have found a fantastic practice that is so caring. My dentist and staff make me feel so comfortable and are very welcoming. They discuss everything with me. I was so nervous when I first came, but the reassurance has truly helped me. They are always there to help."*

But we know that this isn't the case for everyone, and we see evidence of inequalities beyond issues of access to dentistry. The 2025 GP Patient Survey found that people living in the most deprived areas were less likely to describe their experience as good (67% compared with 75% in the least deprived areas). We also see variation in experience by ethnicity. For example, of the people who described their experience of access to an NHS dental service as good:

- 72% of people were from a White ethnic background
- 69% of people were from a Black African/Caribbean or a Black British background
- 65% of people were from an Asian/Asian British background.

Children and young people

Mirroring the adult population, the issues facing children and young people in accessing NHS dentistry have persisted. Dentistry data in England show that the overall proportion of children accessing NHS dentists has improved marginally, from 55% in 2023/24 to 57% in 2024/25.

However, again, performance varies across ICS areas. As at November 2024, in the poorest performing ICS area, as few as 40% of children (aged under 18) saw an NHS dentist in the last 12 months. Whereas in the highest performing ICS area, this figure was 65%. These findings point to persistent challenges with access to NHS dentistry for children and young people, as well as inequalities in access to NHS dentists across the country.

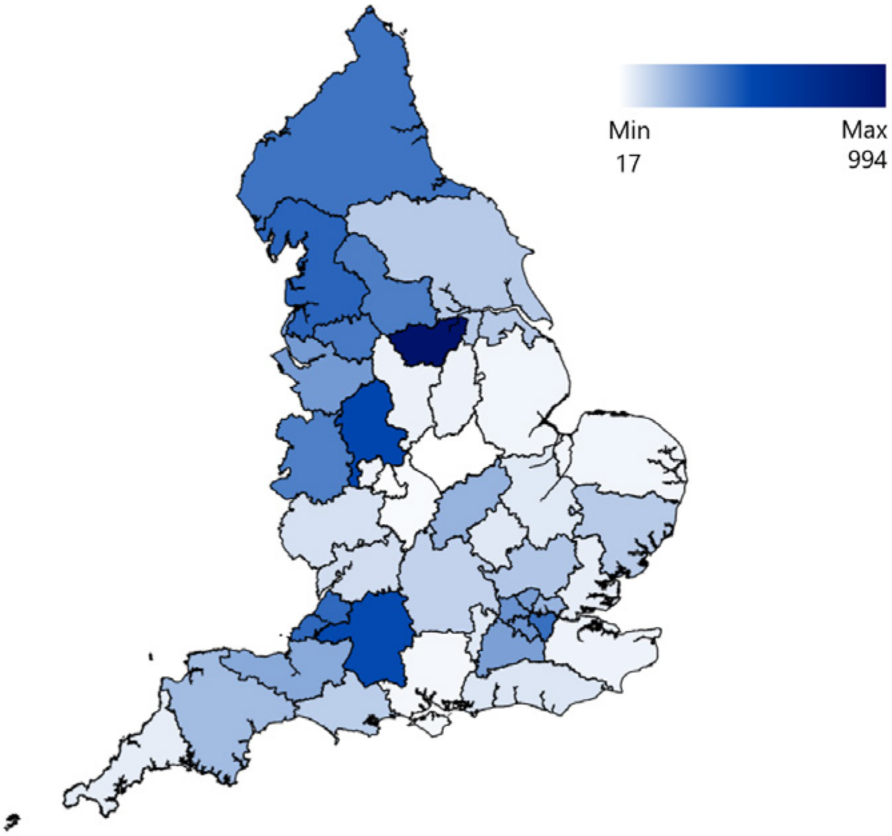
Through our Give feedback on care service, we hear from parents and carers that getting an NHS appointment for their child or young person can be challenging, and this can be compounded by the practice of de-registration, where a patient is removed from the practice list following gaps in attendance and/or missed or cancelled appointments due to factors including illness. When they have been de-registered, patients reported struggling to access alternative NHS dental services. A lack of communication between practices and patients about de-registration was also prevalent in feedback shared:

> *“They de-registered my children before COVID! I’ve requested numerous times for my children to be registered and got nothing but excuses! My children have waited years to see a dentist. It’s appalling.”*

This concern speaks to an overall confusion about people’s rights to registration. For example, according to research from Healthwatch England, over two-thirds (68%) of respondents mistakenly believe they have the right to register with an NHS dentist in the same way they do with an NHS GP.[9]

In the context of concerns around access to routine and preventative dental services for children, data shows geographical variation in the rate of children and young people who are admitted to hospital for tooth extractions due to tooth decay per 100,000 young people under 19 years, as measured by finished consultant episodes. At the extremes, one ICS had a rate of 994 per 100,000 young people under 19 years, compared with another ICS at 17 per 100,000 young people under 19 years in 2023/24 (figure 3).

Figure 3: **The rate of decay-related tooth extraction episodes per 100,000 young people aged 0 to 19, by integrated care system in 2023/24**



Source: UK Gov HES

Analysis undertaken by the Office for Health Improvement & Disparities also highlights that in 2023/24, the decay-related tooth extraction rate for children and young people living in the most deprived communities was nearly 3.5 times more than for those living in the least deprived communities.[10]

It is good to see this recognised in NHS England's 10 Year Health Plan for England, which states, "Children will be our urgent priority. Tooth extraction is the leading cause of hospital admission among children aged 5 to 9 years old, yet it is almost entirely preventable."[11] Addressing the backlog of tooth extractions in hospital for children is also one of the 5 areas of focus in NHS England's Core20PLUS5, which aims to support the reduction of health inequalities at both national and system level.

District nursing

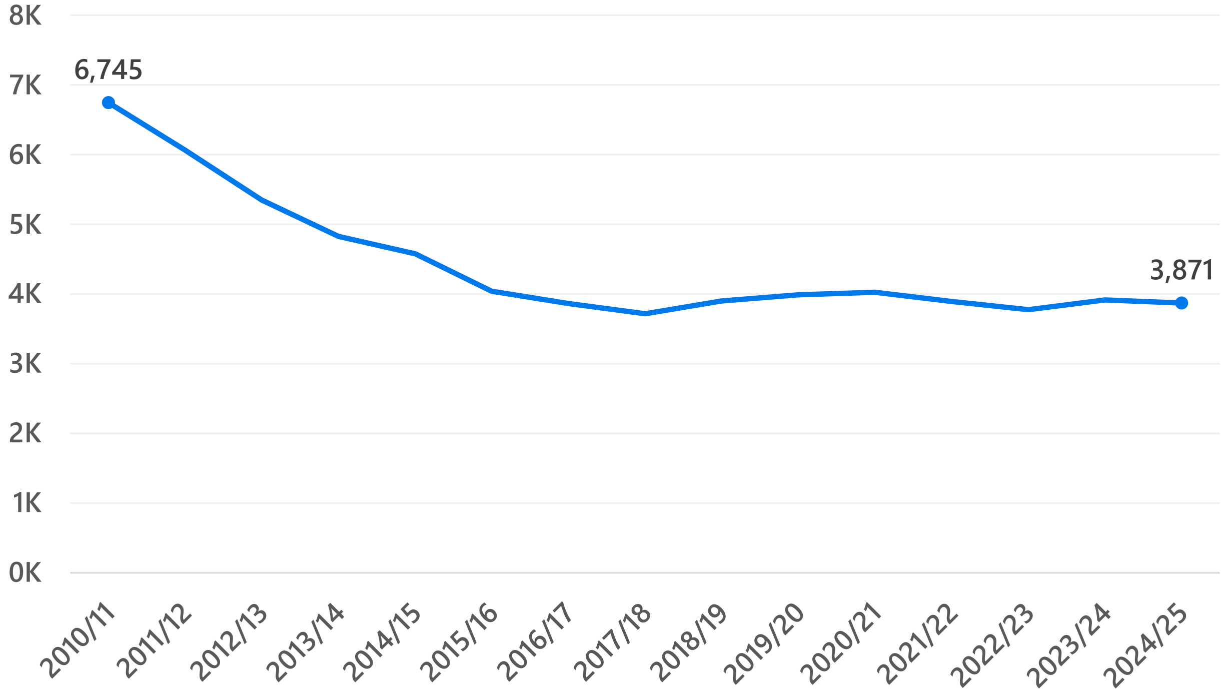
District nursing services deliver a wide range of nursing care to people in their own homes, support people to live more independently, and prevent and treat acute illnesses. Disabled adults, people who are near the end of their life, and older people living with frailty and long-term conditions often need these services.[12] These services can take pressure off secondary care services by preventing admissions to an acute hospital and facilitating earlier hospital discharges. District nursing services are delivered by multi-disciplinary teams, with their core role being the qualified district nurse.

Effective district nursing services are an important part of delivering the government's 10-year plan to transform the NHS – specifically, its aim to shift care from hospital settings into the community.[13]

Data from NHS England shows that the monthly average of full-time equivalent (FTE) level 1 qualified district nurses has fallen from 6,745 in 2010/11 to 3,871 in 2024/25, which is a 43% drop overall (figure 4). Some of this early decline may be influenced by the transfer of some staff to Community Interest Companies (CICs) following the Health and Social Care Act 2012, but there continues to be significant decline since 2012/13.

In the context of an ageing population that relies on this service, this reduction presents a 50% drop in qualified district nurses per 10,000 people aged 65 and over (from 7 in 2011/12 to 3.5 in 2024/25).

Figure 4: **Monthly average FTE level 1 qualified district nurses in England, April 2010 to March 2025**



Source: NHS workforce statistics

Note: this analysis is based on the NHS England officially published workforce statistics and excludes non-level 1 practitioners and staff from non-NHS providers (particularly CICs). The decline from 2011/12 to 2012/13 is influenced by the transfer of some staff to CICs following the Health and Social Care Act 2012.

In addition, the demand for district nursing services is rising. Based on our analysis of a bespoke extract of NHS England Community Services Dataset, the volume of new referrals to district nursing services for people aged 65 and over has risen by 28% between 2021/22 and 2024/25 (from nearly 2.7 million to just over 3.4 million). If we also include the growth in closely associated Crisis Response Intermediate Care services (which include other professions but rely on district nursing staff for short-term reactive care), the volume of new referrals has increased by 50%. The monthly average of FTE qualified district nurses has reduced slightly in this period, falling by 3%.

This increase in demand is reflected in the results of a 2023 national survey of District Nurse Team Leaders from the Queen's Institute of Community Nursing, with over 1,500 UK staff responding. The number of team leaders who reported a team caseload of over 600 cases increased from 12% in 2019 to 16% in 2023, while those reporting a team caseload of under 200 cases decreased from 32% to 28%.[14]

Findings from the 2024 NHS Staff Survey reflect the impact of the increased demand for district nursing services on workloads, with only 40% of district and community nursing staff reporting that they could meet all the conflicting demands on their time at work, compared with 47% of all respondents. Also, 71% of district and community nurses reported doing unpaid overtime compared with 58% for registered nursing overall and 50% for all respondents.

The survey from the Queen's Institute of Community Nursing also showed that the district nursing workforce was struggling to meet all the demands placed on it, with 32% of respondents saying they delay or defer visits every day, and 90% saying they do this at least once a week.

Clearly, this is having an impact on the people who use these services. When the survey asked district nurse team leaders which aspects of patient care were not undertaken to a satisfactory professional standard:

- 43% said psychological care and support
- 39% said assessments
- 31% said continence care.

Team leaders commented that the lack of time and resources were driving their services to focus on task-orientated care rather than holistic care for their patients – especially regarding their emotional and social needs. This sentiment is also fed back from nurses contributing to a 2025 report by the Commission on Palliative and End-of-Life Care, another service largely delivered by district nursing.[15]

Exploratory analysis has shown that there is a relationship between the year-on-year decline in provision of qualified district nursing and acute hospital re-admission rates for people aged 65 and over (from 2013/14 to 2023/24).

During our inspections of community healthcare services, we have noted the risks of services taking on too many referrals. For example, we found that one provider of district nursing services had created lists for people who were prioritised for visits into either a ‘red’ (or ‘critical’) list or a ‘deferred’ list of people who were lower priority. Some people spent many days on the ‘deferred’ list but ended up on the ‘red’ list as their health had deteriorated. We also observed additional problems in relation to a shortage of qualified district nurses.

The shortage of qualified district nurses is partly a result of many years of insufficient recruitment of trainees. Our analysis of NHS electronic staff record data shows that total annual numbers of new trainees are rarely more than half the number of staff leaving the profession. The government announced an ambition to expand centrally-funded places for district nursing trainees by 150% by 2031/32 in the NHS Long Term Workforce Plan, but it remains to be seen whether this will have a sufficient impact on the supply of this vital staff group.

Use of artificial intelligence (AI) in general practice

In the NHS 10 Year Health Plan, harnessing the advances in artificial intelligence is seen as one of the core elements of shifting care from analogue to digital. We carried out some work to find out the views of key stakeholders on the use of artificial intelligence (AI) in general practice. By speaking with GPs, patients, commissioners, healthcare providers and professionals, and AI organisations and developers, we gathered insights from over 30 organisations to inform our regulatory approach to AI in general practice.

We published guidance for providers on the use of artificial intelligence (AI) in GP services, and the Equality and Human Rights Commission has also published guidance to help public sector bodies embed equality considerations regarding the use of AI.[16]

Views of the public

In March 2025, we surveyed 2,000 members of the public who had visited their GP in the last year. A large majority (nearly 9 in 10) of respondents are at least somewhat familiar with the term ‘AI’.

However, more respondents expressed negative feelings (47%) towards AI than positive (35%), and 19% were unsure – signalling mixed sentiment.

People had very different thoughts on a GP specifically using AI to support clinical decision-making, with 41% feeling positive and 42% feeling negative about AI supporting clinical decisions.

Respondents were most concerned about:

- AI making errors (83%)
- staff being over-reliant on AI (82%)
- loss of human connection (81%)
- data protection and security (69%).

However, people felt there is potential for AI to improve access to a GP, as 41% believe AI would make it easier to get an appointment, and 40% felt it would reduce waiting times for treatment.

Only 27% of respondents thought the use of AI by GPs will make their care better, with 41% unsure.

Views of GPs

We also surveyed GPs in April 2025 to find out their views and experiences of using AI. We received 156 responses from GPs across England so, although not representative, this sample provides some indicative insights.

When asked whether their practice was currently using AI:

- 42% said ‘yes’
- 31% said ‘no’
- 27% said ‘no, but we’re currently looking into adopting AI’.

Respondents said the most common use of AI was for administrative purposes, such as note-taking, triage and appointment scheduling, and the key motivation to adopt AI is to help improve efficiency and reduce administrative burden (93%), followed by improving the quality of care for patients (76%). One respondent summed this up by saying:

> *“AI does not replace the relationship between a patient and their GP. When AI is used right, it should make space for more human connection, not less, by taking away the busy work so clinicians can focus more on people.”*

Over four-fifths (81%) of GPs thought that AI will have a positive impact on GPs in the next 5 years. However, nearly half (46%) were unsure if AI would improve health inequalities.

The main barriers that limited adoption of AI in general practices were:

- lack of funding (73%)
- unclear regulatory requirements (69%)
- concerns over professional responsibility or liability (66%).

When asked how practices monitor AI, by far the most common answer was ‘There is no formal monitoring in place’. The majority of respondents (81%) said that a national AI safety checklist or framework would help improve oversight of safety, as the following point highlights:

> *“It feels inevitable. As GPs, we are being asked to achieve more and more with less and less resource, and so AI is likely to be able to perform some tasks for us. I am, however, deeply worried about how it will be governed. I can foresee a future where I have no option but to adopt AI based GP software, but am then held liable for its errors.”*

Adult social care

Key findings

- Demand for local authority-funded social care support continued to rise – new requests for care were 4% higher in 2023/24 compared with the previous year, and 8% higher than in 2019/20.
- While the majority of these requests (68%) are from older people, there has been a large growth in demand for support from working-age adults. Requests from working-age adults per 100,000 population were 14% higher in 2023/24 than in 2019/20, while requests per 100,000 population increased by less than 1% for older people over the same period.
- The proportion of older people receiving local authority-funded long-term social care has fallen over the last 20 years from 8.2% to 3.6%. Local authorities with a larger older population have lower rates of access to this care.
- Vacancy and turnover rates for staff across adult social care have continued to fall. However, vacancy rates in adult social care are 3 times higher than those in the wider job market, and worse for homecare than for care homes.
- We are hearing how adult social care workers are leaving the sector due to being overworked and undervalued – people working in care homes and their families are twice as likely to live in poverty as the average UK worker.
- The growth in international recruitment has declined rapidly from late 2023. Given the sector's reliance on overseas workers, the announcement that new care worker visas would end causes concern, as there is a risk of the sector returning to the workforce pressures that peaked in the aftermath of the pandemic.
- The number of homecare services has increased by 11% in the last year, but our data suggests that sustainable growth may be limited due to rising costs and growth in the number of very small services that may be less financially resilient.
- Lack of capacity in social care services, as well as delays completing transfer plans to social care, accounted for 23% of delayed discharges of people who had been in an acute hospital for 14 days or longer in March 2025. However, more delays were linked with accessing rehabilitation, reablement and recovery services (26%). Although these services may be delivered within social care settings, they are also often provided in community hospitals and specialised facilities.

Demand for adult social care

Analysis of NHS England data shows that the demand for local authority-funded social care support continued to rise in 2023/24. New requests for adult social care were 4% higher in 2023/24 compared with the previous year, and 8% higher than in 2019/20.

While older people still make up the majority (68%) of requests for local authority-funded social care support, there has been a large growth in demand for support from working-age adults in recent years. The rate of requests for support from older people per 100,000 population was less than 1% higher in 2023/24 than it was in 2019/20. However, the rate of requests from working-age adults increased by over 14% in this period, equivalent to nearly 100,000 additional requests for adult social care from adults of working age.

The King's Fund partly attributes this increase to more disability among working-age adults, with 23% reporting a disability in 2022/23, compared with 16% in 2012/13 (with mental health the most prevalent impairment among this age group).[17]

The proportion of requests that were met by providing long-term care or a package of short-term care designed to maximise independence has also increased slightly in the latest year's data, from 20.7% in 2022/23 to 21.4% in 2023/24. However, working-age adults are less likely to be supported by this type of provision. In 2023/24, around a quarter (26%) of new requests for support from people aged 65 and over were met with long-term care or a package of short-term care designed to maximise independence, but only just over 1 in 10 (11%) new requests for support from adults aged 18 to 64 received this form of support.

The data also shows a recent increase in requests for social care from working-age adults who were subsequently advised to contact universal services (which includes GPs, community health services and voluntary and community groups) or other services: 35% of new requests from this age group were directed in this way in 2022/23, increasing to 37% in 2023/24. Although people can be supported well without formal social care services, it is important that the right care is given to those who need it.

A personal story – navigating the highs and lows of care at home

Susan has a number of long-term health conditions and uses a wheelchair. After an operation to amputate one of her legs, her occupational therapist told her that she would be able to qualify for care support. This was only mentioned as her husband was worried about her when he went off to his full-time job.

After an intrusive assessment process, Susan was allocated 7 hours of care support a week to cover personal care, meal preparation and some tidying.

Susan described her first care worker as “amazing”. They got on very well and she attended when she said she would and for the full length of time. Susan’s quality of life improved and her husband was happy that she was safe and well cared for when he was at work. Sadly, the carer ended up leaving to go back home to her birth country.

After a period when she was supported by her husband, Susan was then given a good agency carer for a year, so she was devastated when that ended. She ended up with a new agency that she described as “a nightmare”. Care staff were not turning up when they said they would and were not staying for the 2 hours they were meant to. They would arrive at 4pm and try to put Susan to bed.

One of the carers was rude to Susan, and said personal comments like “Oh, having a lazy day”. As Susan suffers from chronic fatigue, she felt insulted and unsafe. She complained to social services who told her to cancel the agency. Again, she was left with nothing. Her social worker advised her that she wouldn’t get the hours she’d had as it’s not “cost effective”, and that she needed to rely more on family and friends.

Susan’s lack of care started to affect her husband’s mental health. He was carrying the load, working full time and supporting her.

Susan thinks navigating the system is so complicated – “No-one explains to you how it all works”. Susan always feels like she is being a pest. And she is in debt. All Susan wants is a care worker that is reliable, understands her health conditions and needs, and has a caring nature

(Interview with a member of the public)

Although we note these recent differences between the level of demand and provision of support for working-age people compared with older people, there has been a longer-term trend of reducing access to publicly-funded social care, particularly for older people.

Analysis published by the Institute for Government shows that the proportion of older people receiving council-funded long-term social care has reduced over the last 20 years from 8.2% of the population in 2003/04 to 3.6% in 2023/24.[18] This analysis also shows that geographical variation in older people’s access to local authority-funded social care is not only tied to levels of deprivation, prevalence of disability or by how many older people live alone, but also by the size of the older population in the area. Local authorities with a larger older population have lower rates of access to publicly-funded long-term social care.

Adult social care workforce and capacity

Staffing capacity

Overall, staff vacancy levels are reducing across the adult social care sector. Estimates from Skills for Care show that vacancy rates across adult social care have fallen back in line to where they were before the COVID-19 pandemic (7%) and turnover levels have also reduced.

Every year, we collect information from registered adult social care providers through our provider information return. Data for care homes shows that staff vacancies have continued to reduce throughout 2024/25, with the vacancy rate just under 5%. This is around half the rate recorded in 2021/22 (10%). The turnover rate for staff in care homes is now 25%, which is 8 percentage points lower than in 2021/22.

While this has improved, vacancy rates in adult social care remain higher than in the wider job market, and Skills for Care's data highlights that in March 2025, vacancy rates in homecare were just over 10%, which is more than double that of care homes.

The improvements in rates of vacancies and turnover of social care staff follows a period of increased international recruitment, which has helped ease staffing pressures. However, recent policy changes, such as restrictions on overseas recruitment and the cessation of new care worker visa applications, pose challenges to sustaining this progress, as we describe below.

We have heard through our local authority assurance assessments that there are still delays for some people in getting access to care due to shortages of homecare staff and shortages in the workforce delivering reablement services. Pressures around staff shortages are also reflected in the ADASS Spring Survey 2025, which found that 55% of directors of adult social services were 'quite' or 'extremely concerned' about increased costs due to the high level of vacancies in the adult social care workforce for older people.[19]

People told our Experts by Experience that they were noticing how care workers are leaving the sector due to being overworked and undervalued:

> *"I think it all comes down to salary, the wages, the minimum wage. It's a really hard job. They've got so many different things to remember. Like one person might be blind, the next person might have paraplegia, the next person dementia, so that it's very difficult for someone who's getting £12.50 an hour who might only have a half an hour call to have the skills to look after your mum and your dad, your auntie."*
>
> (CQC Expert by Experience)

We commissioned research on workforce equality in health and social care, which highlights how discrimination in the workplace can affect staff wellbeing, capacity and delivery of care.[20] This work found that nearly a third (32%) of the 130 adult social care workers who responded to the survey had experienced or witnessed race or ethnicity-based discrimination at work. Over 80% of these staff said this affected their working environment and relationships at work, while more than 40% said this affected the quality of care provided to people using services. The individual attitudes of leaders and managers was noted as the biggest contextual factor behind inequalities in adult social care services.

Example of valuing adult social care staff

Working in adult social care can be rewarding and satisfying. In a care home that we rated as outstanding, we found that staff at all levels were extremely proud of the work they do, and they genuinely aimed to have a positive impact on the lives of the people they cared for. One member of staff told us, “This is my first job as a carer – I love it. We are all family here – the staff, the residents, even our management team. It feels like a home.” This was reflected in the results of the provider’s staff satisfaction survey, with 95% of staff stating they were proud of the job they did, felt valued by their manager and supported by the team as a whole, and enjoyed their roles.

Staff validated an ongoing culture of learning and improvement in the service. The registered manager told us, “For me it’s about training. It’s the basis of everything so staff understand why we do things. We often talk to staff about what motivates them to work in care. We all want to keep improving.”

As an example, dementia champions had been trained to observe care, provide feedback to colleagues, and support the development of care plans. This had been instrumental in reducing people’s anxiety and periods of distress.

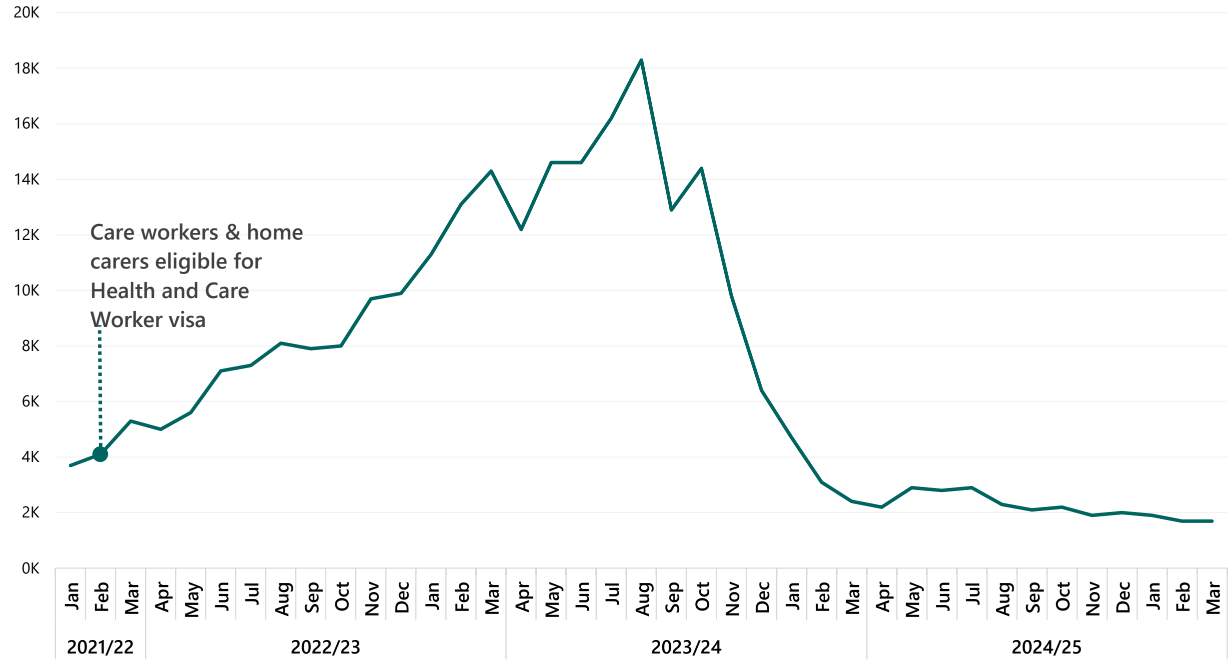
International recruitment

In February 2022, a change in policy enabled care home and homecare workers to be added to the government’s Shortage Occupation List visa route. Subsequently, applications for the Health and Care Worker visa rose steadily, peaking at 18,300 in August 2023 – a 395% increase from January 2022.

However, from late 2023, the volume of applications declined sharply. This was likely due to more scrutiny applied by the Home Office to employers in the health and social care sector, and compliance activity taken against employers of migrant workers. Further reductions in applications followed after new policy measures were introduced, including restrictions on the eligibility of dependants, higher qualifying salary thresholds and increases in visa sponsorship fees.

By March 2024, the number of monthly applications had reduced to 2,400 and a year later it was even lower at 1,700 (figure 5).

Figure 5: **Health and care worker visa applications, January 2022 to April 2025**



Source: Adapted from Home Office: Monthly entry clearance visa applications, March 2025

This pattern in visa applications is reflected in Skills for Care's 2024/25 report on the size and structure of the adult social care workforce. This shows that international recruitment into adult social care has more than halved, falling from 105,000 recruits in 2023/24 to around 50,000 in 2024/25.

In May 2025, the government announced it would end overseas recruitment for new care workers, citing concerns over the abuse and exploitation of migrant workers. Given the sector's reliance on overseas workers, the change in policy causes concern, as it could result in reduced staffing levels.

In our statutory Market Oversight scheme, we assess the financial sustainability of care providers that have a large local or regional presence, which local authorities could find difficult to replace if they fail and become unable to carry on delivering a service. Providers of care homes for older people in the scheme have told us that services in some regions have relied heavily on staff recruited from overseas to reduce their staff vacancy rate and reliance on agency staff. If these overseas workers leave and cannot be replaced by domestic workers, there is risk of a return to the social care workforce pressures that peaked in the aftermath of the pandemic, limiting the delivery of care and having wide-reaching impacts for the health and care sector.

The impact of staffing issues on people's experiences

Even as the overall trend for staff turnover and vacancy rates is improving, our inspectors continue to hear the challenges around recruitment and retention of staff, with providers reporting high numbers of staff vacancies and citing low pay and an increased cost of living as the main contributing factors.

People who use adult social care services tell us about the impact on them when they experience issues with staffing. For example, in our focus groups with CQC Experts by Experience, we heard how staff turnover can lead to uncertainty for people receiving homecare:

> *"One man said to me, 'I don't know who's coming through the door, and if that's in your own home and you've got strangers turning up all of the time, it's not very nice for you'."*

People also told our Experts that they often receive rushed care, or that care workers are late due to staffing pressures. This could affect their health, wellbeing, dignity, and independence in different ways, for example if they do not:

- get people up, washed and dressed
- give people their medicine on time
- have enough time to talk to people, to benefit their overall wellbeing
- supervise mealtimes
- tidy up after themselves.

Issues with staffing are also highlighted in our inspections of care homes. For example, we inspected a care home in response to concerns regarding the safety and quality of care, where people and their relatives told us that there were not enough staff. One person told us, *"Staff don't get time to sit and chat… I get lonely."* Staff at the service also told us that they needed longer to get to know people, and understand each person's needs, with new staff having only *"3 days training and then they are thrown into a shift."*

In this inspection, we also found that processes to ensure there were enough competent staff on duty were not always effective, and staffing was not reviewed following incidents of concern or falls to ensure that staffing levels were at the required level. After our inspection, we took urgent action to prevent the provider from taking further care packages without our agreement. As well as rating the service as inadequate, we placed it in special measures, which means we will keep it under close review to ensure people are safe while sufficient improvements are made.

By comparison, an inspection in 2024 of a homecare agency found that it fostered a culture of learning, improvement, and innovation to make sure its staff were trained well to meet people's needs. The service used a 'Time off to train policy' for professional development, which had a positive impact on staff and people. For example, one member of staff said they had completed a chiropody and foot care course and had shared their new-found knowledge with colleagues and people using the service. In another example, an outstanding supported living service for autistic people and people with a learning disability introduced quick response (also known as QR) codes, which enabled staff to access short information videos to promote learning.

Example of improved governance

With the right intervention and commitment, failing services can improve. One care home improved from a rating of requires improvement to outstanding, partly by improving its governance.

On the previous inspection, we found there were no systems and processes to assess, monitor, and improve the quality and safety of care, and to maintain accurate and complete records. Care records were not always documented or kept up-to-date on aspects of care such as repositioning or nutrition, which is in breach of the regulation relating to governance. Although the provider's monthly audit of infection control showed compliance in all aspects, we found concerns in this area.

But at our next inspection, the service was no longer in breach of the regulation as it had made improvements and embedded the appropriate governance systems. The registered manager carried out daily, weekly, and monthly checks to monitor and improve all aspects of people's care. This included ensuring that the information about people's needs was accurate and up-to-date, and that action plans were discussed with staff. The service had also developed a strong focus on continuous learning, innovation, and improvement across the organisation and local system. For example, they were working closely with the National Institute for Health and Care Research to improve the time taken to discharge people from hospitals.

Supporting staff to support people – outstanding leadership and culture

We inspected a care home for people with dementia and age-related frailties towards the end of 2024, which we rated as outstanding. Contributing to this rating was excellent leadership, which nurtured a very positive culture and ensured the staff team embraced their roles, and consistently prioritised people's individual needs and preferences.

They did this partly by matching the approaches, skills, and strengths of staff to people's individual needs.

Leaders promoted an inclusive environment where staff were encouraged to raise their viewpoints on the delivery of care and management practices, and suggest improvements. For instance, a member of staff directly highlighted the staffing challenges in a particular area of the home to senior leaders. In response, leaders conducted a thorough review and analysis, ultimately increasing staffing levels to address the issue.

The home had robust polices that promoted best practice related to workplace equality, inclusion, and diversity, and staff at all levels were accountable for preventing bullying and harassment. One member of staff had acted in a way that could have affected a colleague's personal and cultural needs, so they were invited to participate in constructive discussions about their behaviour, with a focus on teamwork and inclusivity.

Diversity was championed as integral to a positive, inclusive, and high-performing workforce. For example, a member of staff who was undergoing a protected characteristic change received sensitive, tailored support that included meaningful and proactive adjustments to their working pattern. As a result of these leadership adjustments and ongoing support, their performance and wellbeing improved considerably.

We continue to support the work of Skills for Care's Workforce Strategy, which seeks to ensure that, over the next 15 years, there are enough people working in social care who feel valued and have the right training, skills, qualifications, and pay to meet the changing and increasing needs of our population.

Adult social care provision and capacity

Care homes

Although the number of care home beds in services registered with us has remained static over the last year, as a rate per 100,000 population aged 65 and over, the number of beds has reduced by nearly 2%. Additionally, our analysis of information submitted by services through provider information returns shows a steady rise in the proportion of care home beds that are occupied – from 78% in 2021/22 to 84% in 2024/25.

London not only has the fewest care home beds per population aged 65 and over (just over 3,000 per 100,000 population), but the region also continues to show the highest bed occupancy rates in 2024/25, at 87%.

Data from our Market Oversight scheme provides insight into the association between occupancy levels and funding: care homes for older people with a higher proportion of residents receiving local authority-funded care also have higher occupancy levels compared with care homes that have more self-funded residents.

With continued rising costs, local authorities may not only have less funding to provide social care, but also fewer care home spaces available to them. We are concerned that this could leave a reduced range of options for people whose care is funded by a local authority.

Supported living

In our State of Care report for 2022/23, we reported on our collaborative work to drive the improvements needed to change outcomes for people who access supported living services. These can enable adults to live as a tenant in suitable accommodation that is treated as their own home, with the help they need to be independent.

This year, we note that the number of adult social care locations that offer supported living services has increased by nearly a half in the last 2 years from 2,612 locations to 3,823 locations. The greatest increase has come from services offering homecare services alongside supported living.

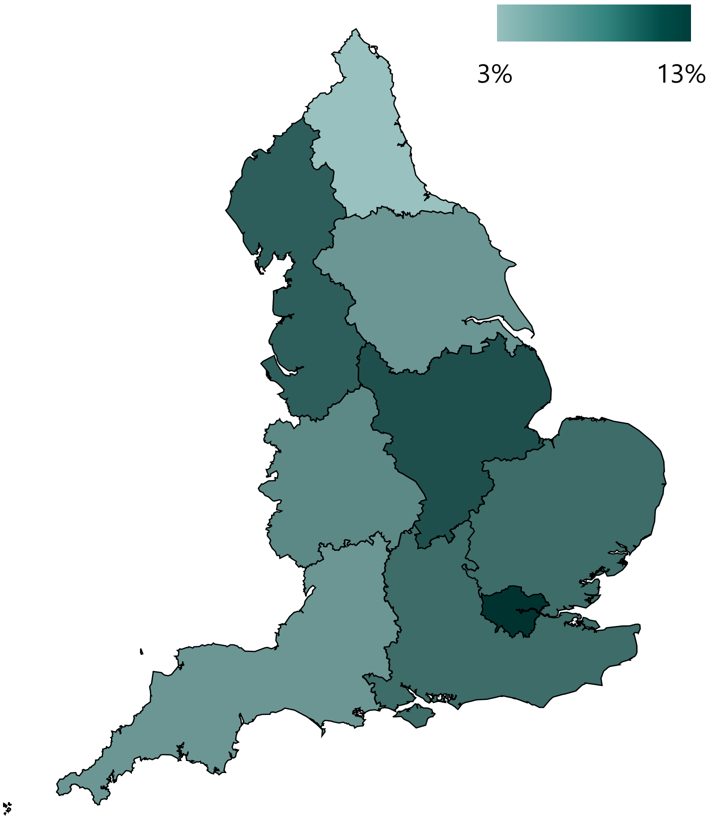
While increased provision in supported living is positive, as it can enable adults to live independently in their own home, we are still concerned about the inconsistent quality raised in our previous report.

Homecare

In the last year, we have seen the number of new homecare services registered with us increase by 11%.

The area with the largest increase in the number of services per 100,000 adults aged 65 and over was London, which saw 13% growth compared with the England average of 9% (figure 6). The North East saw the lowest growth in homecare services, at 3% in the last year, as well as having the fewest homecare services per 100,000 adults aged 65 and over (69 compared with the England average of 116). The change we’ve seen this year has widened the gap in the number of homecare services available for people living in different areas of the country, which may have implications for their choice of service.

Figure 6: **Increases in homecare services in the past year by region**



Source: CQC HSCA Register snapshots as at 9 April 2024 and 1 April 2025

The growth in the homecare market is also reflected in ADASS Spring Survey 2025. It shows the total number of homecare hours delivered between January and March 2025 was over 5% higher than in the same period in 2024, reaching just over 47.5 million hours of care delivered.

These changes reflect the policy shift in local authorities to aim to commission more community services to support more people to stay in their own homes for longer. We are also seeing this policy shift reflected in our work on local authority assurance, with most authorities aiming to commission more community services for this reason.

However, despite this overall increase in the number of registered homecare services and hours of care delivered, we see factors that could limit the growth needed to support the shift towards increasing care in community settings, set out in the government's 10 Year Health Plan for England.

The data we gather to determine our annual fees for providers shows that the volume of the homecare market made up by very small services (providing care to 4 people or fewer) has grown by 7 percentage points in the last 2 years – making up more than 28% of the market in April 2025.

Our concern is that these small providers may be less financially resilient (through a lack of reserves or diversification of services, for example) or may be more likely to come and go from the market, which has implications for people receiving care.

Additionally, using 'EBITDARM', a high-level measure of profit that excludes key expenses such as rent, depreciation and interest charges, our Market Oversight scheme data shows that profitability in homecare providers within the scheme has decreased slightly to 16.2%, and at the end of March 2025 was down nearly 1 percentage point compared with one year earlier.

We analysed data for a subset of homecare providers in the scheme for whom we can make a like-for-like comparison over time (these providers account for 40% of care hours delivered by providers in the scheme). This also shows that the total number of hours of care delivered reduced by just over 3% between the beginning of 2023 and beginning of 2025. This is equivalent to a reduction of over 13,000 hours of care delivered.

Providers in the scheme give various reasons for this reduction – including declining or handing back contracts in the context of rising costs and fees that do not cover these costs. They also say that some local authority commissioning practices are slow to use available capacity, which is being split between more providers.

Spotlight on people's experiences of homecare

Our Experts by Experience have their own lived experiences of care, and regularly speak with people using services as part of our inspections. They told us about some of the implications of limited adult social care provision, as described above, with a focus on homecare.

Living in a rural area can affect the choice of homecare providers available. People have found that when the services are at capacity, alternative options are unavailable so people can become stuck receiving poorer quality care or having no care at all:

> *"The only other agency down the road hasn't got any space for me. Where do you expect me to go? I'm telling you what's wrong and the things I'm not happy with, but I don't feel like I've necessarily got a choice to change that."*
>
> (CQC Expert by Experience)

Due to staff shortages or poor communication, people also experienced a lack of choice when voicing their preference for a care worker of a specific gender. For some, this had implications for their health and wellbeing:

> *“A lady would not let a male give her care or wash her, but was happy for him to take meals. Family asked not to send men, but this had not happened. Sometimes he comes 3 days in a row, so the lady doesn’t wash for 3 days. As she is incontinent, she gets sore and smells; she is therefore ashamed and refuses visitors.”*
>
> (CQC Expert by Experience)

By contrast, a homecare service that provides support to autistic people and people with a learning disability, as well as those living with physical disabilities or sensory needs, was recently rated as outstanding. The inspection report describes how people can be supported to make informed choices.

The service considered people’s strengths, abilities, aspirations, culture, unique backgrounds, and protected equality characteristics. When people were due to move into the service, a detailed, comprehensive transition plan was developed with them and those important to them. One person was extremely anxious about receiving support, as they had not previously received formal support. Staff empowered them by seeking their input into a job description and advertisement for a suitable care worker who could support their specific needs. They were also invited to hold interviews, with the support of senior staff, and as a result found a new member of staff who the registered manager described as a “100% match.” The person’s relative told us:

> *“The relationship is brilliant. They are really good mates. It’s definitely 100% person-centred care. Staff encourage (the person) to also try out new things. Their confidence has really improved in going out and doing things.”*

Our Experts also told us how poorly-organised homecare, and late or missed calls, could have a negative impact on people who are incontinent, with some people sharing that they had been left to sit or lie in soiled or wet clothing for hours while waiting for their care worker to arrive. Delivering care in an untimely way can significantly affect people’s health and dignity, reducing their ability to live independently and comfortably:

> *“One family had an elderly relative who was [cared for in bed], and they had requested certain visit times throughout the day, including one last thing at night and one first thing in the morning because the elderly*

relative needed incontinence pads and couldn't get out of bed by herself. The care company couldn't meet the times for the lady's needs so the family said they'd come in and put her to bed at 4pm and then nobody would visit until 11am, by which time the bed was soaked."

A personal story – issues with homecare visits

Leanna has a care worker who comes 3 or 4 times a week. Although the support is definitely helpful, she says it's not what it was promised to be, as "you never get the allocated time". She has also had her support scaled back over time. She used to have help with physiotherapy, but that stopped. They said she could have someone take her to the shops but that stopped.

Leanna often feels bad for her husband who has to pick everything up – "It makes me feel more like a burden than an equal partner. It makes me feel like I am a shadow rather than my own person."

(Interview with a member of the public)

People and their relatives gave us feedback about a specific homecare agency that provided services for older people, people with dementia, and younger adults with a range of needs, including people with physical disabilities. Although they said that staff were kind and caring, some raised concerns with the agency's leaders that staff were not arriving at the scheduled time or staying for the full duration of the allotted visit.

Our inspection of this service in February 2025 resulted in a change of rating from good to requires improvement. During the inspection, we found that the provider failed to ensure that its management team had effective oversight of the Electronic Call Monitoring system. We found that care staff were logged into different locations simultaneously, showing ineffective oversight of care worker allocation or whether staff were staying at their calls for the right length of time. This placed people at risk of harm. We discussed this with the provider and served a Warning Notice to ensure that it took immediate action.

Conversely, effective care leaders promote a culture of openness and learning. An inspection of a homecare service in London in 2025 resulted in a rating of outstanding. We noted how the provider shared lessons learned with staff through weekly structured online sessions. This gave staff a platform to ask questions and receive advice, which was shared on the provider's intranet for transparent communication. Staff involved in incidents were required to complete a specific reflection exercise to ensure lessons were learned for the future. The provider also shared examples of good practice with staff, including from other services.

Experts by Experience highlighted that continuity of care – including having one consistent care worker – is a key aspect of good homecare. However, they heard that some people do not receive support from one regular care worker, with one person saying they have around "10 different carers come in to support them."

When an individual care worker supports people regularly, they can become 'part of the family', which has a positive impact not just on the person receiving care, but on their families and significant others.

Having the same regular care worker helps people feel safe. They foster a sense of familiarity, which helps people to trust their care. Additionally, regular care workers often know and understand the person who they are visiting, so can more quickly notice when they are unwell:

> *"Regular carers [are] really important because... [they notice] when somebody is not themselves... or they notice something about their skin and act on it."*

Adult social care and the wider system

Causes of delayed discharges from hospital

Last year we reported in State of Care that "waits for care home beds and home-based care accounted for 45% of delays in discharging people who had been in an acute hospital for 14 days or more". New definitions introduced by NHS England in 2024 present a different perspective of the causes of delayed discharges.

NHS England data for March 2025 shows that lack of capacity in social care services, or delays completing transfers to social care services accounted for 23% of delayed discharges of people who had been in an acute hospital for 14 days or more. However, 26% of delayed discharges were due to the same issues affecting access to rehabilitation, reablement or recovery services. Specifically, the monthly data shows that capacity within bed-based rehabilitation, reablement or recovery services is consistently the biggest cause of delayed discharges nationally.

Although rehabilitation, reablement or recovery services may be delivered within social care settings, this type of care is also often provided in community hospitals and specialised facilities. There is a need for increased investment to expand capacity within services, including in the workforce, to ensure people can move out of hospital efficiently and be supported to mobilise and regain independence in appropriate settings.

Our survey of 144 people aged over 65 carried out by National Voices highlighted the importance of care provided in the community after people are discharged from hospital after a stay as an inpatient.

The majority of respondents who had received care agreed that the follow-up care they received had allowed them to recover fully, regain or maintain their independence and reduce the amount of support they required from family and friends. We talk more about this survey in the section of this report about ‘Health and care for frail and older people’.

A&E emergency admissions and adult social care

Across England there is variation in the rates of attendance for urgent and emergency care, emergency hospital admissions (including avoidable admissions), and emergency readmissions of older people. Health and social care services are interdependent – challenges in one sector have an impact on other sectors. We have started work to investigate how variation in the capacity, accessibility, and funding of social care services can affect the volume of hospital attendances and admissions.

The initial stage of this work focused on a correlation analysis using a range of publicly available data on adult social care and Hospital Episode Statistics data at local authority level. This explored which indicators are associated with higher or lower rates of hospital activity for older people aged 65 and over. We also considered a range of contextual factors, such as deprivation, population age and distance to health care services.

The findings show strong associations between levels of self-funding of social care, local authority expenditure on social care, costs per unit of social care and levels of hospital activity for older people (this includes rates of A&E attendances, emergency admissions, avoidable admissions and emergency readmissions):

- In areas where a greater proportion of people self-fund their care (such as homecare or a care home) there are lower rates of attendance at emergency departments, emergency admissions (including avoidable admissions) and readmissions within 30 days for older people.
- In areas where the gross expenditure of local authorities per population on social care is higher, there is increased attendance at emergency departments for older people.
- The lower the rate that local authorities pay per unit of care (such as a week in a care home or an hour of homecare), the higher the rates of emergency department attendance and emergency admissions (including avoidable admissions).

These associations are likely to be best understood in the context of deprivation, which also showed a strong association with levels of hospital activity.

Areas that are more deprived typically have fewer people self-funding their care and higher local authority expenditure on social care services. People living in more deprived areas are also more likely to live in poorer health and face a higher risk of A&E attendance and emergency admission – in part due to issues with accessing primary care, as highlighted elsewhere in this report. As reported in last year's State of Care, "in 2023/24, attendance rates for urgent and emergency care for people living in the most deprived areas of England were nearly double those for people in the least deprived areas", and this has continued in 2024/25.

The 10 Year Health Plan acknowledges the impact of deprivation on health and proposes a range of measures to try to counteract its effect with a view towards halving "the gap in healthy life expectancy between the richest and poorest regions".

Collaborating to improve the quality of life for people in care homes

In last year's State of Care, we highlighted the launch of the Vivaldi social care project. The project, which was co-produced with people who live and work in care homes, is a collaboration between University College London and organisations in the care sector, such as The Outstanding Society, Care England, Skills for Care and the Care Provider Alliance. The project is transforming the way social care-led research is carried out in care homes to improve people's quality of life.

Since January 2025, the care homes involved in the Vivaldi social care research study for older adults in England have begun to share data on their residents with the NHS, making it possible to track important events like hospitalisations and rates of infection by care home. This data sharing between health and social care for research is enabling evidence-informed decision making between these sectors.

Adult social care pressures and reform

Additional budgetary pressures are affecting adult social care services this year, such as the increase in employers' national insurance contributions and national living wage, on top of increases in the cost of living. This means it is unlikely that local authorities will be able to sustain the current provision of care. Through the ADASS Spring Survey 2025, directors of adult social services have also warned that the need to make substantial savings to adult social care budgets will have an impact on the choice and quality of care and support that people can access at a local level.[21]

As local authorities around the country increasingly look to make savings, it seems likely more will signpost people to support in the community, ration the care they do provide, and reduce the provision of other statutory and non-statutory services. As well as negatively affecting the health and wellbeing of those in need of social care support, this could increase the pressure on the health and care system and the voluntary, community and social enterprise sector, and further increase the burden on unpaid carers. It is also likely to incur wider societal costs, as outlined in the Health and Social Care Committee's report, Adult Social Care Reform: the cost of inaction, published in May 2025.[22]

There is a lot of activity taking place to drive change in adult social care, with examples including:

- the independent commission into adult social care chaired by Baroness Casey
- the fair pay agreement
- the 10 Year Health Plan
- the adult social care workforce strategy, led by Skills for Care.

But it is important that these initiatives are connected across government and the wider sector. To help this, we are bringing people together to improve our understanding and planning on key topics.

Mental health

Key findings

- Demand for mental health services has continued to grow in 2024/25, with an average of 453,930 new referrals to secondary mental health services every month – an increase of 15% from 2022/23. We have also seen how people continue to face long waits to get the care they need.
- Alongside rising demand and lengthy waits, people's needs are becoming increasingly complex. When people can't access the care they need when they need it, this can lead to their conditions worsening. In some cases, this is being exacerbated by outside influences, such as difficulties finding housing and employment. In addition, more care being provided in the community and challenges with accessing hospital care mean that more people with higher levels of risk are being managed in the community.
- Inconsistencies in commissioning are leading to a huge variation in care, where the quality of care a person receives, as well as the ability to access services, depends on where in the country they live.
- Systemic recruitment and retention issues remain. These issues are creating significant challenges around staff experience, skills and competencies. Gaps in the workforce are exacerbating pressures on services and staff, with staff feeling burnt out and overworked, and that they are constantly fighting fires, with little long-term impact.
- System-wide pressures on mental health services mean that people are still struggling to get person-centred care that meets their needs. Over a third of respondents (36%) to the Community mental health survey said they were not given a choice about how their care and treatment would be delivered, and over 1 in 4 (28%) said they did not feel in control of their care.
- Significant challenges remain around funding and system working. Communication and collaboration between services and problems with shared care protocols are having a negative effect on people's experience of care, the co-ordination of their care and transitions between pathways.

Access to mental health care

A high demand for services and long waits for mental health care are well-known. These are longstanding challenges that have been exacerbated in recent years by the impact of the COVID-19 pandemic, austerity, the cost-of-living crisis and challenges with housing.

Over the last 5 years, we have consistently reported our concerns that when people cannot get the care they need when they need it, their mental health can deteriorate and they may then end up requiring urgent and emergency care.

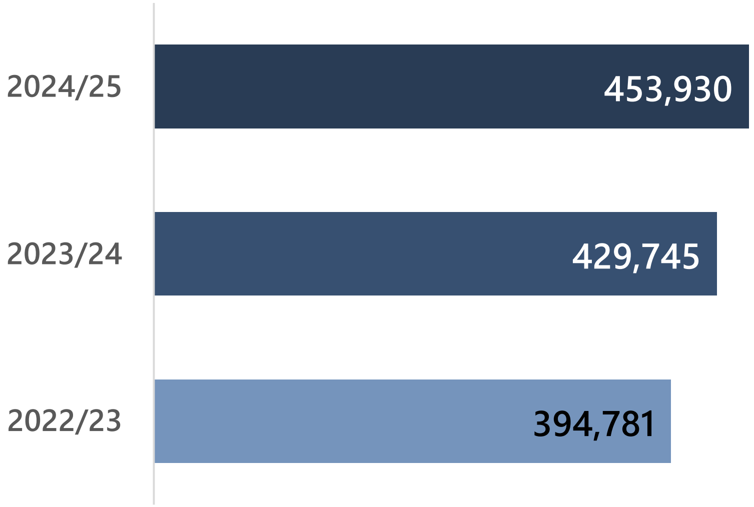
Last year, our rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) highlighted particular concerns about the systemic issues within community mental health care. This year, we started a comprehensive programme of inspections of community mental health services for working-age adults, crisis services, and health-based places of safety (HBPoS). This programme aims to give us a better understanding of where the quality of care, patient and public safety, and staff experience in community mental health services is not up to standard.[23]

To help shape our inspections, we held sessions with people who had experienced adult community mental health services and people that work in NHS trusts providing these services. In this section, we use the findings of this research to explore the challenges for people needing adult community mental health care, and the implications for the mental health care system more widely.

Increasing demand and more complex needs

Data from NHS England shows that the number of people needing mental health care continued to grow in 2024/25, with an average of 453,930 new referrals to secondary mental health services every month. This is an increase of 15% from 2022/23, when there was an average of 394,781 new referrals to secondary mental health services each month (figure 7).

Figure 7: **Average number of new referrals each month to secondary mental health services**



Source: NHS England's Mental Health Services Monthly Statistics

Data from NHS England shows that between 2023/24 and 2024/25, the number of contacts with community mental health services increased by 8%, rising from a monthly average of 2.5 million to 2.7 million (this is defined as having a care contact resulting from a referral, such as a face-to-face appointment, phone call, or home visit). The increase in the number of contacts varied by age group, with the number of contacts with mental health services for children aged 6 to 10 growing by 16% in the same period.

During the same period, NHS England's Mental Health Act statistics show that the number of new community treatment orders (CTOs) continued to rise, increasing by 17% from 2023/24 to 2024/25.[24] NHS England shows that since April 2023, there has been a steady increase in the number of people with serious mental illness who have accessed community mental health services at least twice in the previous year, rising 11% from 576,081 on average per month in 2023/24 to 640,619 on average per month in 2024/25.

Results from the 2024 Community mental health survey, published in April 2025, show that in this context, people are still waiting too long for mental health care and are unable to access the care they need when they need it. The survey found that:

- a third of respondents (33%) reported waiting 3 months or more between their assessment and first appointment for treatment
- 14% reported waiting more than 6 months
- two-fifths (40%) of respondents felt that the waiting time was too long.

These findings are supported by feedback from our focus groups with Experts by Experience, held as part of our focused review of community mental health services for working age adults, crisis services and HBPoS. People described how services would tell them that they were being put forward for specialist support, such as psychotherapy, only to then be stuck on waiting lists for prolonged periods. In some cases, people were discharged to community mental health services and then waited a long time before being told that they were going on a waiting list.

> *"It's been, I think probably 3 1/2, or 4 years since I've been inpatient, and I still haven't received any psychological support. Only in December did they say, OK, we'll put you forward for psychotherapy."*

Sometimes, the gap between the initial assessment and being put on a waiting list lasted for years, meaning people were waiting for specialist support for extended periods following the initial assessment. Some people linked the long wait for care with a lack of investment in staff and resources (see also 'Impact of workforce pressures on people').

People were also concerned about how thresholds for accessing different services varied across the country, which may lead to people falling between the gaps in care pathways. For example, a person may be considered too high risk for NHS Talking Therapies, but not high risk enough for community mental health services. People told us about their frustrations when they, or those they cared for, had not met the risk threshold for a service:

> *"I haven't received in my 15 years of being in mental health support a structured psychotherapeutic intervention because I've kept kind of yo-yoing between thresholds and different areas, and different areas won't accept certain levels of risk and others will."*

People told us that this could be a particular challenge after being discharged from crisis or inpatient services, as their risk threshold was sometimes considered to be too low to access community mental health support or interventions, despite voicing their struggles and need for this support. This meant a risk of deteriorating to the point of needing to be admitted as an inpatient, or of not receiving adequate support to enable them to feel better or well.

The same challenges we see in access to care for working-age adults also remain a concern for children and young people. The latest annual report from the Children's Commissioner highlights huge inequalities when it comes to accessing support, with some young people waiting up to 17 times longer than others depending on where they live. The report also shows 50,000 more children with active referrals were still waiting for treatment to begin at the end of March 2024 compared with the previous year (320,000 in 2023/24 up from 270,300 in 2022/23).[25] Concerns around these long waits are discussed in more detail in our section on children and young people.

Through our engagement events with providers, held as part of our focused review of community mental health services for working age adults, we heard how alongside rising demand and lengthy waits, people's needs are becoming increasingly complex. As we have reported previously, when people are not able to access the care they need when they need it, it can lead to their conditions worsening and/or reaching crisis point. In some cases, outside influences, such as difficulties finding housing and employment, are exacerbating this. At the same time, more care is being provided in the community and access to hospital care is becoming more challenging because of higher thresholds, delayed discharges and fewer beds, with NHS England's data showing that bed occupancy continues to be above the 85% target.[26] As a result, more people with higher levels of risk are being managed in the community.

A personal story: Impact of long waits

Arjun spoke with us about his experience of seeking mental health care and support, and the long waits for care he experienced.

Arjun told us he was first diagnosed with depression and anxiety by his GP in November 2020. He described how he initially did not want to take medicine because he was worried about the potential side effects, and wanted to try to manage his condition through therapy. After a 6-month battle with his GP about taking medicine, they agreed he would start taking medicine alongside therapy sessions.

However, Arjun then faced a further 9-month wait to be able to start the therapy. During this time, he faced a number of personal issues that affected his mental health. While he did go to the therapy sessions, his mental health deteriorated and his GP referred him to a mental health nurse.

In June 2024, Arjun's mental health deteriorated to the point where he was having suicidal thoughts. Arjun spoke to his GP and explained what was going on and how he felt. He was then referred to a mental health clinic. Arjun found the referral process exhausting as he had to repeat everything again and, once accepted, still had to wait over 3 months to be seen.

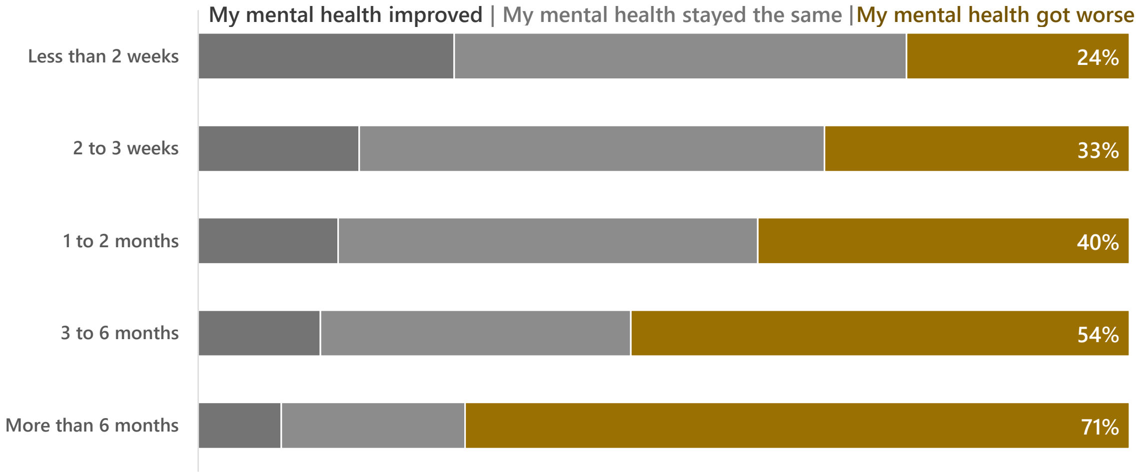
Arjun is now under the care of the clinic and feels that he is getting the care he needs, though is frustrated at the length of time this took. Under the clinic's care, Arjun is on more appropriate medicine and feeling in a much better place. Arjun's goal is to learn how to manage his mental health and reduce his medicine so he can be discharged back to his GP.

(Interview with member of the public)

The challenges facing crisis services

Waiting a long time for care can lead to a deterioration in people's mental health. Results from the 2024 Community mental health survey showed that the longer people wait, the more people reported that their mental health got worse. Among people who waited less than 2 weeks for help, 24% said their mental health got worse, compared with 71% of people who waited more than 6 months (figure 8). Overall, while an improvement on the 2023 survey findings, more than two-fifths (42%) of respondents said they felt their mental health got worse while waiting.

Figure 8: **While waiting, between your assessment with the NHS mental health team and your first appointment for treatment, did you experience any changes in your mental health?**



Source: 2024 Community mental health survey

As we have reported previously, not getting the care they need when they need it can lead people to end up in crisis. In the last 2 years, the number of urgent and very urgent referrals to crisis services has continued to rise. Data from the NHS England (MHSDS) shows 77% more very urgent referrals in 2024/25 compared with 2023/24 (rising to 60,935 from 34,455). There are known quality concerns with this data, with a small number of trusts contributing a large percentage of these very urgent referrals. Improvements to data quality and reporting will be required to give us a confident picture of the pressure on crisis care services.

Feedback from our inspection teams suggests the reasons for this increase are complex and varied. Issues such as the ongoing impact of the pandemic, long waiting times, lower bed capacity and people with more complex needs being cared for by community teams are all having an impact.

To support people in crisis to get compassionate care that meets their needs, in July 2023 the government published the Right Care, Right Person (RCRP) framework.[27] This set out a national commitment from the Home Office, Department of Health and Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England to work to end the inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs. Local areas were tasked with agreeing a joint multi-agency plan for implementing and monitoring the RCRP approach.

The national framework sets out when it is appropriate for police to respond to a mental health-related incident, including:

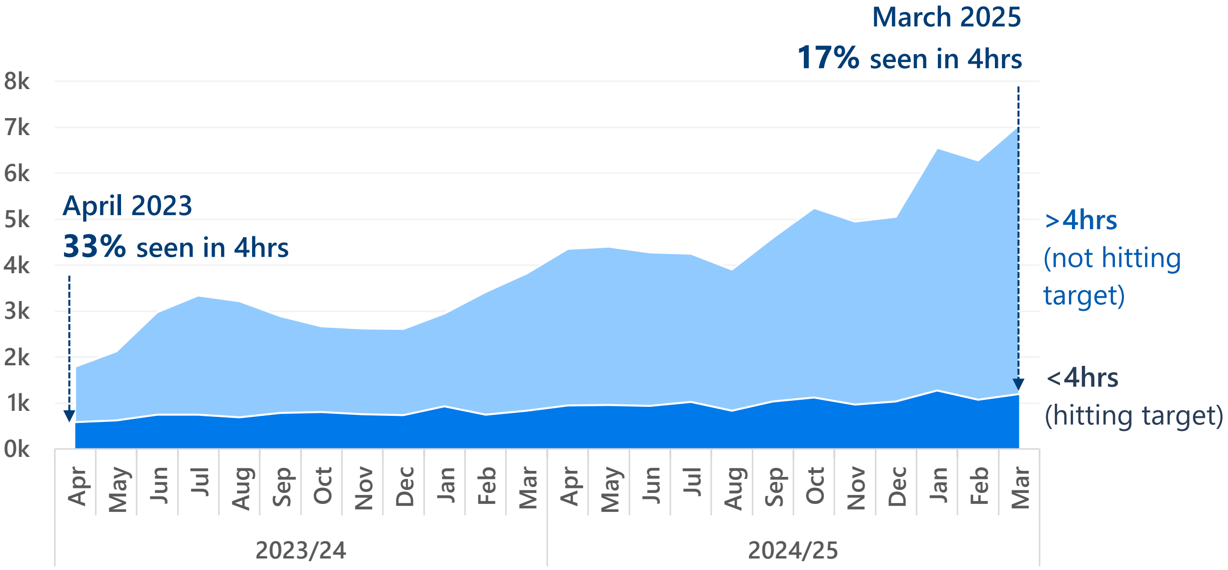
- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.

When this threshold is not met, partners in local areas will agree the best health-based approach to support those in crisis. The aim is to ensure people in crisis are responded to by the right person, with the right skills, training, and experience to best meet their needs. However, as previously highlighted by NHS Confederation, this reduction in support from police adds to the already rising demand and pressure on mental health services, increasing the risk of people falling through the gaps.

Standards for crisis teams are that they should see very urgent referrals within 4 hours and urgent referrals within 24 hours. Over 2024/25, the total number of people who were seen within 4 hours increased. However, data from NHS England shows that as the number of very urgent referrals continues to increase, the number of people who are actually seen within 4 hours is not increasing at the same rate.

As at March 2025, data from NHS England shows 17% of new very urgent referrals were seen in 4 hours, down from 33% in April 2023 (figure 9). This is supported by the results of the 2024 Community mental health survey, which found that of the respondents who contacted an out-of-hours crisis team, over a quarter (27%) did not get the help they needed. Mental health service providers that participated in our engagement events described the increased pressure on crisis teams and inpatient beds as ‘overwhelming’ and ‘scary’.

Figure 9: **New very urgent referrals to crisis teams, including people seen face-to-face and within 4-hour time standard for reporting month (all referrals/ all age groups)**



Source: NHS England's Mental Health Services Monthly Statistics

As we highlighted in last year's State of Care report, when people reach crisis point but can't get help from specialist crisis services, they may attend an emergency department to seek help. However, once at hospital people are then facing long waits for assessment, treatment and discharge.

In July 2025, the government announced as part of the 10-year Health Plan for England that it would be investing up to £120 million to develop more dedicated mental health emergency departments, to ensure patients get fast, same day access to specialist support in an appropriate setting.[28]

Inconsistencies in care

Providers of community mental health services told us how inconsistencies in commissioning meant there was huge variation across the country, leading to disparities in pathways, access to services, and the provision of services. This variation can be a result of factors such as differences in:

- geographical areas
- the populations served
- funding and commissioning
- understanding of people's needs.

Without an agreed model for how services should be structured or delivered, we have also heard that there is huge variation in the types of services trusts offer and how these are delivered.

We heard how this could lead to variation in care, where the quality of care a person receives, as well as the ability to access services, depends on where in the country they live. One person in our focus groups with Experts by Experience told us this could lead to a sense of being stuck in their local area, as this is where their support network is, and they wouldn't know about the quality of care available if they moved to a different area:

> *"[You feel] pinned down in one town or city because that's where your support network is, therefore if well enough to work or have a relationship with someone somewhere else, you cannot move."*

Providers told us they would like to see commissioning of services meet the level of need in the community as, although provision could be similar across both urban and rural areas, the levels of need were very unbalanced.

Providers in our engagement events as well as people in our focus groups felt that standardised approaches to commissioning would help to combat geographic healthcare inequalities. As one CQC Expert by Experience told us:

> *"We need to address the postcode lottery. There needs to be standardisation so that every area has good quality care. It is not fair that people are not entitled to quality care because of the area they live in. Equity of quality of care, for marginalised groups, for those who are disabled, for all intersections of the community."*

Mental health workforce

Despite a growth in the workforce over the last few years, systemic issues with recruitment, retention and skills gaps continue to have an impact on patient experience and safety.

Resourcing and capacity challenges

In both last year's State of Care report and our 2023/24 Mental Health Act Annual Report, we highlighted how the size of the mental health workforce has not kept up with the rising demand for mental health care (see Increasing demand and more complex needs). Despite an increase in the number of staff over the last few years, the NHS Vacancy Statistics shows that 9% of roles in mental health trusts in the NHS were unfilled in March 2025.

Evidence from our adult community mental health inspection programme has shone a light on some of the challenges facing the mental health workforce, and the impact of these on staff, providers and people who use adult community mental health services.

We know that some staff face additional challenges. We look at the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standards (WDES) as part of our assessment of workforce equality, diversity and inclusion, under the well-led key question. We discuss the findings from the 2024 NHS WRES and WDES data in our section on Workforce challenges.

Through our engagement events, providers told us how gaps in the workforce are exacerbating pressures on services and staff, and that they are not always able to cope with increasing levels of demand. In some cases, we heard how the NHS mental health transformation programme had contributed to these workforce challenges, creating vacancies and recruitment issues as well as concerns around staff training.

Recruitment and retention issues are also leading to significant challenges around staff experience, skills and competencies. Providers and our inspectors have shared concerns around the pace that some staff are being promoted and of the loss of experienced staff in teams. Providers, along with Experts by Experience, raised concerns about the impact of skill mix, experience, and staff turnover on the quality of care.

These pressures are having a negative impact on staff wellbeing. Providers told us staff were burnt out, overworked and experiencing low morale. They described how teams feel they are ‘on their knees’, constantly fighting fires and seeing little longer-term impact, which is in turn contributing to burnout and issues with staff retention.

This is supported by data from the 2024 NHS Staff survey which shows that for mental health and learning disability trusts, and mental health, learning disability and community trusts:

- less than half (49%) of people felt able to meet all the conflicting demands on their time
- over a third (34%) of people reported always or often finding their work “emotionally exhausting”
- a quarter (26%) of people reported they were always or often feeling “burnt out because of their work”.

In addition, as highlighted in our section on Workforce challenges, the overall sickness absence rate for England increased in 2025.

Impact of workforce pressures on people

We reiterate our concern that high demand for community mental health services without the capacity to meet it affects people’s ability to get the help they need when they need it. In our focus groups with Experts by Experience, some people linked the lack of staff and resources with long waits for care (see also Increasing demand and more complex needs). People also described how it could lead to a lack of continuity in care:

> *"For me, it's the continuity of support that's challenging, having to repeat their story and rebuild the relationship. This keeps happening in a short space of time. I've had 4 care co-ordinators over the space of a year, which is ridiculous."*

Some providers that took part in our engagement events also described the impact of under-resourcing, and how this was making caseloads unmanageable. They highlighted how this meant risk assessments and care plans might not be completed, with staff having to choose between managing caseload numbers and delivering an effective quality of care for patients. We heard that this was compounded by a lack of national standards and guidelines around managing caseloads.

Through our inspections we have found a more mixed picture of how services are managing caseloads in the face of rising demand. In some services, there are high caseload numbers but no waiting lists, while others have lower caseload numbers but a large number of people waiting to be allocated care co-ordinator. Inspectors raised concerns that this could lead to 'hidden waiting lists', where a person has been referred to the service, but is not receiving support because they do not have a named care co-ordinator.

A few people in our focus groups with Experts by Experience also suggested that long wait times and waiting lists were a direct result of a lack of investment in community mental health services, particularly the lack of specialist staff and resources. This sentiment was supported by feedback from providers in our engagement events, who told us that greater investment and better placing of staff is needed to attract and retain staff with the right skills. They also highlighted the need for system-wide standards for managing caseloads.

Quality and safety of care

The increasing pressure on community mental health services is affecting the ability of providers to manage risk effectively, meet the needs of patients adequately, and provide person-centred care.

In this section, we provide an insight into some of the key challenges around the quality and safety of mental health care.

Lack of involvement and person-centred care

Guidance from the National Institute for Health and Care Excellence (NICE) states that care and treatment should take into account people's individual needs and preferences. People should also have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.[29]

In last year's State of Care, we highlighted how people are struggling to get person-centred care that meets their needs. This year, our focus group with Experts by Experience showed that this is still an issue. People told us they need greater involvement, autonomy and choice in how their care is planned and delivered. They described how decisions about their care are sometimes made without involving them, and that they do not always feel listened to, or that staff do not always understand their needs. People particularly wanted greater involvement in decisions around their medicines (see section on Medicines optimisation).

The results of the 2024 Community mental health survey support these experiences, as over a third of respondents (38%) said they did not have a care plan. Of those who did have a care plan, 70% were involved in agreeing their care plan to 'a large' or 'very large extent'. When asked if they were given a choice about how their care and treatment would be delivered 36% of respondents said they were not, and over 1 in 4 (28%) said they did not feel in control of their care.

Some people in our focus group with Experts by Experience talked about not being involved in meetings with multidisciplinary care staff. One person told us they were not able to see the notes from the multidisciplinary team meeting, despite decisions about their care being made in these meetings. People who had been involved in multidisciplinary team meetings still described feeling like they were not being involved in their own care. They described this as annoying, that it made them feel out of the loop, and that the lack of involvement was "a shame".

People also described how their family or carers were not consulted or included in conversations about care planning when they wanted them to be. Again, the results from the 2024 Community mental health survey also found that over 1 in 5 respondents (21%) would like their family or friends to be more involved. People in our focus groups mainly talked about friends and family not being informed about care plans, and not being told what warning signs and side effects from medicines they should be looking for. This left their family or carers feeling unsupported and uninvolved.

A lack of involvement could lead to problems when staff do not understand people's experiences, history and needs. For example, a couple of people in our focus groups told us their experiences of being in a mental health crisis but staff advising them to "get a cup of tea" or to "have a bath". They believed that staff had not looked at their clinical notes and/or had not tried to understand their needs. These kinds of situations could leave people feeling more stressed than before they had contacted community mental health services. In some instances, people said that not feeling listened to could make them want to disengage from services.

This echoes the findings from our Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust. Published in March 2024, our review found repeated concerns about a lack of person-centred care, including people not feeling involved in creating their care plans or with changes to their medicine, feeling dismissed, and not listened to.

However, where people in our focus group had positive experiences of involvement, they said staff had taken the time to better understand their needs and the approaches that would suit them. They described how this supported them in continuing their treatment.

Important role of care co-ordinators

Both providers and people who use services emphasised the key role of care co-ordinators in providing person-centred care. As well as being a named contact, care co-ordinators give people greater continuity of care, with oversight of their care throughout the pathway.

We heard about some positive experiences during our focus groups with Experts by Experience, with one participant telling us they had the same care co-ordinator for several years. This meant they were able to build up a rapport with them, and the co-ordinator knew and understood their needs. Other participants with additional needs described their care co-ordinators as being “vital” and “worth their weight in gold”.

However, we heard how the high volume of work for care co-ordinators could compromise the quality of care they provided. We also heard examples where people had had many different care co-ordinators, locum psychiatrists, social workers, and support workers. This often meant the new worker did not know the person and they had to repeat their experiences, which could be distressing. Participants mentioned that a lack of continuity in their care also meant that, at times, they did not know who they would be seeing; for some people this led to increased anxiety and uncertainty.

Without adequate support from mental health professionals in the community, people from our focus groups described having to rely on their support networks, usually friends and families, to provide care. We heard about the impact this could have on the life of a friend or family member, including a deterioration in their physical health and a breakdown in family relations.

Challenges affecting the safety of services

Several providers at our engagement events raised concerns around ageing estates that are increasingly not fit for purpose and do not meet the needs or safety of patients and staff. These concerns have been highlighted by our inspection teams, where the condition of some of the buildings used by community mental health services was not always supporting the delivery of safe and effective care.

People need to feel safe in therapeutic environments that are appropriate for the service they are receiving, and we have found during inspections that not all premises are suitable for the purpose for which they were being used. As well as the poor physical condition of some premises, concerns have been found regarding unreliable technology and the impact this has on staff being able to provide effective care.

Wider system pressures on community mental health services – particularly the challenges around resourcing and capacity (see section on mental health workforce) – are also affecting their ability to deliver safe and effective care that improves patient outcomes.

We previously highlighted evidence from our regulatory activity that showed how problems with staffing and skill mix are a key concern. Along with wider system pressures, this is affecting providers' ability to effectively manage risk over supporting people's longer-term recovery.

Providers at our engagement events had concerns about their ability to appropriately manage and understand the impact of patient risks, particularly when staff are under pressure and don't have capacity to do so. Some described having to manage these risks as 'firefighting'. Inspectors told us during our focus groups that they are seeing issues around providers not properly recording or effectively managing risks.

We heard how this ongoing pressure meant there was no opportunity to pause and reflect on how to balance and manage potential harms and learn from deaths. Providers noted higher levels of aggression and violence in community services and raised concerns that current system challenges meant that what happened in Nottingham was not an isolated incident and could happen again elsewhere.

Participants in our focus groups with Experts by Experience told us about the impact these challenges were having on people. They described how pressures on services could lead to people being discharged from services before they were ready, increasing the risk of relapse or re-admission.

> *"In my case they said 'Right she's ready to be discharged we'll get rid of her' because they've got waiting lists and they want to free up space, but you're not ready to be discharged, they've made that decision, not you."*

This feedback reflects the findings from our review of quality of care provided by Nottinghamshire Healthcare NHS Foundation Trust. This found issues including a 'lack of clarity of thinking' in the multidisciplinary team in relation to the decision to discharge, and people not being involved or notified of this decision.

Increased pressure across the system may, in part, explain the increase in people with serious mental illness needing to access community services.

Medicines optimisation

Medicines can be used to treat or prevent the symptoms of most mental illnesses as part of a comprehensive treatment plan.[30]

Taking a person-centred approach and ensuring people are taking their medicine in a safe and effective way is essential to achieving the best possible outcome. When mental illness is treated poorly, either because of delays in starting medicines, people stopping taking their medicine (non-adherence), under-prescribing or over-prescribing, the consequences for people can be devastating and increase the risk of relapse and being admitted to hospital.[31]

Guidelines from the National Institute for Health and Care Excellence (NICE) are clear about the need for good communication between healthcare professionals and patients, to involve patients in decisions about their medicines, and to support adherence.[32]

We commissioned Ipsos to look at good practice in managing medicines in the community from the perspective of people providing this type of care. Some professionals who took part said an important part of sustaining adherence is making sure people feel empowered in their care. This means patients having the same information as the professionals caring for them and actively involving them in the decision-making process. Having accessible patient information was an important factor in this.

In our focus groups with Experts by Experience, some people had positive experiences of communication and being involved in decisions about their medicine, but others raised concerns about a lack of information and choice about the medicines they were taking. They mentioned not understanding how to take their medicine or not having an opportunity to understand any side effects. The Ipsos research found that professionals reported these challenges were greater for people who don’t speak English as a first language, as they face significant barriers in understanding diagnoses and treatment plans, and accessing information about available services.

In the Ipsos research, professionals reported that side effects were the most common concern for people (80%), with nearly three-quarters (74%) of respondents describing it as a key reason for people not adhering to their medicine regimen. Respondents described how people’s frustration with side effects can lead some to disengage from treatment altogether.

We can see this reflected in the findings of the 2024 Community mental health survey. Nearly 1 in 3 respondents (29%) who were taking medicine said that the side effects of their medicine had not been explained to them. Similarly, over 1 in 3 (35%) said they had not received an explanation of what would happen if they stopped taking their medicine.

Some people in our focus groups with Experts by Experience described feeling a lack of involvement in decision making. This included feeling they were given little choice about the medicine they were prescribed. It was a case of ‘this is what you’re being prescribed’, rather than a discussion about available options. Reasons around the lack of choice varied from not being able to access the appropriate staff to change their medicine, to participants feeling they were not being heard when querying the choice of medicines.

In the Ipsos research, participants believed regular medication reviews were essential for maintaining patient engagement. However, people in our focus groups with Experts by Experience raised concerns around the lack of reviews, or the prolonged length of time people spent waiting for a review, with one participant telling us they went 5 years without a medication review. This is supported by the findings of the 2024 Community mental health survey, which found that nearly a quarter of respondents (23%) said their mental health team had not checked how they were getting on with their medicine in the last 12 months.

A lack of reviews led to fewer opportunities to talk to clinicians about their medicine and the possible side effects. Inspectors described how this was a specific problem when patients were prescribed medicines that did not need regular contact and monitoring with their community teams.

Providers also spoke of the need for more effective monitoring of side effects, physical health, and non-adherence where people stop taking medicines. They identified a need for a consistent approach in raising and acting on concerns to support people. The systems and technologies used in community mental health care to support the safe and effective use of medicines are often not designed for the setting. This means providers often need to use workarounds or are unable to use the technology optimally.

Providers also raised concerns about a lack of accountability of prescribing and variation in accessing certain medicines across primary and secondary care. They also highlighted the need for clear guidance around community mental health and medicines, and the value of pharmacy staff in supporting community teams and optimising people’s care and treatment with medicines. However, use of dedicated pharmacy support varies across the country.

In March 2025, the government announced it had agreed funding with Community Pharmacy England worth an extra £617 million over 2 years as part of its plans for rebuilding community pharmacy and to support people to have easier access to care and support locally.[33]

Lack of holistic care

In our focus group of Experts by Experience, several people told us there was too much focus on the medical model, and less of a holistic approach looking at people’s care. Participants reflected about being given medicines, but not being asked about other aspects of their life, such as sleeping, diet, and physical health.

In some cases, although they had multiple conditions, only one condition was treated at a time. This led them to feel that their physical or mental health had been forgotten while being treated for another condition, and that services could only deal with either the physical or the mental conditions as opposed to looking at the whole person.

This was reflected in the results of the 2024 Community mental health survey. Only 1 in 3 (29%) respondents said that their NHS mental health team had definitely supported them with their physical health needs in the last 12 months. A further 39% of respondents stated they did not have support for physical health needs, but they would have liked it.

But holistic care is not just about meeting people's physical and mental health needs. There are social factors and wider system pressure – notably housing – that prevent people from getting the care they need. Providers in some areas discussed the challenges associated with poor availability of appropriate and supportive accommodation. This can result in people being discharged from secondary care as homeless, which can have an impact on the quality of care services can deliver.

Lack of social and other support was another finding of the 2024 Community mental health survey, with 67% of respondents saying their NHS mental health team had not offered any help or support with finding financial advice or benefits in the last 12 months. Similarly, more than three-quarters (77%) of respondents said they had not received any help or advice with finding support to manage the cost of living.

As part of its Community Mental Health Transformation programme, NHS England has committed to creating a more holistic model of care to meet people's needs, which brings together services across the system. This is supported by the ambitions of the NHS 10 year plan to move care from hospital into the community.

System-wide challenges

Funding and the changing mental health landscape

Lord Dazi's Independent investigation of the NHS in England in 2024 highlighted the chronic and long-standing under-investment in mental health services and how this, along with low productivity, has led to a treatment gap for people across the country. In the report, Lord Darzi also describes how long waits have become normalised.

Throughout our engagement events, providers discussed the significant challenges around funding for mental health services. We heard about the impact of a lack of funding in multiple areas including workforce, capacity and integration of services. This includes inpatient services. We will be discussing more around the challenges facing mental health services and the impact on people based on our monitoring activity in our forthcoming 2024/25 Monitoring the Mental Health Act report.

A recent report from the Centre for Mental Health noted the benefits of investing wisely in mental health. It highlighted that the introduction of NHS Talking Therapies in 2008 and the more recent development of community perinatal mental health services have both led to significant improvements in people's lives, as well as economic and social benefits.

In 2019, the government published the NHS Long Term Plan. This, and the subsequent NHS mental health implementation plan, set out plans for improving mental health services through new and integrated models of primary and community mental health care. While many providers at our engagement events welcomed these ambitions, they told us that implementing this model has created additional challenges for them, and that there was a sense of ‘change fatigue’.

More recently, as part of the 10 Year Health Plan for England, the government has made a number of commitments to improving mental health care including the introduction of Young Futures Hubs to support children and young people’s mental health, funding for mental health units to fix their buildings, and the introduction of 24/7 neighbourhood care models.[34]

In July 2025, NHS England announced the first 6 providers chosen to pilot a 24/7 neighbourhood mental health centre. These centres bring together a range of services under one roof, including crisis services, community mental health services and short-stay beds. People with serious mental illness such as schizophrenia or bipolar will also be able to walk in without an appointment if they need mental health support, as well as advice on employment, housing, or volunteering.[35]

Communication, collaboration and system working

Through our engagement events with providers, many told us that a lack of collaboration between services and across the mental health system was their biggest challenge. We heard how poor collaboration has an impact on people’s experience of care, the co-ordination of their care and transitions between pathways.

Providers expressed frustration around poor communication and information sharing, including sharing care plans between providers. They told us that sharing care plans was vital for communicating people’s treatment plans, risk assessments, and for reducing the burden on the person themselves, so they do not have to repeat the same information multiple times.

Findings of the 2024 Community mental health survey show that poor communication is a prevalent issue, with 76% of respondents saying that they had to repeat their mental health history to their NHS mental health team. Over a third (36%) of these respondents said it happened often. Participants in our focus group of Experts by Experience described how having to repeat their history was distressing and could send a message that services and staff did not care.

People also told us that poor communication between services could also lead to indecisiveness about who would provide care. This led to them being in limbo about who would provide their care and if they would even get it at all. One participant told us that they were refused care as the service thought they were being cared for by a different service, despite that not being the case.

Good communication was seen as particularly vital when a person is discharged back to primary care. Providers spoke of the need to ensure all discharge notes are available to a person's primary care doctor (GP) – ideally immediately. Providers told us this was important to reduce both risk and the potential for people's wellbeing to deteriorate, and possible future hospital admissions or crisis. Poor communication around discharge was an issue we identified in our Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust.

We heard from providers that information can get lost in translation, and that there were too many handover points. A lack of shared computer systems to store and access information across services added to difficulties in communication and contributed to 'working in a silo'. Another factor from providers was that there are too many IT systems in place that do not 'speak to each other'. This resulted in not being able to produce key data metrics to effectively monitor service delivery and identify risk areas, and staff having to use workarounds to input and extract information, such as flagging when people do not attend appointments.

Shared care protocols

Providers and people who use services told us that the relationship between community mental health services and primary care was challenging and needed improvement. This was a particular concern in relation to shared care protocols (see also section on medicines safety).

In the research we commissioned from Ipsos, over a quarter (26%) of respondents said that shared care protocols were one of the main challenges for services when supporting people who are taking psychotropic medicines in the community. Both mental healthcare providers and GP respondents expressed frustration and concerns around shared care protocols. Through our engagement with providers, we heard how some GPs were not always providing shared access to patient information or had withdrawn from shared care protocols. This was said to be adding pressure on community mental health services.

In February 2025, we held a workshop with GPs and hospital pharmacy leads to better understand the challenges for each sector more widely. At the workshop, GPs described how their workload was increasing and how they felt that shared care protocols were often for patients with medically complex conditions, which they did not have the knowledge to manage. They were concerned about patient safety and how shared care protocols increase the burden on already stretched resources. These concerns were reflected by the Ipsos research findings, with GPs expressing a lack of capacity and confidence to effectively manage patients under shared care agreements.

These findings were further supported by participants at our focus groups with Experts by Experience, who similarly told us that GPs are often happy to take on simple medication regimens, but are less likely to take on complicated medicines, making it much harder to get them changed. We heard how, in some instances, community mental health services had advised GPs to not make any changes to a person's medicines. In others, GPs were said to be pushing back on medicines prescribed by community mental health services.

While shared care protocols are designed to make care more convenient and accessible, these challenges mean that many patients experience delays and inconsistency and find the system confusing. At our focus group with GPs and hospital pharmacy leads, GPs told us that issues with communication and transfer of care between specialists and primary care often left both the patients and GPs struggling to navigate between services. This was supported by findings from the Ipsos research, in which professionals described how patients frequently find themselves caught in the middle of a fragmented and confusing system.

We have shared the concerns identified through our workshop with GPs and hospital pharmacy leads with the Department of Health and Social Care (DHSC) and NHS England. We highlighted how system-wide reform is needed to deliver better patient-centred, safe and consistent shared care systems. This includes developing national leadership, equitable funding, integrated IT systems, stronger regulation, and workforce support.

DHSC is working with NHS England to further understand and explore challenges with shared care prescribing, including how this interacts with private prescribing. As part of this, it launched an open call for evidence on private (non-NHS) prescribing in August 2025.

Secondary care

Key findings

- Demand for urgent and emergency care services remains high, but the way in which people are accessing this care is changing. While the volume of calls to NHS 111 reduced in 2024/25, calls to ambulance services have continued to increase, with the volume of hear and treat responses also rising. Attendances at all types of urgent and emergency services have also risen, with the biggest increases at single service facilities for specific conditions and minor injury units.
- People are continuing to face long waits for care in emergency departments. In 2024/25, more than 1.8 million people waited over 12 hours from the time of their arrival to either admission, transfer, or discharge – 169,000 more than the previous year. The number of people waiting for more than 12 hours for an emergency admission to hospital has also risen. These continued waits suggest that the flow of people through hospitals into the community remains challenging.
- The volume of delayed discharges has remained high during 2024/25. When hospital beds remain occupied, the capacity of hospitals to accommodate incoming patients is limited, creating a knock-on impact and maintaining pressure throughout the system.
- Once discharged from hospital, the whole system needs to work together to keep people well. Not doing this effectively can lead to people being admitted to a hospital again. Over the last 10 years there has been a steady increase in the percentage of emergency readmissions, with older people and people living in more deprived areas more likely to be readmitted within 30 days of being discharged from hospital.
- While there has been some improvement, people are still facing long waits for elective care, with the length of waits varying across the country. This is a particular concern for people waiting for cancer treatment where we continue to see that, despite some improvement, services are still struggling to meet national standards.
- Pressures on workforce are continuing to affect the quality of care for patients. Staff have told us about the ongoing strain they feel from persistent understaffing, poor skills mix, and pressure to admit patients despite a lack of capacity and ward beds, which has an impact on their wellbeing and the quality of care patients receive.

Urgent and emergency care

In last year's State of Care report, we highlighted ongoing concerns that, despite some improvement, urgent and emergency care services were still falling below the expected performance standards. This remained the picture in 2024/25.

Mixed picture for NHS 111

Over 2024/25, there were nearly 20 million calls to NHS 111 – a drop of over 1.8 million calls compared with 2023/24.

At the same time, 3.4% (658,000) of calls to NHS 111 were abandoned (when the caller hangs up at least 30 seconds after they have been queued to speak to an advisor). This is a dramatic fall from the previous year, where 9.8% of calls (over 2 million) were abandoned. However, this still does not meet the abandoned call standard of 3% or less. While some NHS regions achieved a rate of 2.5%, less than half (42%) of providers met the standard in 2024/25.

The length of time people were waiting for their call to be answered also improved, as the national average speed to answer calls was 3 times quicker than that in the previous year (1 minute compared with 2 minutes 58 seconds). However, this is still well below the standard for the average time to answer calls of 20 seconds or less. Over the last year, only 2 out of 19 providers (11%) were meeting the 20-second standard.

As highlighted in last year's report, when people have to wait a long time for their call to be answered, there's a risk that they will either:

- abandon the call and not receive advice on appropriate care or treatment
- seek care from a service that cannot meet their needs appropriately, or face delays in receiving the correct care
- not seek treatment at all.

This can lead to delays in receiving appropriate triage and treatment, which in turn can have an impact on people's outcomes.

Once through to the NHS 111 service, if your symptoms meet the criteria, you will be offered a callback from a clinician, and given a timeframe in which this will happen. Ninety per cent of people who require a clinical callback should receive this within the agreed timeframe. For people who need an urgent callback, this should happen within 20 minutes. While there has been a slight improvement in urgent callback times, with 40% of people receiving a call within the 20-minute standard (up from 31% in 2023/24), it is still well below the standard of 90% or more. In 2024/25, no provider met the 90% standard.

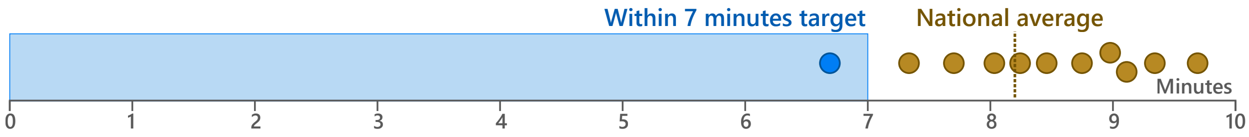
Ambulances still in high demand

Pressure on NHS ambulance services grew again in 2024/25, with 13,376,000 ambulance control room contacts – 283,000 more contacts than in 2023/24. This is an increase in demand of 2.2%.

In the face of these challenges, it is encouraging to note that the average time taken to answer a 999 call for an ambulance has improved in the last few years – from 39 seconds in 2022/23 to 5 seconds in 2024/25. But how quickly calls were answered varied across the country, from an average of 12 seconds in the East of England to 1 second in the North West.

The continued pressure has also meant that ambulance services are still struggling to meet the expected standards for response times to reach a patient. For the most serious category 1 calls, ambulances should respond, on average, within 7 minutes. These are life-threatening events that need immediate intervention and/or resuscitation, such as cardiac or respiratory arrest. In 2024/25, the average category 1 response time was 8 minutes 19 seconds, with only 1 ambulance trust meeting the 7-minute standard. This was slightly faster than in 2023/24, where the average response time was 8 minutes 27 seconds (figure 10).

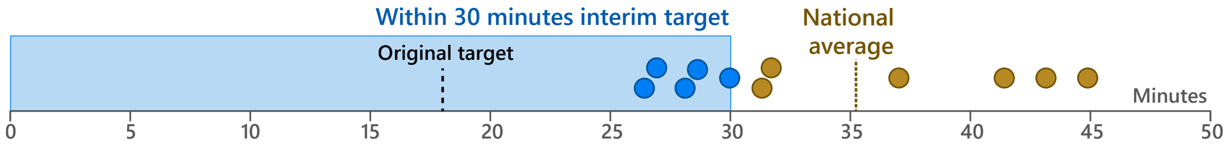
Figure 10: **Category 1 responses by ambulance trusts against standard**



Source: Ambulance Quality Indicators

The picture is similar for category 2 calls. These are emergency events that need intervention and/or taking to a hospital, including injuries such as burns, epilepsy or strokes. All ambulance trusts should respond to category 2 calls in an average time of 18 minutes. In response to the ongoing pressure, NHS England introduced an interim objective to respond within 30 minutes, which has been in place since January 2023 (figure 11).

Figure 11: **Category 2 responses by ambulance trusts against standard**



Source: Ambulance Quality Indicators

In 2024/25, performance for category 2 calls varied across the country. On average only 5 out of 11 ambulance trusts met the interim response time of 30 minutes in 2024/25. Nationally, ambulances took an average of 35 minutes 22 seconds to respond. Across integrated care system (ICS) areas, response times for category 2 calls ranged from 21 minutes 43 seconds to 1 hour 1 minute 57 seconds.

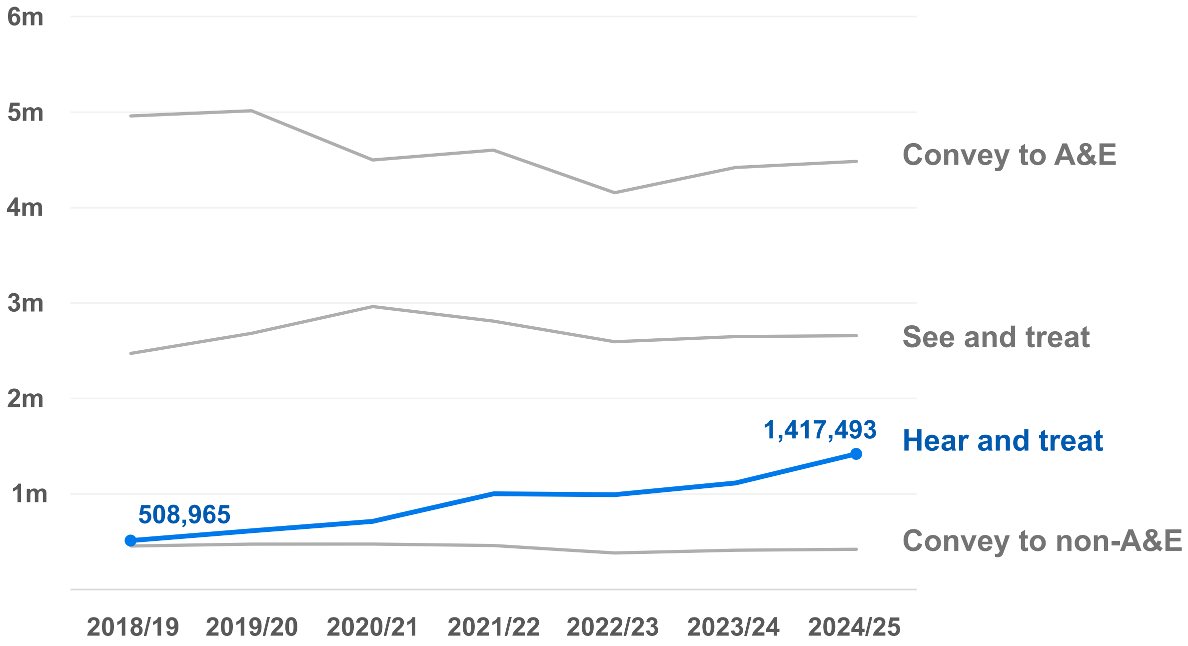
In an emergency, waiting a long time can be extremely frustrating and distressing for people, and can potentially affect their outcomes. In the free text responses to our 2024 Urgent and emergency care survey people told us that this is a particular concern for older people.

In many cases, people who call for an ambulance do not need to go to hospital, with NHS England stating that 1 in 5 people who attend the emergency department don't need urgent or emergency care.[36] To help people to stay at home, ambulance services also provide the following services:

- See and treat – this is where an ambulance crew responds to a call face-to-face but, following assessment and/or treatment, does not take the patient to hospital.
- Hear and treat – the ambulance service provides advice over the phone to people who do not have a serious or life-threatening condition.

In line with the government's 10-year plan to move more care from the hospital into the community[37], since 2018/19 the volume of see and treat responses has increased from 2,471,000 to 2,660,000 in 2024/25 – an overall increase of 8%, but down from its peak in 2020/21 during the COVID period. Hear and treat responses have seen the greatest increase; since 2018/19, the volume of hear and treat responses has almost tripled, from just over 500,000 to over 1.4 million in 2024/25 (figure 12). The London Ambulance Service reported how, for them, providing more hear and treat responses has freed up thousands of hours for ambulance crews, and reduced the time it takes for paramedics to reach the sickest patients.

Figure 12: **Ambulance responses 2018/19 to 2024/25**



Source: Ambulance Quality Indicators

Joined-up approach to providing urgent care

In November 2023, East Kent launched its new urgent community response service. The integrated service was created following a merger of East Kent's geriatrician-led frailty hospital at home (virtual ward) and nurse-led urgent community response services.

The service is co-located with ambulance services and hospital providers. Although focused on frailty, it provides care to all population groups. Using the combined skill set of the multidisciplinary team and co-location of staff, they are able to provide an urgent community response, a virtual ward, and a single point of access to a multidisciplinary team that works together to provide the best care pathway for each individual person.

The introduction of the new combined services has:

- increased rates of both hear and treat and see and treat responses
- improved ambulance response times
- increased referrals to urgent neighbourhood services
- reduced acute admissions and bed days.

Source: Nuffield Trust

In June 2025, NHS England published its Urgent and emergency care plan 2025/26, which set out plans to build on the progress made through both hear and treat, and see and treat services. Backed by nearly £450 million additional funding, the plan will enable ambulance services to prioritise the most critical cases while providing alternative pathways for those with less urgent needs.[38]

While there are positive moves to mitigate the pressure on ambulance services, the current levels of demand and pressure are continuing to have a negative effect on the staff. Results from the 2024 NHS staff survey show that ambulance staff continue to report poorer experiences of work:

- 39% said they felt burnt out compared with an average of 30% for all NHS staff
- 39% felt most exhausted at the thought of another day/shift at work compared with an average of 27% for all NHS staff
- 56% felt the most worn out at the end of their working day/shift compared with an average of 42% for all NHS staff.

Pressure on ambulance staff is compounded by the increased risk of abuse and violence they face. In 2024, nearly half (43%) of ambulance staff reported experiencing harassment, bullying, or abuse at work from patients, people using services, their relatives or members of the public in the last 12 months. Thirty-one per cent reported they had experienced violence at work from people using services or their relatives, or the public.

A report published by the Association of Ambulance Chief Executives (AACE) in April 2025 raised concerns about the increasing incidents of violence, aggression, and abuse directed at staff. It reported that in 2024/25, there were 22,536 incidents across the 14 UK ambulance services – an increase of almost 15% on the previous year.

Ambulance handovers

It is important that ambulances are able to transfer people into hospital as quickly as possible after they arrive, as delays can put patients' safety at risk and affect the quality of care they receive.

In April 2025, Unison published the findings of its survey of ambulance staff on their experiences of waiting times in emergency departments. Of the 588 respondents, more than two-thirds (68%) of ambulance workers reported patients' health deteriorating during long waits, and 1 in 20 (5%) said people had died in their care because of long delays in being admitted to hospital wards.

The standards for the length of time to hand over patients between ambulances and emergency departments are:

- all handovers within 60 minutes
- 95% within 30 minutes
- 65% within 15 minutes.[39]

However, high demand for ambulance services and pressures on urgent and emergency care departments mean that ambulance crews continue to struggle to meet these standards.

The following is taken from an inspection report, which highlights this issue:

“Difficulties with discharging ward patients was affecting ambulance handover targets. Patients at [this] hospital had longer ambulance handovers compared to other sites. The ambulance service reported a consistently larger percentage of handovers taking more than 60 minutes at [the] hospital when compared to the average for all hospitals served by the ambulance trust. The percentage of handovers taking more than 60 minutes at the site increased during periods of winter pressure... However, an improved ambulance handover and ‘cohorting’ process was implemented in December 2024 which had started to see a reduction in wait times.”

As well as increasing the risk to patients, delays can affect how quickly ambulance crews are able to respond to new emergencies.

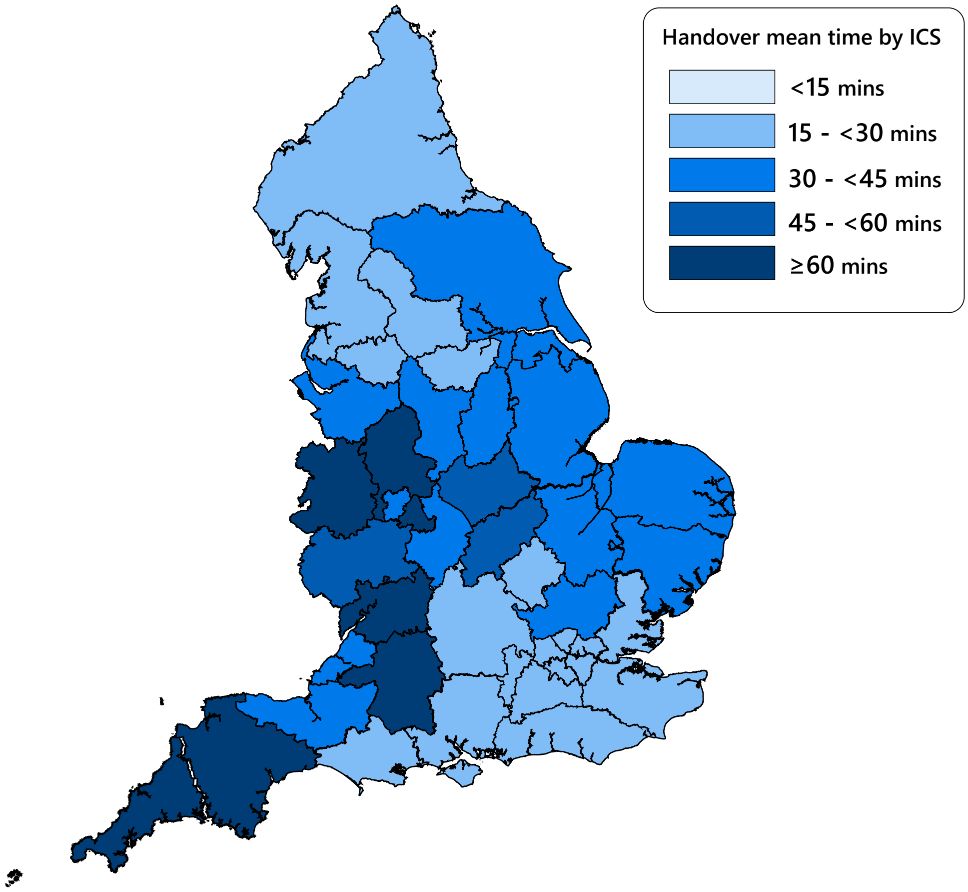
In total in 2024/25, there were 4,956,000 ambulance handovers. Of these, 4,712,000 had a recorded handover time as follows:

- 89% within 60 minutes
- 70% in 30 minutes
- 32% in 15 minutes.

From October 2024 to January 2025, average ambulance handover times were consistently worse than in the same period in 2023/24. However, this had improved in spring as average handover times in February and March 2025 were faster than the same period in 2023/24. In 2024/25, the national average handover time was 34 minutes 57 seconds.

The speed at which people were transferred from the ambulance into hospital continued to vary across the country. At ICS level, the average handover time ranged from 16 minutes 8 seconds to 1 hour 50 minutes 39 seconds (figure 13).

Figure 13: **Handover mean time map by integrated care system (ICS)**



Source: Ambulance: Management Information - Response times

People's concern at waiting in an ambulance may be alleviated by understanding the reason for delays and how long they may have to wait. However, results from the 2024 Urgent and emergency care survey showed that, overall, just under half (47%) of respondents who had to wait in an ambulance were definitely told why they had to wait, with nearly a third (27%) saying they were not kept informed.

Pressure on hospital services

Urgent and emergency care services struggling

In State of Care 2019/20, we reported how the number of people attending emergency departments at the start of the pandemic dropped dramatically. This made it more feasible for hospitals to manage patient flow in a safe and effective way. However, since the pandemic we have consistently raised concerns about the increasing pressure on urgent and emergency care services and the resulting impact on people who need to use these services.

For example, on one recent inspection of a type 1 urgent and emergency care service, we noted that capacity constraints and patient flow across the hospital meant that people couldn't always get care, treatment and support quickly enough. Attendances had increased in 2024, and the full capacity protocol was used 99 times in the last year.

In England, there are 3 main types of urgent and emergency care services:

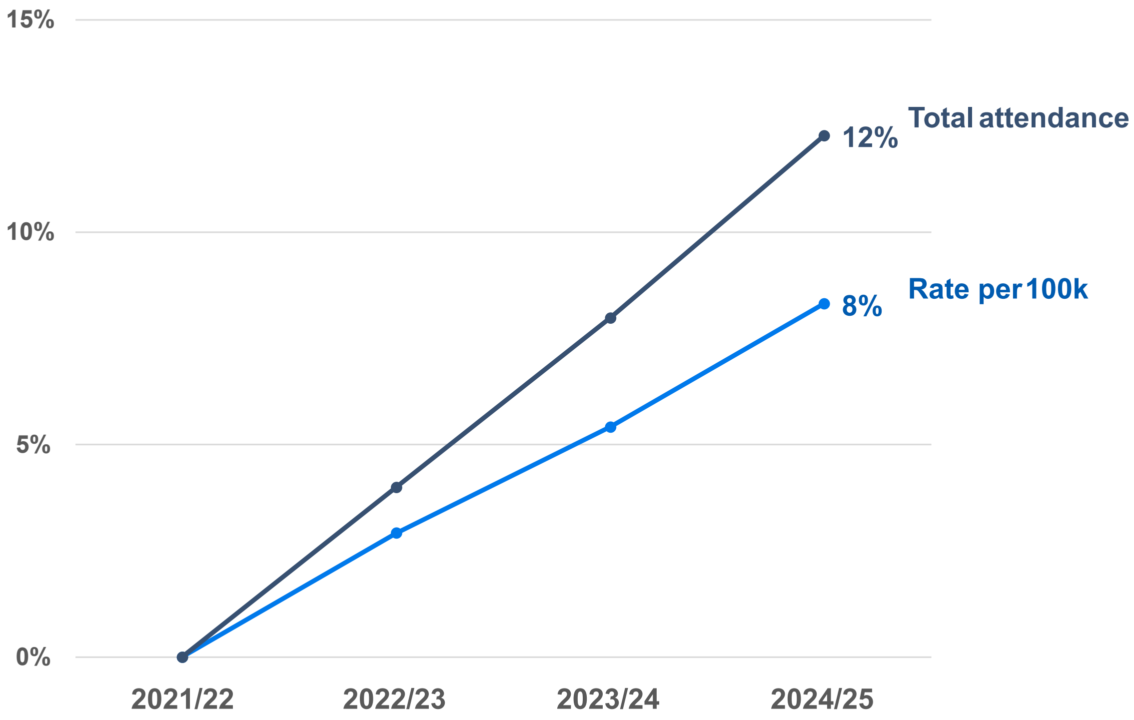
- type 1 – consultant-led 24-hour emergency departments with full resuscitation facilities and patient accommodation (also referred to as accident and emergency (A&E) or casualty)
- type 2 – consultant-led single service facilities for specific conditions, for example eye conditions or dental problems, and patient accommodation
- type 3 – GP-led urgent treatment centres, also called minor injury units.

Following the drop in attendances in 2020/21, there was an upsurge in attendances at all (type 1, type 2 and type 3) urgent and emergency care services, though this was still lower than before the pandemic. This upward trend in attendances has continued over the last 4 years, increasing by 12% (3 million):

- 24.4 million in 2021/22
- 27.4 million in 2024/25.

Looking at attendances at urgent and emergency care services over time, in line with the increase in overall numbers of attendances, there has been a corresponding increase in the rate per 100,000 population. From 2021/22 to 2024/25, attendances per 100,000 grew by 8% from 43,100 to 46,700 (figure 14).

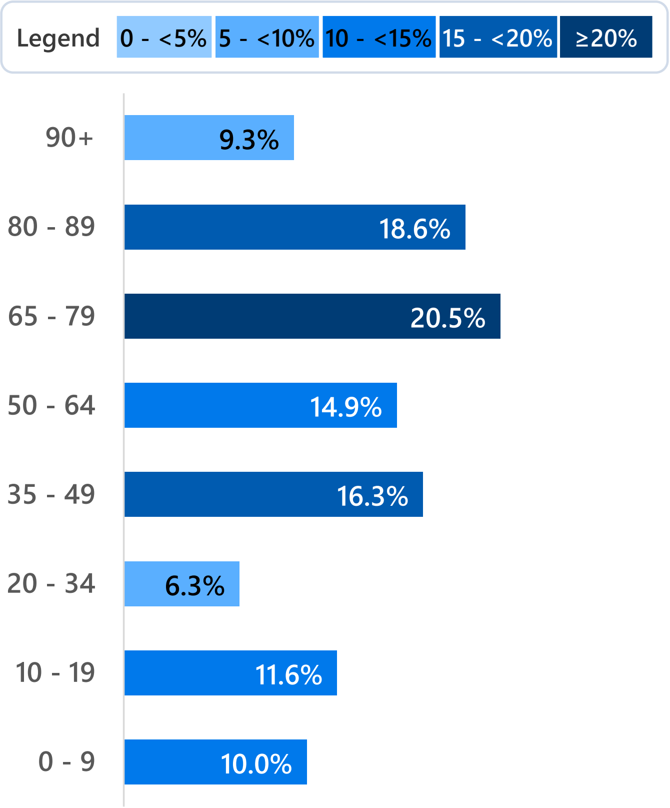
Figure 14: **A&E attendance percentage increase from 2021/22 to 2024/25, by count and rate per 100,000 people**



Source: A&E Attendances and Emergency Admissions - Quarterly Annual Time Series

Levels of demand vary across age groups. In last year's State of Care, we highlighted how attendances by children significantly increased following the COVID period and into 2022/23, though they did fall in 2023/24. From 2021/22 to 2024/25, the greatest percentage increase in attendances at urgent and emergency care services was in adults aged between 65 and 79 (up by 20.5%), and in adults aged 80 to 89, which increased by 18.6%, compared with 2021/22 (figure 15).

Figure 15: **Attendances at urgent and emergency care services by age group, 2021/22 to 2024/25**



Source: Hospital Accident & Emergency Activity 2024-25

As in previous years, demand also varies across the country, with people in more deprived areas more likely to attend urgent and emergency care services.

The number of attendances continues to rise across all 3 types of urgent and emergency care services. However, since the pandemic we have seen a shift in the way people are accessing these services, with the greatest growth seen in type 3 services. In 2024/25, attendances at type 2 services grew by 11% (59,000 additional attendances) and attendances at type 3 services grew by 8% (750,000 additional attendances) from the previous year. This compares with a 1.4% growth in attendances at type 1 services (237,000 additional attendances).

We have also previously raised concerns about people not being able to get the care they need from primary care and other services, which adds to the pressure on urgent and emergency care. As part of our analysis for this year's State of Care, we interviewed more than 20 patients to explore their experiences of the urgent and emergency care pathway. While it was not always clear whether the attendance could have been avoided, for some patients a lack of responsive and effective care in the community continued to be a reason why they had sought urgent care.

The results from the 2024 Urgent and emergency care survey also suggest that a lack of timely access to other services may still be contributing to unnecessary attendances at urgent and emergency care services.

This survey found that two-thirds (66%) of respondents who visited an emergency department (type 1) and 50% of respondents who used an urgent treatment centre (type 3) said they had contacted another service first. Where respondents had contacted another service first, they were most likely to have contacted NHS 111 or their GP.

Of the 34% of respondents who went to the emergency department first, 26% said they had not gone to another service first because they wanted to be seen on the same day. In addition:

- 16% said ‘my condition was life threatening’
- 20% (1 in 5) said they did not think their GP would be able to help
- 41% (4 in 10) said that they thought they might need a test.

While other options are available, this could suggest that people feel they need to go to an emergency department in order to be seen on the same day.

Long waits for urgent and emergency care

Recent figures from the Office for National Statistics (ONS) highlight the importance of people being seen promptly on arrival at urgent and emergency care services. The data, published in January 2025, shows that patients who wait in the emergency department for more than 2 hours have an increased risk of death. This risk continued to increase the longer patients waited beyond 2 hours.[40]

The NHS Constitution pledges that people should wait no longer than 4 hours in urgent and emergency services from arrival to either admission, transfer, or discharge. However, results from the 2024 Urgent and emergency care survey show that people are continuing to face long waits for care, with nearly two-thirds of people (64%) saying their visit to the emergency department lasted more than 4 hours. Nearly a third (29%) reported that they were in the emergency department for 8 hours or more.

Long waits, which we see mostly in type 1 emergency care services, are reflected in performance data from NHS England. On average in 2024/25, people waited under 4 hours in 74% of attendances across the 3 main types of urgent and emergency care services. Waiting times were longer for type 1 services, where only 59% of attendances were under 4 hours. In both cases, the figures are below the current temporary target of 78% and well below the 95% target set out in the 2010 operational standards.

We’ve heard directly from people about the impact of such long waits through our Give feedback on care service:

> *“[At] our visit to the new emergency department … [in] January… we were there for 12+ hours … 9 hours of that my partner hadn’t been seen by anyone not even obvs, she was very tachycardia.”*

Recent research from the Royal College of Emergency Medicine (RCEM) has revealed how older people (aged 60 and over) are more likely to experience a long wait in the emergency department. It shows that last year more than a million older people faced waits of 12 hours or more in emergency departments in England.[41]

Analysis of free text responses to our 2024 Urgent and emergency care survey highlights the impact of these long waits and the additional consequences on older people and people who are frail. We found that older people were often disorientated and had a profound sense of helplessness during extended waits for urgent care services:

> *“At [a very old] age she was kept waiting 6 hours plus. In the end she was tired and hungry and we took her home without treatment. She was taken to … hospital 2 days later and diagnosed with an eye stroke. I feel to keep someone of that age waiting 6+ hours is unforgiveable.”*

> *“They were muddled in some of their explanations and we ended up waiting longer than necessary because medication hadn’t been given. As an elderly patient who hadn’t had much sleep, this made the experience more challenging.”*

A personal story: Long wait for urgent care

Fiona told us about her father’s experience of being admitted to hospital following a fall at home.

Despite having a number of hip and shoulder operations over the years, Robert, who is 87 years old, was still very active and able to live an independent life. In 2024, Robert started to have minor falls and accidents at home. Unfortunately, one day he ended up having a more serious fall at home and dislodged his hip.

Fiona called for an ambulance as Robert was in agony. He was taken to their local emergency department at around 6pm and seen quickly. However, due to a lack of available beds on the wards, he was pushed to a corridor at the back of the emergency department. There was little or no communication as to how long it would take to find him a bed and when he would be having an operation to put his hip back into place. He was just left there.

Fiona stayed with her father and got him water. She needed to return home and expected that he would be moved onto a ward. When she left at 3am he was still not on a ward. Her father wanted to go home with her; he didn't understand what was happening and why he wasn't being moved. Fiona went home to get some clothes and when she returned to the hospital, she found her father was still in the same place. They were given no information about when he would move or when he would be having his minor operation to put his hip back in place.

The staff had occasionally checked his blood pressure and offered him some food once, but there was no reassurance that a bed would be found. While she understood that nurses and doctors are overworked and underpaid, often working with low resources, Fiona felt that a little reassurance and compassion for her father would have helped her feel much better. It was very stressful for him and upsetting. He was in a lot of pain and, mentally, it was not good for him to be under the stress of not knowing what was about to happen and just being left out in a corridor.

The next morning, they told him they would operate on him that same day. After the operation he was on the ward for recovery. Once he was in the ward he was comfortable and they cared for him and they were very kind and brilliant. He left the hospital after 2 days on the recovery ward with his intermediate care package in place.

Robert has recovered well and is in a much better mental state. However, following his experience he is scared of going back into hospital.

(Interview with member of the public)

While not an inevitable consequence of ageing, frailty is more common among older adults.[42] The British Geriatrics Society states that any interaction between an older person and a health or social care professional should include an assessment that helps to identify whether the person has frailty.[43] As part of its Care of Older People Quality Improvement Programme, the RCEM shows that between 4 October 2023 to 3 October 2024 just over half (56.27%) of older people attending emergency departments were screened for frailty.[44]

Through our inspections of urgent and emergency care services, we have found examples of services that are working to address the specific needs of older patients attending emergency departments.

For example, in an inspection of an urgent and emergency care service, we saw evidence of different teams working together to improve care for older people:

During our inspection, we heard feedback about joint working between the medical services team and the urgent and emergency care team at another NHS hospital. There was joint working with the frailty team to review frail patients who attend urgent and emergency care services by ambulance. Patients with a high frailty index score may deteriorate quickly, so the frailty team could work as an admission avoidance service. The frailty service was co-located in the emergency department. A project had also been undertaken with the service's pharmacy team to improve timely dispensing of medicines for discharge.

But exceeding the 4-hour wait target in urgent and emergency care is only part of the picture. Since February 2023, NHS England has published figures showing how many patients have to wait more than 12 hours from arrival to either admission, transfer, or discharge. These show that in 2024/25, 1,809,000 people waited over 12 hours from the time of their arrival; this is 169,000 (10%) more than in 2023/24.

During our inspections, people have told us about experiencing long waiting times in an emergency department:

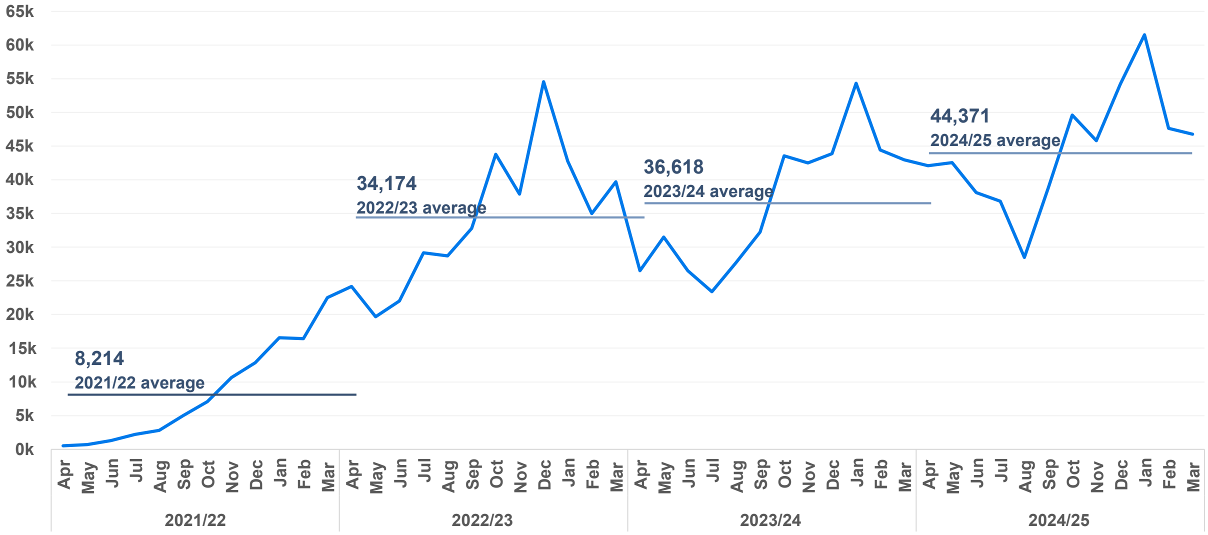
When we arrived at one emergency department, the longest waiting time for a bed or admission was 22 hours at 10am. A larger percentage of patients at the hospital were spending more than 12 hours in the emergency department compared with other sites in the region and nationally.

At another inspection, most patients we spoke with told us they had experienced long wait times while in the emergency department. After the decision to admit had been made, some waiting times were in excess of 40 hours.

The number of people who need to be admitted to hospital after attending an urgent and emergency care service also continues to increase. In 2024/25, 4.87 million people needed to be admitted to hospital from the 3 main types of urgent and emergency care services – over 90,000 more than 2023/24 and over 200,000 more than in 2021/22.

Before 2022, long waiting times for admission to hospital were rare. While admissions through urgent and emergency care services have only increased by 5% since 2021/22, people are facing much longer waits to be admitted. Data from NHS England shows that 532,500 (11%) people waited for more than 12 hours in 2024/25, increasing from 98,600 (2%) in 2021/22 (figure 16).

Figure 16: **Number of people waiting over 12 hours from decision to admit to admission**



Source: A&E Attendances and Emergency Admissions - monthly data

People's feedback through our Give feedback on care service highlights the additional strain this puts on emergency departments and the impact on people:

> *"My mum spent 2 days in A&E waiting for a bed on a ward. During that time I saw that there were clearly not enough staff, resulting in a 1 hour wait for a commode and my mum subsequently wetting herself. At one point there were not even enough commodes to meet patient needs. Whilst some staff on A&E were kind, there were some who were rude and bordered on aggressive."*

Providing care in inappropriate spaces

The ability to move people out of the emergency department is affected by how many beds a hospital has available on the wards. To be able to manage variations in demand and ensure that patients can flow through the system, NHS operational guidance recommends that no more than 92% of beds should be full at any one time. However, the Royal College of Emergency Medicine (RCEM) recommends that hospitals should define thresholds for occupancy, and justify if they exceed 85%.[45]

The average occupancy levels of general and acute beds have continued to sit at 93% during the last 3 years, rising to 94% over the winter months. The number of general and acute beds has steadily increased over the last few years from an average of 95,000 in 2021/22 to 102,000 in 2024/25, a rise of 7.4%. While the total number of beds has continued to increase, over the last 3 years it has only been keeping pace with the growth in population, meaning that capacity remains tight.

A lack of available beds not only increases delays in emergency departments, but can also lead to patients being placed in inappropriate settings. Through our Give feedback on care service, people have told us of instances in which they, or a family member, had to wait to be seen and/or treated in side rooms, which offered little or no privacy, or of being left on trolleys in corridors for hours on end without any interaction with medical staff.

Results of the 2024 Adult inpatient survey showed that of the people who had to wait to get a bed on a ward, people were asked to wait in the following locations:

- treatment bay (46%)
- corridor/hallway (18%)
- storage room/cupboard (1%)
- waiting room (31%)
- somewhere else (10%).

Older people in this situation are particularly vulnerable due to their increased risk of frailty. In the free text responses to the 2024 Urgent and emergency care survey, frail older respondents were highly critical of the care they experienced in inappropriate settings, though they did acknowledge the dedication and patience of staff:

> *"… waiting on a corridor on a trolley for more than 24 hours. This is particularly harrowing for an elderly, poorly person. This seems to be the norm at [hospital] and we have witnessed other patients waiting on trolleys suffering and totally neglected."*

> *"… I decided that instead of having to go through the horrors of spending three nights on the corridors of [hospital] I was prepared to die."*

> *"… sometimes I was left on a trolley by the doctors and nurses' desk as not enough cubicles were available. Doctors and nurses were forced to shuffle patients in [and] out of cubicles to examine them. Due to my age and health conditions I was at risk of contracting infections, but was placed by another patient with breathing difficulties that was possibly COVID, to which I later caught during my attendance."*

This was echoed in comments received through Give feedback on care, where staff and people told us their concerns about people being cared for in hospital corridors:

> *“Corridor care is putting patients across the wards at risk, for example, an unexpected death occurred recently which, if investigated properly, will show that the patient’s obvious deterioration was not escalated and an opportunity to intervene earlier was missed.”*

> *“Corridors full of people on stretchers. No beds. Patients who have been waiting for over 12 hours have not been offered any water or food. [A] woman with broken hip [has] been waiting on a stretcher for over 8 hours so far. Over 45 patients for 2 nurses.”*

A June 2024 report from the Royal College of Nursing raised concerns about the impact on patients of care in inappropriate settings. Based on a survey of 11,000 nursing and midwifery staff, the report found that nearly two-thirds of nursing staff (63%) were worried that patients were receiving unsafe care, with 67% of respondents saying that corridor care was compromising patients’ privacy and dignity.[46]

Concerns around the use of inappropriate spaces are not new. In 2018, we published Under pressure: safely managing increased demand in emergency departments. This found that, despite clear guidance to NHS trusts that it is not acceptable to use inappropriate spaces, many hospitals were routinely using inappropriate spaces with no plans in place for alternative, safer accommodation.[47]

We are continuing to see the same issues arising on our focused inspections of the urgent and emergency care pathway. We have made it clear in our guidance to trusts that the use of inappropriate spaces is not acceptable. Patients should receive safe and effective care in an environment that allows for their privacy and dignity to be protected, and that ‘corridor care’ must not become normalised.

However, the results of the 2024 Adult inpatient survey show that in some cases the short-term use of temporary escalation spaces to relieve pressure across the urgent and emergency care pathway is a reality. As recommended in our Under pressure report, trusts need to make a trust-wide assessment of the safest places to care for any patient, taking into account the physical environment but also the staffing available. Patients should not be cared for in unsuitable spaces such as emergency department corridors, or in ambulances on the hospital forecourt. Trusts also need to have agreed metrics for measuring capacity in the emergency department, which can then be used to manage crowding and monitor against hospital resources, for example bed capacity.

The length of time spent in hospital can also have an impact on people, with unnecessary stays in hospital linked to worse health outcomes.[48] The proportion of people staying over 7, 14 and 21 days has remained similar to 2023/24, with patients staying over 7 days accounting for half of all adult general and acute hospital beds (47,600 out of 90,600). Almost a third of adult patients (28,200) stayed in hospital over 14 days, and 1 in 5 (18,400) stayed over 21 days.

A 2015 report by the Nuffield Trust highlighted how reducing the length of time that people stay in hospital could help to manage demand for beds and flow through hospitals.[49] NHS England has recognised this, with the NHS Long term plan and 2024/25 NHS operational guidance both committing to reducing the length of hospital stays.

However, we recognise the challenge for hospitals in ensuring patients are well enough to return home. As highlighted in our section on discharges, if people are discharged too soon it can lead to them being readmitted at a later date.

Challenges with hospital discharges

Patients who have long hospital stays (3 weeks or more) tend to be in poorer health and may need more support when they are discharged.[50] In its May 2025 Quality Watch, the Nuffield Trust reported that discharge delays, where a person has not been discharged from hospital despite being assessed as being medically fit to leave, is one of the biggest challenges facing the NHS.

Latest figures from NHS England suggest that, after a substantial increase in 2021/22 and into 2022/23, the volume of patients who were medically ready to be discharged but remained in hospital has stayed stable over the last 3 years. On average, this meant there were 12,660 patients each day in 2024/25, compared with 12,690 in 2023/24 and 13,230 in 2022/23.

The high volume of delayed discharges also highlights a lack of substantial improvement in patient flow out of hospitals to more appropriate care settings. This in turn maintains pressure across the wider health and care system, as hospital beds remain occupied, limiting capacity for incoming patients and creating knock-on effects throughout the system.

On average, in March 2025 nearly 6 in 10 patients (58%) who were medically ready to be discharged on a given day experienced a delay. This varied across the regions, from 44% in the East of England to 66% in the North West in the same period. As highlighted in our section on adult social care, issues with capacity within care homes or home care services as well as bed-based rehabilitation, reablement or recovery services, risk exacerbating these delays.

We commissioned research with National Voices, in which people were asked about their experiences of the discharge process. On the whole, people reported having a positive experience when it came to being discharged from hospital and receiving follow-up care in the community, with the majority of respondents to the questionnaire saying that they were happy with where they were discharged to.

However, some people described how issues such as discharge delays, a lack of co-ordination, or a breakdown in communication during the discharge process left them feeling confused and unhappy.

One interviewee who had negative experiences of being discharged from hospital described how they were told they were ‘bed blocking’ and so were being discharged regardless of whether they felt ready to leave.

> *“The doctor who I hadn’t seen had a look at my notes and deemed me fit for discharge, at which point a physio came along and introduced me to a pair of crutches and said we’ve got to go down to the end of the ward and do the stairs [...] I couldn’t manage the crutches, I was going in different directions, totally unsafe, so she dumped me in a wheeled commode.”*
>
> (Interview participant)

People described how an inadequate discharge process can also have an impact on emotional wellbeing, leading to a sense of frustration and/or heightened anxiety. One interview participant who eventually went on to have a good experience of follow-up care described how a poor experience during her hospital stay and discharge process left her feeling dehumanised.

> *“Two days after [discharge] a physio and a paramedic [came to see me]. The paramedic was doing the job of the [occupational therapist] and the nurse. The community physiotherapist actually burst into tears when she started talking to me because [I said that I] actually felt seen and I felt heard as a human being rather than a lump of meat, which is what I had felt for most of the time in hospital.”*
>
> (Interview participant)

The research we commissioned from National Voices found that a poor discharge experience can be damaging for people who are more at risk of experiencing health inequalities as it can lead to exacerbating poor health outcomes.

This is supported by evidence from the 2024 Urgent and emergency care survey, which showed that frail older people are particularly affected by poor discharges. This can have a detrimental effect on their recovery, potentially exacerbating existing health issues and making them more severe and long-lasting. Poorly planned discharges can sometimes lead to increased risk of harm, or unplanned readmissions, as is illustrated through this experience from Give feedback on care:

> *"I am writing this on behalf of ... [my] brother-in-law. He has cerebral palsy and is non-verbal and severely disabled. His sister and I accompanied [my brother-in-law] to A&E on 2 consecutive days. Day 1 he was taken to A&E by ambulance after a fall caused by a serious infection affecting his mental awareness. After spending 12 hours in A&E (overnight) he was discharged, despite our concerns that he was too unwell. Day 2 after being home for 2 hours it was obvious to us that he should not have been discharged. We took him straight back to A&E and spent another 20 hours there (overnight again) before he was finally admitted as an inpatient. He was discharged 12 days later. A terrible traumatic experience for an elderly, disabled man."*

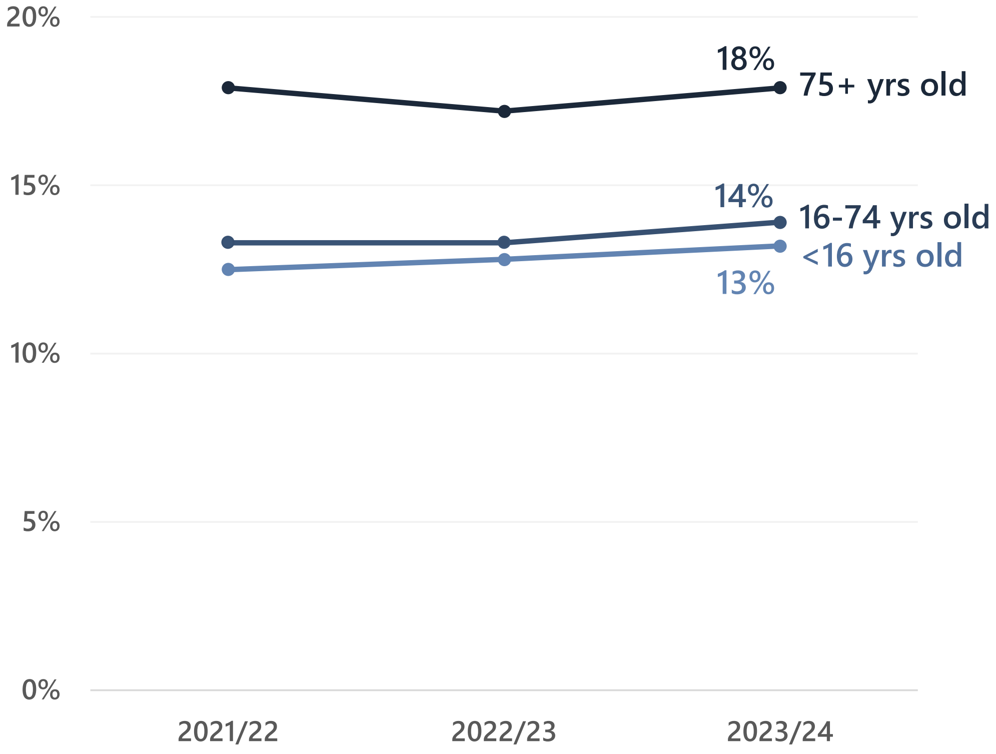
People needing emergency readmissions

Once discharged from hospital, the whole system needs to work together to keep people well. Not doing this effectively can lead to people being admitted to a hospital again.

Data from NHS England shows a steady increase in the percentage of emergency readmissions over the last 10 years. In 2023/24, the latest data available for a complete year,14.8% of all emergency admissions were for patients who had been previously discharged from a hospital within the last 30 days.

The older a patient is, the more likely they are to be readmitted to a hospital within 30 days of the most recent discharge. The highest proportion of readmissions for this measure has consistently been people aged 75 and over, with 17.9% patients readmitted within 30 days of their most recent discharge in 2023/24 (figure 17).

Figure 17: **Percentage of cases in which the patient was admitted to a hospital within 30 days of the most recent discharge by age group**



Source: Compendium - Emergency readmissions to hospital within 30 days of discharge - NHS England Digital

People living in the most deprived areas of England are also more likely to be readmitted to a hospital within 30 days compared with the national average.

People waiting for hospital care

More people needing diagnostic tests

Diagnostic activity forms part of over 85% of clinical pathways.[51] The NHS Constitution states that this should happen in less than 6 weeks after being referred. This is important, as a prompt diagnosis can save lives, saves time and money, and can prevent conditions from getting worse.[52]

Since 2008/09, the average number of tests carried out for people on the waiting list has doubled. However, as we highlighted in last year's State of Care, waiting lists have continued to grow, rising nearly fourfold over the same period. In 2024/25, the average number of people waiting for a test rose by just over 36,000 to 1,627,000 from 1,591,000 in 2023/24. This suggests demand for diagnostic tests continues to increase.

Strain on diagnostic services has also been exacerbated by an increase in unscheduled diagnostic tests, with the number of unscheduled diagnostic tests increasing from an average of 478,000 to 520,000 per month over the last year.

Long waits for planned treatments

According to The King's Fund, waiting times for hospital treatment consistently rank as one of the public's main concerns, and have a big impact on patients' experiences of the NHS.[53]

Furthermore, the Nuffield Trust highlights that waiting a long time for treatment can have detrimental effects on patients. It can result in worse prognosis, a need for more complex surgery, increased medication, and a slower process of recovery.[54] This is supported by the results of our 2024 Adult inpatient survey, which found that 43% of elective patients said their health deteriorated while waiting to be admitted to hospital.

During the COVID pandemic, the number of people waiting for elective treatment grew substantially. As we reported last year, between March 2019 and March 2024, waiting lists for elective care increased by almost 80% (from almost 4.2 million to just over 7.5 million people). As at March 2025, this had reduced to 7.42 million people waiting for treatment, and stood at 7.37 million by June 2025.

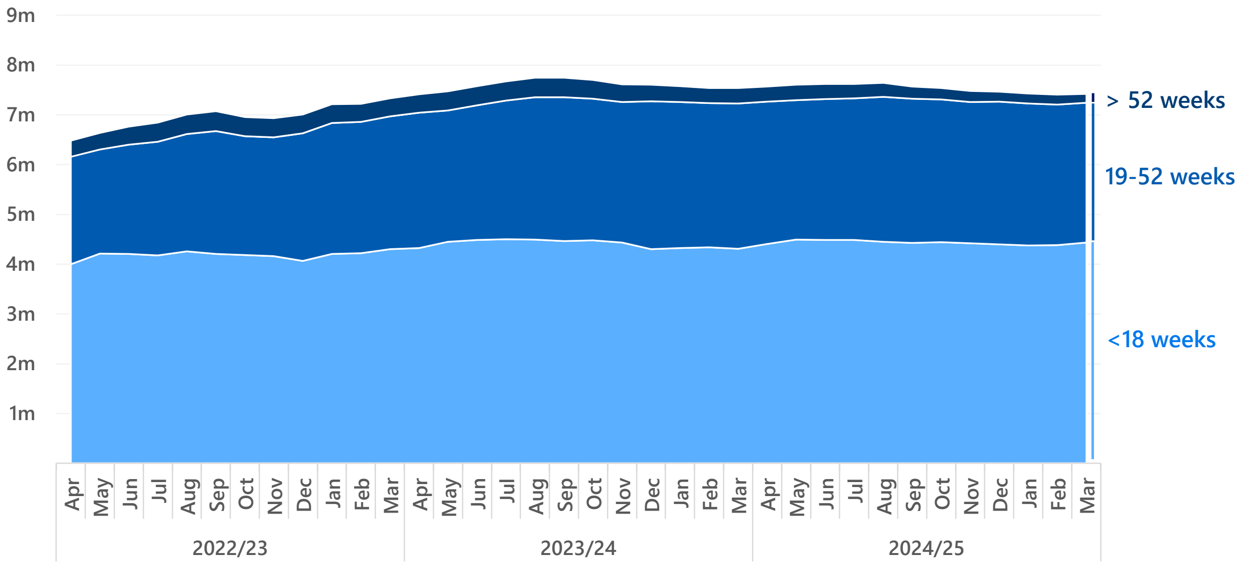
The length of time people have to wait for treatment following referral from their GP or consultant, or through the emergency department, is known as 'referral to treatment time'. In this period, the patient may undergo diagnostic tests and scans, have medicine or therapy prescribed, or have their referral revised.

The NHS Constitution states that 92% of patients should wait no longer than 18 weeks from referral to treatment.[55] The last time this standard was met was in February 2016.

To tackle this issue, in January 2025 NHS England set out its commitment to meeting the 18-week standard by March 2029 in its Elective Reform Plan. It also set out a midterm commitment to ensure 65% of waits were under 18 weeks by March 2026. As at March 2025, 59.8% of patients had been waiting 18 weeks or less. While this positive upward trend has continued into 2025/26 (61.5% in June 2025), it remains to be seen whether the March 2026 commitment is achievable (figure 18).

The number of people on the waiting list for more than a year increased from 1,150 (0.03% of the waiting list) in March 2019 to 180,000 in March 2025 (2.4%). While respondents to the 2024 Adult inpatient survey were generally still positive about their experience of how long they had to wait before being admitted to hospital, 42% of people felt that they had to wait too long.

Figure 18: **Total number of active referral to treatment pathways by waiting time**



Source: Statistics » Referral to Treatment (RTT) Waiting Times

The proportion of people waiting 18 weeks or less varies between types of services. As of March 2025, no service type met the standard of seeing 92% of referrals in 18 weeks. However, 8 service types met the midterm standard of seeing at least 65% of referrals in 18 weeks, with elderly medicine service performing best at 81.3%. Oral surgery was the poorest performing service with 50.7% of waits of 18 weeks or less in March 2025.

NHS England has recently published a demographic breakdown of people on the elective waiting list at the end of July 2025. This shows that the proportion of people waiting for 18 weeks or less varies by age, with the shortest waiting times for those in the over 65 group (63.5%), compared with 59.3% for young people aged 0 to 18 years, and 58.1% for people aged 19 to 64 – a gap of 5.4 percentage points from best to worst. This pattern is largely followed at the integrated care system (ICS) level, though for some ICSs the gap between the age groups is much larger. In one ICS there is a gap of 16.9% between those with the longest waits (51.6% of young people aged 0 to 18 waiting 18 weeks or less) and the shortest waits (68.4% of people over 65 years).

While waits of 18 weeks and over for young people aged 0 to 18 are lower than some, they are still too high. In January 2025, a group of children's charities and medical organisations, including the Royal College of Paediatrics and Child Health and NHS Providers, published a joint statement calling for urgent action. Noting the pending introduction of the NHS 10-year plan and the focus on prevention, the statement highlighted how early intervention in childhood is central to ensuring a healthier future for everyone, and the need for greater investment in childhood services.[56]

Where people live in England continues to affect how long they have to wait. In 2024/25, no ICS achieved the 92% standard for waits of 18 weeks or less. In the same year, 8 out of 42 ICSs met the 65% midterm standard at least once in the 12 months, compared with 6 in 2023/24. The proportion of people waiting 18 weeks or less varied from 70.2% to 50.8%.

The recently published demographic breakdown of those on the elective waiting list also highlights differences based on the level of deprivation where people live. The proportion of people waiting for 18 weeks or less in the most deprived areas is 59.2%, compared with 60.9% for the least deprived – a gap of 1.8 percentage points. Again, this varies more at an ICS level, with a gap for one ICS of 10.2 percentage points.

People told us their experiences of waiting for elective care through our Give feedback on care service. They described often having trouble making appointments and waiting a long time before actually being seen. People also told us that appointments were often cancelled and/or re-scheduled at short notice, often with little or no explanation as to why this had happened.

For example, one person said his appointment had been made and cancelled on 4 separate occasions. Not only did this create concerns around his health status, it also affected his working life as he had to negotiate time off to attend appointments that were then cancelled.

> *"... my mother... is under the care of vascular surgery. She has not been given an appointment in over 2 years; over this time they have cancelled 5 appointments without giving any reason. Despite the fact she is a high-risk patient with chronic circulatory issue in both legs. Her GP has re-referred her to help get her seen, but again the appointment was cancelled without any indication of another appointment being offered. This was nearly 3 months ago and still no appointment has been offered for the cancelled appointment."*

> *"I have been referred back to audiology because my hearing impairment has changed. Even with my hearing aids I find hearing what people are saying tricky. I am fit and well otherwise and I continue to work full time as a teacher. The classroom environment with young children is often noisy and I depend on my aids so that I can continue to work. I was referred back to [the hospital] in January. My letter said that if I didn't hear from audiology by 22nd June to ring. This I did and was told there was an 18-month wait to be seen. I feel this is far too long and that in reality this service is being run down forcing people to turn to private hearing aid providers. I feel very strongly that, particularly in my circumstances, maintaining quality hearing in older people is critical. In my case, clear hearing means I can continue to work, but I understand*

that there is recent research that shows good communication skills, including hearing help to thwart dementia. It also stops social isolation."

Care and treatment for cancer

In our 2 previous State of Care reports, we have highlighted our concerns around the length of time people have to wait for referrals for cancer tests, as well as delays in starting treatment. While there has been some improvement, in many cases performance is still not meeting standards.

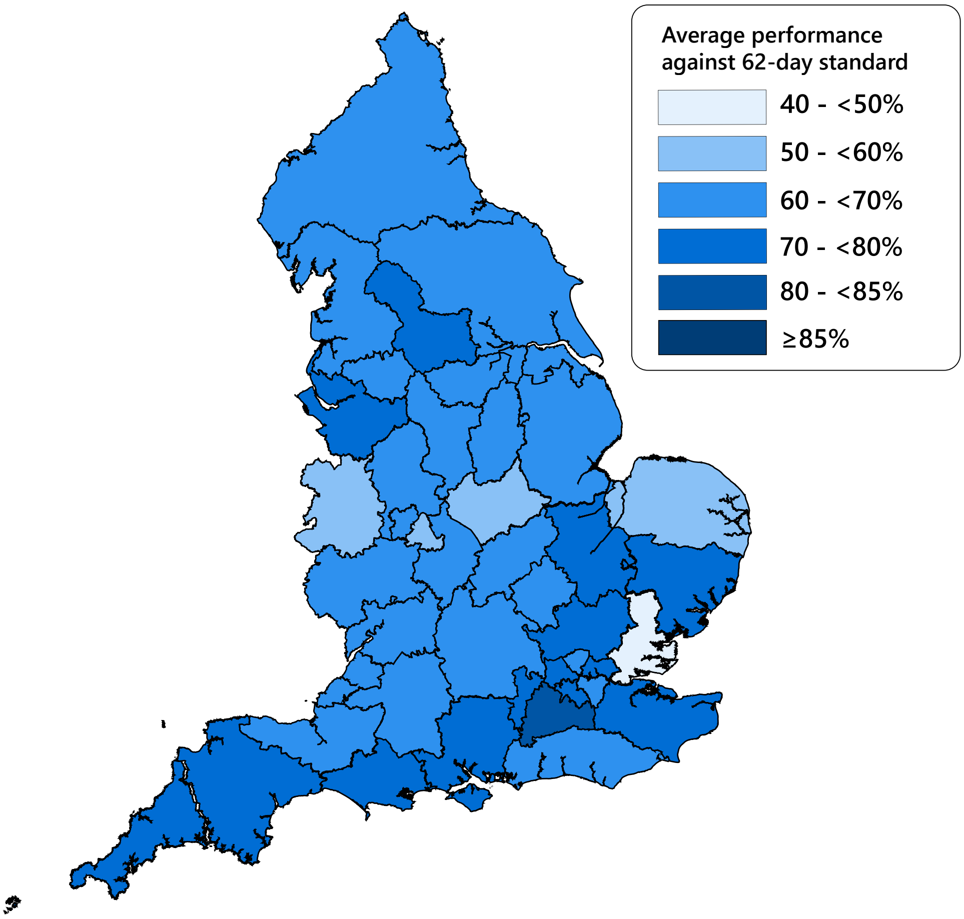
NHS guidelines state that 75% of people should have a diagnosis of cancer or have cancer ruled out within 28 days of being referred. Last year, we reported seeing some improvements in performance against the 28-day faster diagnosis standard.

This has continued into 2024/25 where, except in 3 areas, average performance has improved in all integrated care system (ICS) areas. The average national performance for the year was 76%, with 85% of cases meeting the 28-day standard in the best performing ICS area. Average performance in the worst performing area was 67% which, although below the standard, was still a 7% improvement from the previous year. However, the picture is less positive for people who start treatment after being diagnosed.

Ninety-six per cent of people should have their treatment started within 31 days of a decision being made to treat their cancer. Last year, we reported that the 31-day standard had not been met nationally in the period we reviewed. This year, we have continued to see a struggle to meet the national standard, with only 9 ICS areas meeting the standard at least once in 2024/25. This is an improvement from the previous year, where only 5 out of 42 ICSs met the standard at least once in 2023/24.

For those with an urgent referral, 85% of people should have treatment started within 62 days. Last year, we reported that performance against the 62-day standard is poorer than the other targets. While there has been improvement in performance in 37 out of 42 ICSs in 2024/25 compared with 2023/24, the standard was not met nationally, and no ICS area met the standard in 2024/25. Performance varied widely, ranging from 80% of cases seen within 62 days in the best performing ICS area to 49% in the worst performing areas (figure 19).

Figure 19: **Average performance against the 62-day standard from an urgent referral to the first treatment for cancer in 2024/25**



Source: Statistics » 2024-25 Monthly Cancer Waiting Times Statistics

As highlighted by Cancer Research UK, cancer that is diagnosed at an early stage, when it isn't too large and hasn't spread, is more likely to be treated successfully.[57] In 2019, the NHS Long Term Plan set out an ambition that by 2028, 75% of all cancers will be diagnosed early (stage 1 and 2). The latest available data from 2022 showed that 53% of cancers were diagnosed early at stage 1 or stage 2.

Respondents to the survey carried out by the Nuffield Trust reported a mixed picture of progress against inequalities in early cancer diagnosis. While 17% reported 'significant progress' in this area, 39% reported 'very little' or 'no progress' (31% 'very little' progress, 8% 'no progress').

People who wait a long time for care and treatment for cancer continue to speak to us about the negative consequences it has on their lives. Waiting a long time for test results and diagnoses means that the quality of life for some people is severely diminished due to uncertainty and fear, especially when communication with care providers is difficult or unpredictable, and there is a lack of emotional and practical support.

Some people have told us how long waits for diagnostic tests means that their chances of making a recovery have been badly affected. In a few cases, people tell of missed signs and wrong diagnoses leading to delayed or missing care. When people do receive care, some find that their care is not joined up between different parts of the system, leading to miscommunication, confusion, missed treatments, and ultimately poorer outcomes for people with cancer and their loved ones.

Quality of care for people in hospital

Patients consistently tell us that their experience with staff is key to their experience of healthcare. Most respondents to our 2024 Adult inpatient survey had a positive experience in their interactions with doctors and nurses, such as being treated with respect, dignity, kindness, and compassion. However, overall, the survey shows that people's experiences of care have become less positive since 2020.

This is supported by analysis of our Give feedback on care submissions, which highlights concerns around the quality of the care people received and the attitude and behaviour of staff.

In some cases, people were worried that staff were not meeting people's basic care needs:

> *"My concerns are that my Mum is not proactively getting her basic care needs met so that she is deteriorating to an extremely poor state. She is cold and dehydrated and the ward staff are not doing anything about it."*

> *"I am worried that my family member is not getting the care they need. If the ward carries on the way it is, a patient could be seriously injured or worse. A fatality may happen. This needs to be addressed immediately."*

There were also concerns that the lack of adequate monitoring of patients, particularly older and frail people, compromised their safety. For example, we heard of people being left in wet and/or soiled clothing for extended periods. Not only does this increase the risk of infection, but it also has a negative impact on the dignity of the person concerned, as the following experience shows.

> *“Laying in own urine and faeces. Family called at 07.52am and found patient still laying in his own urine and excrement at 11.30am upon visiting. When family have been present to alert staff to his double incontinence the call bell goes unanswered; daughter timed 15 and 22 minute delay and the latter was answered by a [healthcare assistant] who was very rude towards patient unaware family on FaceTime call to him. Patient called as he was in significant pain writhing on bed. Distressing to see by family.”*

People also described being concerned about the knowledge and competency of some of the medical staff who were taking care of them, which they felt could be detrimental to patient safety:

> *“I also got the impression staff have limited knowledge on physical health of the mother, they had knowledge of foetuses and babies but when I raised concerns about my own physical health I was dismissed as if it was nothing, without even so much as my observations being checked.”*

As we have reported previously, a lack of support for staff can affect their wellbeing and have a direct effect on the quality of care being delivered. Examples include making errors with medicines, not respecting people’s choices, and people receiving poorer quality care or less care than they need.

The 2024 NHS staff survey found that:

- less than half (47%) of staff say they are able to meet all the conflicting demands on their time at work
- only 34% said there are enough staff at their organisation for them to do their job properly
- 30% of NHS staff feel burnt out.

While all these measures have improved in the last 2 years, they show staff are still under significant strain.

In our review of the urgent and emergency care pathway, we interviewed both patients and staff to understand their experiences. Staff told us about the ongoing strain they feel. They said that persistent understaffing, poor skills mix, and pressure to admit patients despite a lack of capacity and ward beds was having an impact on their wellbeing. Some staff described how support from leaders and colleagues made it easier to manage pressure. However, others commented that they felt there was a lack of support from managers and senior leaders.

Feedback received through Give feedback on care submissions similarly shows ongoing concerns around workplace cultures. This includes staff reporting incidents of bullying and intimidation from both managers and colleagues, as these experiences show:

> *"Witnessed the [intensive care unit] matron being bullied by her manager and others ganging up on her. She seems to have a lot going on and no one supporting her."*

> *"There is a culture of bullying and gossiping amongst senior nursing staff specifically on the main surgical ward. They engage in professional character assassination and intimidation of junior nursing staff. Also, senior nursing staff frequently verbally discredit past nursing staff to current junior nurses – engaging in ugly gossip and unfounded professional character assassination."*

Strong workplace and patient safety cultures in healthcare are key to both improving safety and eliminating harm for staff and patients.[58] A good safety culture is one in which staff feel valued, well-supported, respected, and psychologically safe (where staff feel that they will be treated fairly and compassionately if they speak up).[59, 60] We will continue to look at the culture of organisations under the well-led key question.

The importance of good communication

Open and collaborative communication is at the heart of patient-centred care, and NHS organisations, including commissioners and trusts, have legal duties to provide accessible and inclusive health communications for patients and the public.[61]

NHS England advises that communications should give clear, easy to understand steps for the patient's care, and ensure that patients fully understand their diagnosis. This will help reduce anxiety and enable the patient to have an informed discussion about their treatment.[62]

To support them to do this, NHS England introduced the Improvement framework: community language translation and interpreting services. This framework is designed to support the NHS to provide consistent, high-quality community language translation and interpreting services to people with limited proficiency in English.

In addition, in February 2025, CQC introduced a new self-assessment and improvement framework to support integrated care systems (ICSs) to address health inequalities by improving their engagement with people and communities. This framework supports a whole-system approach to embedding meaningful engagement and reducing health inequalities.

Findings from our 2024 Urgent and emergency care survey show that while many patients have a good experience of communicating with staff, this is not the case for everyone. In particular, the survey shows that in type 1 emergency care services, frail patients had worse than average experiences for most communication-related questions. This included not having enough time to discuss their condition and treatment with a doctor or nurse, not feeling listened to, and not receiving explanations about their condition, treatment, or test results in a way they could understand. They were also less likely to feel involved in decisions about their care and treatment, and to feel treated with respect and dignity.

Furthermore, the survey also shows that older and frail respondents often linked issues with communication with negative staff attitude and rushed interactions. Poor communication with family members and lack of co-ordination between services were frequently reported.

Poor communication was a theme emerging from our analysis of Give feedback on care submissions. Many people described feeling like they were not listened to, that their concerns were dismissed, or they were given conflicting information. Relatives also described difficulties in getting information about the treatment of loved ones and many also felt that their concerns were ignored and often dismissed:

> *"...the patient care I have received has been less than exemplary, especially at a time where pregnancy care is under so much scrutiny. The poor communication and listening skills and overall incompetence has been appalling."*

> *"No transparency over who is making the decisions, no ability to escalate concerns to the people making the decisions as we aren't told who they are. No communication about decision."*

> *"Relative complained of pain during Christmas. Our family reported this to nurses alongside sickness. Concerns ignored and a doctor didn't examine this issue until over 10 days later. They have had a stroke this week. The hospital did not bother to inform [next of kin] he had a stroke."*

Poor communication was a particular issue for people being discharged from hospital. Results of the 2024 Adult inpatient survey show that fewer respondents felt involved in decisions about their discharge from hospital, with less than half feeling they were given enough notice before being discharged. Nearly half (46%) of respondents felt certain about what would happen with their care after leaving hospital.

This is supported by evidence from Give feedback on care, with people telling us that discharge planning for them or for family members was poorly organised, chaotic, and sometimes dangerous. They also described issues such as conflicting advice about how their ongoing care would be managed, or being discharged without the correct medication.

> *"This lack of communication and organisation within your department has contributed to a distressing level of uncertainty and lack of trust in the care provided."*

Our research with National voices similarly found that people's experience could have been improved by better discharge planning and communication.

Communication with children and young people

Through our 2024 Children and young people's survey, we found that people were generally positive about communication, particularly about how children and their parents and carers were involved in decisions about care and treatment:

- 8 in 10 (79%) children aged 8 to 11 were involved in decisions about their care and treatment
- nearly 9 in 10 (87%) young people aged 12 to 15 were involved in decisions about their care and treatment as much as they wanted to be
- more than 9 in 10 (92%) parents and carers of children aged 0 to 15 said they were involved as much as they wanted to be
- 92% of parents and carers said staff agreed a care plan with them.

However, we did see room for improvement when parents and carers were raising concerns. Nearly 6 in 10 (59%) parents and carers had raised a concern about their child's care or treatment, but only 62% of them said their concerns were 'definitely' taken seriously (28% said their concerns were taken seriously 'to some extent' and 10% said their concerns were 'not taken seriously at all').

Linked to this, nearly 3 in 10 (28%) children and young people aged 8 to 15 said staff did not 'always' listen to what they had to say (23% said 'sometimes' and 5% said 'not at all').

This was supported by findings from our 2024 Urgent and emergency care survey, with respondents raising similar concerns about feeling listened to. Younger people (aged 16 to 35) were less likely to say they were treated with respect and dignity, and had poorer experiences in relation to waiting, explanations about their treatment, and feeling listened to.

> *"The nurse gave me incorrect information about the amount of time I needed to wear my boot (for an ankle fracture) and the amount of time I needed to not do PE. When the fracture clinic rang my mum they gave different information. The nurse did not take my injury seriously..."*

Actively involving parents in decisions around their child's care and quickly responding to their concerns is critical to safety. In 2023, the Parliamentary and Health Service Ombudsman published the report Broken trust: making patient safety more than just a promise. This identified a small number of cases among recent investigations of complaints where there were clinical consequences because concerns from patients and families were not being listened to.

To ensure that people receive person-centred and responsive care, in April 2024 NHS England introduced a pilot of 'Martha's Rule' in 143 hospitals across England. This reinforces the fundamental principles of listening to people who use health and care services and their families – and acting on what they say. It aims to give patients and their families a way to seek an urgent review if their or their loved one's condition deteriorates and they are concerned this is not being responded to. We will begin to assess the implementation of Martha's Rule as part of our assessments over the second half of 2026.

Martha's Rule and the introduction of the national paediatric early warning system (PEWS) in November 2023 are related to a broader new approach to situations where a patient's condition gets rapidly worse. The prevention, identification, escalation and response (PIER) approach aims to prevent people's conditions becoming increasingly worse, save lives and reduce pressure on hospitals.

Medicines safety

Medicines-related incidents account for around 10% of incidents reported in the NHS, and are one of the most commonly reported types of patient safety incident. Last year, we reported that incidents involving insulin were one of the most commonly reported incidents in trusts. This continued to be the case in 2024/25.

This year, we also heard about problems related to the use of anticoagulation medicines (medicines used for blood thinning). Key issues included doses being missed, poor communication of doses and people not being assessed for the risk of venous thromboembolism on admission to hospital.

We heard how some trusts were carrying out thematic reviews to address these problems, while in other areas concerns had been escalated to the integrated care system (ICS) to enable a system-wide approach to be developed.

System-wide challenges

This year, pharmacy leads have described shared care protocols as one of the biggest areas of risk for people using services.

Shared care protocols enable the transfer of prescribing responsibility from a specialist to a GP when a patient's condition is stable and both the GP and specialist agree to the arrangement. The patient's GP agrees to take responsibility for monitoring and prescribing for their long-term condition, with pathways developed to ensure patients can be referred to their specialist if needed. Shared care protocols are often used in mental health care, and we look more closely at the challenges around these arrangements in our section on Communication, collaboration and system working.

Other system-wide challenges reported to us included:

- trusts being unable to prescribe medicines for supply from patients' local community pharmacies
- problems with the supply of medicines – pharmacists described how early communication between trusts and suppliers, as well as procurement teams and prescribers, was crucial to prevent critical supply issues occurring.

Workforce challenges

NHS staff turnover and sickness absence

As at March 2025, there were 1,378,000 full-time equivalents in NHS hospital and community services, an increase of 2.5% from March 2024. The largest growth in recent years was for staff in ambulance trusts, where staffing rose 12% between September 2022 and September 2024, and by a further 2% to 55,756 by March 2025.

Acute hospital trusts also saw consistent growth. There were 10% more full-time staff in September 2024 than in September 2022, and a further 1% by March 2025. The largest increase was for the number of professionally qualified clinical staff in acute trusts, which had increased by 11% in the period between September 2022 and September 2024, and by an additional 2% to 575,000 by March 2025.

In 2024/25, NHS staff turnover improved slightly, with the annual leavers rate falling to 9.9%, down from 10.2% in 2023/24 and 11.8% in 2022/23.

In March 2025, the overall sickness absence rate for England was at 4.9%, slightly higher than in March 2024 at 4.7%. Anxiety, stress, and depression accounted for 27.5% of absences (up from 27.2% in 2024 and 24.2% in 2023), while colds, coughs, and flu were the second most common cause at 10.3%, down from 10.8% in 2024 and 11.2% in 2023.

Workforce race equality

In 2014, Roger Kline published his report The Snowy White Peaks, which clearly outlined the impact of racism and lack of diversity in leadership on the ability of the NHS to deliver safe care.[63] His 2024 report, Too Hot To Handle: An Investigation Into Racism In The NHS, found that 10 years on, the NHS is still not addressing racism effectively.[64]

These findings are supplemented by a 2024 report from the NHS Race and Health Observatory (NHS RHO), Cost of racism: How ethnic health inequalities are standing in the way of growth. As well as setting out the current picture of institutional discrimination and racial health inequities across the NHS in England, the NHS RHO report shone a light on the emotional and economic impact of racial discrimination on both patients and staff. It described how negligence claims, internal grievances, independent investigations, and higher rates of staff sickness and absence all have a negative impact on workforce retention and recruitment.[65]

Having an ethnically diverse workforce that reflects the population it serves helps to raise awareness of the reality of racism and discrimination. This also supports staff to:

- feel equal and represented
- have role models and advocates for progression
- feel able to speak up and raise concerns.

The NHS Workforce Race Equality Standard (WRES), introduced in 2015, is designed to help NHS organisations identify improvements to manage and monitor inequalities through 9 workforce indicators.[66] We look at WRES data as part of our assessment of workforce equality, diversity and inclusion, under the well-led key question.

Results from the 2024 NHS WRES report show that representation of people from ethnic minority groups in the NHS workforce has again increased over the last year. In March 2024, people from ethnic minority groups made up 28.6% of the workforce (434,077 people) across NHS trusts – this is 53,969 (14%) more people than in 2023.

While representation of people from ethnic minority groups in senior leadership roles and boards has also increased, it still remains low. In 2018, 6.9% of very senior managers were from an ethnic minority background, this had risen to 12.7% in 2024. While this is an improvement, it is still lower than the average for the overall workforce at 28.6%.

However, despite the increase in the workforce representation, the findings from the 2024 NHS WRES report suggest that less than a half (48.8%) of staff from ethnic minority groups felt that their trust provided equal opportunities for career progression or promotion. This was lower than the results for staff in white ethnic groups, where 59.4% felt that their trust provided equal career opportunities. In addition, in 2024, 80% of NHS trusts reported that applicants from people in white groups were significantly more likely than applicants from ethnic minority groups to be appointed from shortlisting.

Staff from ethnic minority groups were also more likely to report experiencing harassment, bullying or abuse from other staff, with White Gypsy or Irish Traveller women and men experiencing the highest levels for the second year in a row (42.6% of men and 34.1% of women).

As part of efforts to tackle discrimination, the NHS published its equality, diversity, and inclusion improvement plan in June 2023. This sets out actions to address direct and indirect prejudice and discrimination that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. This plan is currently being reviewed to ensure it aligns to the ambitions of the NHS 10 Year Health Plan, which includes new staff standards that have been developed in collaboration with the Social Partnership Forum.

Workforce disability equality

As stated in our Guidance for NHS trusts and foundation trusts: assessing the well-led key question, there is strong evidence to suggest that providing equitable working conditions has a direct impact on the quality of care for patients. Analysis of the NHS workforce shows that inequalities experienced by some staff groups have become an entrenched part of their working experience. Further inequalities can happen as a result of having more than one equality characteristic, resulting in some individuals experiencing multiple forms of discrimination or workforce inequality.

Introduced in 2019, the Workforce Disability Equality Standard (WDES) is a set of 10 specific measures for NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. WDES data enables NHS organisations to better understand the experiences of their disabled staff. It supports positive change for all staff by creating a more inclusive environment for disabled people who currently work or would like to work in the NHS.

We look at WDES data as part of our assessment of workforce equality, diversity and inclusion, under the well-led key question.

The 2024 data analysis report for NHS trusts shows that since the previous year, there has been an increase in the number of NHS staff who declare that they have a disability. As at March 2024, 5.7% of the NHS workforce (86,312 members of staff) had declared a disability through the Electronic Staff Record (ESR), representing an increase of 15,446 people from 2023.

The recruitment process showed little bias between disabled and non-disabled candidates (19.5% of non-disabled candidates were appointed from shortlisting, compared with 19.8% of disabled candidates). Disabled representation among board members and executive board members has also increased. However, disabled staff were reported as being twice as likely to enter the formal capability process for performance reasons than their non-disabled colleagues.

Overall, levels of bullying and harassment reported by disabled staff through the NHS staff survey is at its lowest since the implementation of WDES. However, this varied among the professions. In common with the experiences of disabled staff more widely, within the operational ambulance staff workforce, disabled men tend to report a higher degree of abuse by patients and other colleagues, unequal opportunities for career progression, and higher pressure to come to work despite not feeling well enough to perform their duties.

Disabled ambulance staff also reported much lower levels of satisfaction with the extent to which their organisations value their work, lower levels of reasonable adjustments made by their employer to carry out their work, and the lowest staff engagement score.

Chapter 2

Inequalities and concerns for specific groups of people

Inequalities and concerns for specific groups of people

Key findings

- Overall, people aged over 65 reported having a positive experience when it came to being discharged from hospital and receiving follow-up care in the community, with most people agreeing that it helped them stay independent. However, a few people said they didn't feel ready to be discharged, and others said the follow-up care didn't meet their emotional needs.
- The number of people being diagnosed with dementia is increasing. However, staff in health and social care do not always understand the specific care needs of people with dementia and providers do not always have the knowledge of person-centred approaches and dementia-friendly environments.
- Despite the same issues being reported over the last 10 years, efforts to address the underlying causes of poor maternity care have continued to fall short. Too many women are still not receiving the high-quality maternity care they deserve, with some women with protected characteristics under the Equality Act 2010 remaining at greater risk of harm. The national maternity review, announced in the 10-year plan, presents a real opportunity for change.
- Autistic people and people with a learning disability can find it challenging to get an appointment with their GP, because booking systems may not offer the flexibility and choice that they need. Our research also suggests that there are not always the right reasonable adjustments in place to make primary care a positive experience.
- In 2024/25, we delivered a series of Independent Care (Education) and Treatment Reviews (IC(E)TRs) into the care and treatment of autistic people and people with a learning disability in long-term segregation. Some reviews noted there were no discharge plans, or even that some people had not been in discussions about discharge or leaving long-term segregation.
- Longstanding inequalities in mental health care for Black men continue – staff must be properly trained to fight racism and support Black men with respect and understanding, and services need to be held accountable when they fail to do the right thing.
- Between January 2023 and December 2024, the number of children and young people waiting to access community health services increased by 26%. This compares with an increase of 19% for adults waiting for community services. The number of children and young people waiting for over a year for these services increased almost threefold in this period.

- Our joint targeted area inspections with Ofsted, His Majesty’s Inspectorate of Constabulary, Fire and Rescue Services, and His Majesty’s Inspectorate of Probation show that children with special educational needs or disabilities are having to wait too long for their needs to be assessed, which makes them more vulnerable to serious youth violence.
- Applications to authorise the deprivation of a person’s liberty have continued to increase significantly over the last decade, far beyond the levels expected when the Deprivation of Liberty Safeguards (DoLS) were designed, often resulting in lengthy delays.
- Issues with the DoLS system continue to disproportionately affect certain groups of people, as respondents to our survey of Mental Capacity Act leads in hospitals highlighted particular concerns around older people, including those with dementia.
- Our local authority assurance assessments continue to show wide variation in how local authorities are managing DoLS applications – while some local authorities report not having any backlogs, others are still struggling to meet demand.

Health and care for frail and older people

This report highlights where we have seen particular variation and inequalities for some groups of people, including frail and older people. As the health and care sector considers a shift into the community, understanding the support required for frail and older people is crucial to address these imbalances.

Experiences of follow-up care after hospital discharge

To find out more about people’s experiences of care following discharge from hospital, we commissioned research from National Voices (a coalition of health and social care charities) to focus on the support available for older people living with frailty.

National Voices used findings from:

- a follow-up survey that we sent to 704 people who had responded to the 2023 NHS Adult inpatient survey who were aged over 65 and who indicated that they were living with frailty; we collected 144 responses from this follow-up survey
- 9 interviews with people who completed the follow-up survey, complemented by 8 supplementary interviews with people who are more at risk of experiencing health inequalities.

Of the 144 respondents, 78 received care in the community after discharge and 64 did not. Two people didn't know whether they'd received follow-up care or not. Overall, the people who completed the questionnaire and took part in interviews reported having a positive experience when it came to being discharged from hospital and receiving follow-up care in the community. The most common types of follow-up care were a paid carer providing personal care, and NHS nurses providing medical care. Follow-up care also included examples of physiotherapy or occupational therapy.

Emphasising the importance of such care, most respondents who received follow-up care either 'strongly agreed' or 'agreed' that this allowed them to recover fully, regain or maintain their independence, and reduced the amount of support they needed from their friends and family. The vast majority of respondents were discharged back to their home. Most people agreed that the care helped them stay independent and that they felt able to raise concerns if necessary.

> *"I really can't think of anything [that would have improved my experience of care after leaving hospital]. I was surprised how exceptionally good the physiotherapists (both at home and later in outpatients) were."*
>
> (Survey respondent)

However, several interviewees shared issues that emerged from a poor discharge process. Delays, poor co-ordination or poor communication during the discharge process left some people feeling confused and unhappy, which can negate an otherwise positive experience of treatment during their hospital stay.

Similarly, where survey respondents reported dissatisfaction with their discharge experience, this related to not feeling ready to leave hospital and not receiving a safety and welfare check at the right time.

> *"I was discharged with zero plan and my GP organised homecare – I required 148 days of carer visits before being deemed safe to get myself washed and dressed. My husband is also my full-time carer."*
>
> (Survey respondent)

> *"All of a sudden, they said, 'oh you're going home'. I wasn't happy with that [...] It was causing enough anxiety as it was without having to worry about that [...] we haven't got transport, we had to rely on my wife's sister to come and pick me up. It was badly orchestrated."*
>
> (Survey respondent)

While feedback on follow-up care tended to be positive, some negative aspects were highlighted through people's responses to the survey. This included that care didn't always meet people's emotional needs and that staff didn't take the time to discuss people's medical and non-medical needs. Respondents also said that they didn't receive care from the same members of staff throughout their recovery.

> *"They don't see the human being, they only see the problem/ailment to be fixed. I may be old but I have lived a life. Never once did anyone ask me what I thought, what I felt, how I could be helped. I was a problem to address and not a person in my own right."*
>
> (Survey respondent)

> *"I was back into full caring mode for [husband] but I was [recovering] from a double bypass and aortic valve replacement. I didn't have the physical or mental strength to cook, clean, wash, shop for us both [...]. Very depressed but no one I was able to talk to."*
>
> (Survey respondent)

The failure to take a holistic approach to delivering care had a negative impact on the emotional wellbeing of some research participants.

Of the 64 respondents to the questionnaire who did not receive follow-up care after being discharged from hospital, more than half felt that they did need follow-up care at the time. Not receiving follow-up care despite needing it led to wide ranging negative outcomes. These included the need to go back into hospital, friends and family taking on unpaid caring responsibilities and a deterioration in their emotional wellbeing.

> *"I felt very vulnerable both physically and mentally. I had to rely on friends to do a lot as I don't have family nearby. I was unable to have a shower easily and found it difficult to climb stairs. I ended up seeing a psychologist due to PTSD post surgery."*
>
> (Survey respondent)

A personal story of a poor experience of care after hospital discharge

Having been admitted to hospital after a fall, Dan found the discharge process itself to be problematic, as he experienced delays and a lack of communication and co-ordination with his family, “I was waiting for 4 hours before I got discharged and even when they discharged me into my home, they left me on my own, which I wasn’t happy about. Both my partner and my son were both work[ing] the whole day. I was left for... maybe 3 hours to manage on my own. I had no aid, no nothing.”

The subsequent lack of follow-up care had an impact on Dan’s family dynamics, “For about 3 or 4 weeks I wasn’t able to do too much… [my wife] ended up doing a lot more.”

(Interview participant)

Access to GP services

We are concerned that challenges in getting access to GP services can have a different impact on the experiences and outcomes of older or frail people.

Findings from the 2025 GP Patient Survey showed that the likelihood of people not doing anything when unable to contact their GP practice, or not knowing what the next step would be, was highest for people aged 85 and over (23%) and lowest for those aged 35 to 44 (15%).

This is particularly concerning as older adults – especially those living with frailty – are at greater risk of poor outcomes, such as falls or emergency hospital admission because of deterioration from relatively minor ailments.

We also hear feedback from older people and their loved ones about how this can affect their health, wellbeing and trust in services.

> *“My father called the GP surgery every morning at 8am but was consistently met with an engaged line. The surgery was only accepting emergency cases, and no home visits were available. My father is elderly and frail, and should have been given priority for a consultation due to his age and health concerns. He was suffering from a persistent chest problem and pain in his hip and leg. Due to the lack of care and inability to secure an appointment, his health deteriorated.”*
>
> (Give feedback on care)

If people do not have family or loved ones to advocate on their behalf, this may increase the risk of them falling through the gaps. It is important that local systems have effective processes to ensure that vulnerable people without advocates – whether formal or informal – are not at a disadvantage when navigating the health and care system, and receive the support they need.

Hospice services for adults

Since introducing our assessment framework in 2024, we have assessed 25 hospice services for adults. Of these, over a third (9 services) have been rated as outstanding, three-fifths (15 services) have been rated as good, and only one service is rated as requires improvement. No services have been rated as inadequate.

While hospices provide support for people of all ages who need palliative care or are reaching the end of their lives, they can also provide a range of interventions to support older adults experiencing advanced frailty. They can help people to live well until the end of their lives, reducing the need for them to be admitted to hospital and supporting them to achieve their preferred place of death. They can also support an earlier discharge from hospital for frail patients.[67]

Across the 21 inspection reports published in 2024/25, it is evident that the people receiving care from hospices are at the centre of how these services are delivered and run. Reports described services and staff that take time to understand a person's physical, emotional, psychological, and spiritual needs, and who try their best to ensure they meet these needs, resulting in positive experiences and outcomes.

We saw that some hospice providers were taking steps to widen their provision for people living with frailty and other life-limiting conditions that often overlap, such as dementia, as these groups have repeatedly been shown to be under-served by palliative and end of life care services.[68] Changes in care for these people included improving the physical environment and setting up support groups for people with dementia, run by specialist staff such as link nurses or a community dementia nurse. We also saw specialist support groups and outpatient provision for people with Parkinson's or motor neurone disease, and for autistic people and people with a learning disability.

Example of outstanding advance care planning

In May 2024, we rated a North East Essex Hospice service as outstanding. The hospice's internal dashboard showed up the inequality of access to advance care planning for people with conditions other than cancer. As a result, the service launched a collaborative quality improvement project with the local hospital frailty team, which included a palliative clinical nurse specialist. This resulted in a positive impact on the number of referrals to the hospice for people with frailty.

(Taken from CQC inspection report)

As well as adaptations for people already using a service, we have seen evidence of considerable community outreach to ensure that services were proactively targeting people who reflect the demographics of the local community. This included:

- outreach to minority ethnic communities
- links with local faith leaders to tailor provision to people of different religions
- highlighting and attempting to reduce socioeconomic inequalities in access to hospice services
- building relationships with local LGBTQ+ organisations to improve access and quality of care for people in these groups.

Through our inspections, we also saw evidence of providers proactively reaching out to different inclusion health groups in their community, including local homeless populations. One service worked with prisons to ensure people could also access end of life care. Another hospice service rated as outstanding had worked with external organisations to reach out to different communities to raise awareness of their service. For example, the service held events, as part of ongoing community engagement, to encourage people in ethnic minority communities to access services. The service had also reached out to local groups, including women’s groups, refugees’ groups, homeless charities and stakeholders.

Most hospices that we inspected in 2024/25 were providing good or outstanding care – despite pressures in the system. But staff shortages and their impact on safe staffing levels was a recurring theme. Although services had identified risks in this area and mitigated them effectively, there was evidence of negative impacts on enabling people to access care, including long waiting lists for some services.

In most cases it was clear that providers were striving for a 24-hour, 7 days a week service. This included through both in-person assessment and care or advice and support lines as well as inpatient care for those who needed it. Some providers were able to achieve this, either by themselves or in collaboration with others.

However, other providers had to reduce their provision due to staffing constraints. They did this either by reducing inpatient bed capacity to maintain safe staffing ratios, or by reducing the hours of community provision.

For example, a hospice service that we rated as outstanding used a safe staffing tool which took into account staff numbers, skill mix and patient acuity. If the tool flagged ‘red’, the inpatient leadership team would escalate to the Clinical Director who could decide to close the service to admissions. This helped the service ensure and monitor clinical safety and effective patient care. Senior management met regularly to ensure they had clear oversight of performance and risks, and the service was working in partnership with other local organisations to ensure the sustainability of their workforce planning.

In some cases, providers had been able to work with local community and district nursing teams to maintain overnight cover.

Despite these challenges, there is evidence that most of the hospice providers we inspected were committed to working collaboratively and in partnership with other services involved in people's care. We saw evidence of hospices maintaining regular communication with acute hospitals, GPs and community health services to promote continuity of care for people and to ensure their needs and preferences were known and respected by all services involved in their care. We also saw how some providers gave training to other services, such as paramedics and care homes, to support provision of good end of life care, reduce A&E attendances and emergency admissions, and to enable people to remain at home if preferred.

People with dementia

As more people are being diagnosed with dementia it is more likely than not that we will either experience living with dementia ourselves or provide care for a loved one with dementia in our lifetime. The economic impact of dementia is forecast to rise from £42 billion to £90 billion in the next 15 years.

In May 2025, we published a report on health and social care support for people with dementia. This looked at what people were telling us, through surveys and feedback, about their experiences of living with dementia when using health and adult social care services, including the experiences of families and carers.

Our report set out the main themes that influence whether a person's experience is good or poor, and what health and care services are doing to improve these experiences:

- **Access to health and care support:** People told us they were having to wait too long for a diagnosis, and about a lack of ongoing care and support for dementia in the community. However, people who had good support from their primary care services during their dementia journey described the positive effect this had on their wellbeing.
- **Person-centred care is important:** But staff in NHS acute hospitals do not always understand the specific care needs of people with dementia. Also, often adult social care staff were not adequately attending to people's day-to-day care needs, including support with nutrition and hydration.
- **Staffing and training:** Providers have recognised that staff need to improve their knowledge of effective dementia care. Key stakeholders say there is a need for a clear baseline understanding of dementia for everyone who works in health and social care, at all levels.

- **Family and unpaid carers:** Despite their important role, family and carers told us that communication with staff and management could be poor, and there was an over-reliance on them for intervention and advocacy when their loved ones were using health and care services.
- **Inequalities:** Key stakeholders told us that inequality was a root cause of the challenges facing people living with dementia. Persistent misunderstandings and stigma associated with dementia can also lead to inequalities in how care is delivered and commissioned. We also saw limited consideration for the combined impact of dementia and other protected characteristics when carrying out the analysis for our report.

Recent inspections

Findings of poor quality care

Many of the findings in our report on care for people with dementia are also reflected in recent inspections. Inspectors told us in focus groups that they are finding staff have a poor understanding of the specific needs of people with dementia, and that providers and staff do not always have the knowledge of person-centred approaches and dementia-friendly environments, which could affect people's safety.

For example, in a 2025 inspection of a care home that cares for people with dementia (which we rated as inadequate), we found that the service's leaders were failing to manage risks to people's health and safety. Incident reports showed that three-quarters of falls happened during the night shift, but staffing levels hadn't been reviewed. Also, some staff didn't understand their role in safeguarding people and protecting them from the risk of abuse.

In a previous inspection of this service, we found that people were at risk of sexualised behaviour from other residents and this was still the case. Safeguarding concerns hadn't always been referred to external agencies for investigation, and one member of staff thought it was their manager's responsibility to report concerns. We found 5 breaches of legal regulations relating to safe care and treatment, safeguarding, staffing, recruitment, and how the service was managed, and we imposed urgent conditions on the home to restrict accepting any new residents without prior agreement from CQC.

At another care home, which we placed in special measures, our inspectors saw exposed nails in walls and an exposed electrical wire in a light directly above a person's bed, as well as trip hazards elsewhere. This is particularly dangerous as the service was caring for people with dementia, who may be less able to recognise risks to their own safety.

Findings of good quality care

By contrast, at a care home that we rated as outstanding, leaders continually assessed people's changing support needs. For example, a person with dementia was becoming increasingly anxious, therefore with their and their family's full consent, the provider trialled a series of tailored adjustments to the person's environment, particularly during mealtimes, to foster a sense of comfort and security, and to reduce their anxiety. As a result, there was a significant improvement in the person's overall wellbeing, including more restful sleep, which has been recognised as an essential factor in positive health outcomes for people living with dementia.

At a different care home, which we inspected in 2025 and rated as outstanding, the provider had recently opened a 'wellbeing suite', with a working kitchen, dishwasher, oven, sink, and washing machine so people with dementia could take part in day-to-day activities that they might miss from their lives before moving to the home.

This addition was driven by significant evidence that, for people living with dementia, engaging in familiar daily activities can enhance their quality of life, cognitive function, and emotional wellbeing. One person with dementia often became distressed in the afternoon. She had a long history of baking with her family, which was a source of comfort and routine. Staff recognised this and integrated it into her care plan. Whenever she became distressed, staff engaged her in baking simple recipes, which was a calming intervention that fostered positive engagement with staff and other people, and improved her overall mood. Feedback from family members confirmed that the person was happier and more settled.

Another care home, which we rated as outstanding following an inspection at the end of 2024, had employed a dementia specialist consultant who worked extensively with people and their families to maximise their understanding of people's needs and preferences. They ensured that everyone's voices were heard, and that they were supported to overcome potential barriers to living a fulfilling life. For example, the provider told us that after members of the public had raised concerns about noise from the home, they had invited local residents to look around the home to meet people. This gave people the opportunity to increase their understanding of how a care home worked and what it was like to live with dementia.

Maternity care

Every pregnant woman wants a positive birth experience – and every member of staff working in a maternity service wants to provide safe, high-quality care. In most situations that's what happens, but sadly it's not always the case.[69]

Too many women are still not receiving the high-quality maternity care they deserve, with almost half (47%) of services reviewed through our National review of maternity services in England 2022 to 2024 rated as either requires improvement (36%) or inadequate (12%). Under our assessment framework introduced in 2024, we have published the findings of inspections for 15 maternity services. Of these, two-thirds of services (66.7%) have been rated as inadequate or requires improvement, with a third (33.3%) rated as good. No services have been rated as outstanding.

Since 2015 there has been a national ambition to halve the rates of stillbirths to 2.6 per 1,000 births by 2030.[70] While some progress has been made towards this goal, in 2023 the stillbirth rate was 3.9 per 1,000 births.

When things go wrong, the consequences for mothers, babies, their families – and staff – can be devastating. To support services to provide bereaved parents with answers, ensure learning from incidents and prevent future deaths, the national Perinatal Mortality Review Tool (PMRT) was launched in 2018. As stated in the Sixth annual report of the national Perinatal Mortality Review Tool, "The review of care when a baby has died is part of routine maternity and neonatal care and is not an optional extra."[71]

The sixth annual report, which was based on 4,311 reviews completed from January to December 2023, found that 95% of reviews identified areas for improvement in care, and 30% of reviews identified at least one issue with care that may have made a difference to the outcome for the baby.

Concerns around the quality of care in maternity services are longstanding. Over the last 10 years there have been a number of high-profile investigations into the quality of care at individual maternity services, including Dr Bill Kirkup's reviews at Morecambe Bay and East Kent, and Donna Ockenden's investigations at Shrewsbury and Telford, and Nottingham.

In May 2024, the final report of All Parliamentary Party Group (APPG) on Birth Trauma suggested these may not be isolated cases, with the investigation finding a pattern of poor maternity care across the country. Similarly, our National review of maternity services in England 2022 to 2024, published in September 2024, found that issues identified through the Kirkup and Ockenden reviews are not confined to a few hospitals, but are widespread across the country.

Across all these reports, the same themes have been emerging, including:

- workforce challenges
- lack of leadership and oversight
- poor working cultures and siloed working
- poor risk assessment
- lack of communication
- failures to investigate and learn when things go wrong.

To keep people safe and ensure they receive consistently safe, good quality care, we expect services to make sure there are appropriate staffing levels and skill mix. However, our national maternity inspection programme found that chronic issues around recruitment and retention were a key barrier to high-quality care.

This was supported by the findings of the APPG on Birth Trauma. Evidence provided to the APPG revealed endemic issues with under-staffing, a poor physical environment and a harmful working culture. It also suggested that midwives in particular experience high levels of stress and burnout.[72]

This was supported by the findings from NHS England's Maternity and neonatal infrastructure review. Published in September 2025, the review found a clear link between the condition of service infrastructure, the experience of people who use services and staff, and safety.

Latest figures from the 2024 NHS Staff Survey continue to suggest that midwives are experiencing challenges related to work-life balance and wellbeing. The results show that, compared with all staff groups:

- 50% said they cannot meet conflicting demands at work (27% overall)
- 45% reported achieving a good balance (57% overall)
- 57% reported finding their work emotionally exhausting (34% overall)
- 65% said they felt worn out at the end of the shift (42% overall).

Despite the challenges, 68% of midwives reported feeling enthusiastic about their job, which also reflects the trend across all staff groups (68%).

In 2024, the Royal College of Midwives (RCM) estimated that there was a national shortfall of around 2,500 midwives.[73] RCM's data published in June 2025 shows that as at March 2025 the number of midwives on the register had increased by 5.6% from March 2024.[74] However, results from RCM's survey published in the same month show that funding cuts and recruitment freezes mean that midwifery managers are still struggling to hire any, or as many, midwives as they need.

Analysis of maternity inspection reports published between January 2024 and June 2025 also shows ongoing concerns with staffing. Issues included a lack of staff and in some cases a lack of suitably qualified or senior staff, leading at times to an inadequate mix of skills on wards.

The impact of staffing shortages on midwives was reflected in the findings in the NHS Staff Survey, which showed that only 16% of midwives felt there were enough staff at their organisation for them to do their job properly (compared with 34% overall).

Recent inspection reports continue to show challenges with risk assessments. Not all services are able to properly assess and manage risks. Some do not always complete proper risk assessments, or do not properly record these in a way that makes for safe care across the maternity pathway. Where risks are identified, they are not always acted on promptly and effectively.

Ongoing concerns about the learning culture was another theme emerging from our analysis of recent inspection reports. Some staff told us that they were not always encouraged to report incidents, or that services did not always systematically embed learning from incidents. While the NHS staff survey suggests a high proportion of midwives feel their organisation encourages them to report errors, near misses or incidents (91% compared with 83% overall), only 55% are confident their organisation would address their concern (compared with 57% overall).

It is shocking that despite the same issues being repeatedly reported over the last 10 years, efforts to address the underlying causes of poor maternity care have continued to fall short. To address this, in its final report the APPG on Birth Trauma called in the government to introduce a National Maternity Improvement Strategy, led by a new Maternity Commissioner who will report to the Prime Minister.

Maternity care in England is at a significant point of transition. In September 2025, the government announced the terms of reference for the National maternity and neonatal investigation. As well as helping bereaved and harmed families to receive justice and accountability in the future, the investigation aims to conduct and publish 14 local investigations of maternity and neonatal services in NHS trusts. The national investigation not only gives renewed focus on longstanding issues, but presents a real opportunity for change.

Inequalities in maternity care

As highlighted in our report National review of maternity services in England, 2022 to 2024, and our 2023/24 State of Care report, some women with protected characteristics under the Equality Act 2010 are at greater risk of harm. Latest data from MBRRACE-UK shows that, compared with women from white ethnic groups, Black women were more than twice as likely to die during or up to 6 weeks after pregnancy, and Asian women were 1.3 times more likely to die during the same period.[75]

This is supported by the findings of the Black Maternal Experiences Survey by FiveXMore. Published in July 2025, the survey gathered the experiences of Black and Black mixed-heritage women across the UK who had been pregnant between July 2021 and March 2025. Of the 845 responses analysed, the survey found:

- 60% of Black women rated their antenatal care as good or high quality
- 54% experienced challenges with healthcare professionals
- 28% of Black women reported discrimination and, of these, 25% said that this was due to issues around race
- 45% raised concerns during labour or birth; of these, 49% felt their concerns were not properly addressed
- 23% of Black women did not receive the pain relief they requested, and 40% of these women were given no explanation

- Only 39% received advice on nutrition, and just 27% were spoken to about exercise at their booking appointment
- Just 1 in 5 women (20%) had been informed on how to make a complaint, and only 8% pursued a formal process.

The report describes how more Black women are better informed and ready to advocate for themselves when entering maternity care, but that this is more often because they feel they must fight to be heard. It highlights that racism, both structural and interpersonal, continues to shape Black women's maternity experiences, with poor communication, lack of empathy and unequal power dynamics leaving them feeling unsupported and unsafe.

Our national maternity inspection programme found huge differences in the way NHS trusts collect and use demographic data, particularly ethnicity data, to address health inequalities in their local populations. We also found that communication with women and their families is not always good enough, particularly for women whose first language is not English. This affects their ability to consent to treatment and can perpetuate levels of fear and anxiety.

Birth and beyond maternity portal

Around 10 years ago, the maternity team at Royal Surrey NHS Foundation Trust recognised that the antenatal education they provided was not meeting women's needs. To address this, the team started holding classes that provided evidence-based guidance from staff.

When the COVID-19 pandemic arrived, they were forced to innovate and find other ways to deliver this education. Initially the team used Facebook as it was free and easy to access, but later developed this into the 'Birth and beyond portal', which provides:

- videos and written information based on clinical evidence
- toolkits that explain complex areas (such as induction of labour and caesarean sections)
- access to clinical guidelines
- a booking portal to attend online or in-person antenatal classes.

The maternity service actively engages with its population through social media and works closely with the local Maternity and Neonatal Voices Partnership to contact harder-to-reach communities. The portal is also translated into more than 200 languages.

By using polls and questions like "what have you googled lately" they can stay on top of topics that birthing people want access to and provide access to NHS approved and evidence-based information.

Feedback on the portal has been positive, with people who use the service saying it made them feel better informed and prepared.

Health and care for autistic people and people with a learning disability

Barriers and inequalities when accessing and using GP services

In last year's State of Care report, following compelling feedback from our expert advisory group, we introduced our priority area of exploring the challenges and barriers that autistic people and people with a learning disability experience when accessing their GP practice.

The following is a summary of our findings from this project, which informs our work to tackle inequalities in health – a key factor in helping to reduce early mortality for autistic people and people with a learning disability.

Accessing GP services

Our analysis found evidence that autistic people and people with a learning disability can find it challenging when trying to access an appointment with their GP. Sometimes they face difficulties with using the technology to book appointments, such as eConsult or the NHS App.

In our focus groups, our Experts by Experience who have lived experience of a learning disability or autism told us that they would like their GP practices to offer more choice and flexibility when booking an appointment. These difficulties in accessing primary care services are not merely inconvenient but can serve as a significant barrier to receiving care.

One person who has a learning disability and is also autistic expressed difficulties using the booking app:

> *"The NHS app is very confusing. My mum has to help me with that. In my opinion it's very hard, it's very fiddly. I don't think it's made adjustments for people who are autistic, dyslexic, have dyscalculia or people who are blind."*

Difficulties accessing GP services can have a detrimental effect on people. One autistic person reported that a GP practice failed to explain the process for ordering repeat prescriptions, which meant they ran out of the medicines they were taking for their mental health needs. They described how they had to reach a crisis point in order to get the primary care that they needed:

> *"I've usually found that by the time I get got to the point where I'm crying on the phone, they'll actually help. I did get [the medicines] in time, but it usually does end up getting to the point where I have to have quite a big reaction for them to take me seriously."*

Information from adult social care providers submitted through the provider information return also shows the challenges they experience when working with primary care services. Although unprompted, providers told us about difficulties when supporting autistic people and people with a learning disability to book a GP appointment.

However, some comments described primary care providers as being more flexible around appointments, including making home visits:

> *"Adaptations are incorporated into the appointments for individuals who prefer morning or afternoon visits or a quieter timeframe."*

> *"The GP, dentist, ophthalmologists and podiatrist will visit the service rather than have the supported people having to wait for long periods in waiting rooms, which they would not tolerate."*

Using GP services

Poor communication from providers can be detrimental to people's experiences of primary care and may leave them confused or uncertain about the next steps in their care.

Autistic people and people with a learning disability used our focus groups to express a wish for their needs to be taken seriously. Participants also shared examples of good communication from their GP practice and the positive difference this makes to their experience of care. For example, people praised staff who were reassuring and who took the time to acknowledge their needs, such as explaining things in a different way to make sure it was understood.

Comments from adult social care providers in their information return often described how good communication and information from GP practices helped them to offer appropriate care and support to people, and therefore improve their experiences.

For example, some said they had regular, scheduled meetings with their local GP practice to discuss the people who use their services. Others emphasised the importance of having a sense of familiarity between GPs and the people who use services, as it enables continuity of care and understanding of the needs of autistic people and people with a learning disability. One care home said it had worked with its GP practice for "a very long time and those we support are familiar with their long-standing Drs and staff members, including the learning disability nurse". Another service said:

> *"The GP, many surgery staff and the learning disability nurse are known to the people we support enabling continuity of care and understanding of their complex needs."*

During focus group sessions, our Experts by Experience also mentioned the importance of having a named GP. Some participants described feeling distressed when their routine was disrupted or when having to deal with change, for example, seeing a different GP. One person spoke positively about their GP, including how the care they received was strengthened by the GP's consistency:

> *"I love going to the GP because I get the same routine. If there's change, it can really upset me. I like consistency. And some people don't get that."*

Despite the benefits of having the same GP, the 2025 GP Patient Survey found that only 40% of people with a learning disability and 42% of autistic people who have a preferred healthcare professional said they were able to see or speak to them when they asked to 'always or almost always/a lot of the time'.

We welcome the Code of Practice on statutory learning disability and autism training, which aims to ensure that staff have the right skills to provide care, and to boost their understanding of people's needs.[76] The Code will further support us to inspect health and social care providers and assess whether they are training their staff to support autistic people and people with a learning disability appropriately. It will also support us to hold them to account to ensure that they are delivering good, informed, and safe care.

Annual health checks

GPs maintain a register to identify people aged 14 and over with a learning disability who need additional support. Being on this register enables patients to receive reasonable adjustments, in addition to an annual health check.

As at March 2024, there were around 1.3 million people with a learning disability in England, yet only 347,840 (about 25%) were recorded on their GP's learning disability register.[77] This low registration rate means that many people with a learning disability are unable to access an annual health check and receive the reasonable adjustments they are entitled to. Additionally, about 12% of eligible people with a learning disability are registered with GP practices that do not provide annual health checks.[78]

A few adult social care providers noted in their information returns that even if people were listed on the register, staff shortages at GP services meant that people did not receive their annual health checks:

> *"The people we support have not received their annual health review in the past 12 months as the GP has no resources to complete them."*

More positively, other providers talked about the importance of effective joint working with GP services who deliver annual health checks as part of their support plan. For example, one service described their work with the local GP service to facilitate an "Annual GP health check with 6-monthly review of their medication [as part of] a collaborative approach to meeting the needs of the people using [their] service, which starts with their person-centred support plan."

Reasonable adjustments

Through our focus groups, autistic people and people with a learning disability told us that they are not consistently offered reasonable adjustments as their needs were not recorded in their records. This put the onus on them to ask for reasonable adjustments or to arrange adjustments for themselves, and they sometimes lacked the confidence to do that:

> *"With reasonable adjustments, I can't go up to them and ask, I'm just not confident enough. So if they've got on my notes that I'm autistic, it would help if they actually ask what would help, rather than expecting me to say."*

People in our focus groups described how they found waiting for appointments difficult or anxiety-inducing, or that the noises and lights in waiting areas were distressing:

> *"Waiting in the waiting room just doesn't work at all for me."*

> *“We shouldn’t have to wait that long, because we all get anxiety when we have to wait a long time.”*

People also spoke about the importance of having clear and accessible information. One person mentioned that, even though their practice had easy-read versions of leaflets, they were not on display and patients had to ask for them at reception. They said:

> *“If you want something in easy-read, they’ve got to actually find it. Why can’t they have a leaflet there like all the other leaflets? Why is it hidden away?”*

Our analysis of comments in adult social care provider information returns also found that the right reasonable adjustments were not always in place to make primary care a positive experience:

> *“There is lack of understanding of the need for reasonable adjustments for people with learning disabilities and autism among most healthcare professionals, and that often leads to delayed treatment. Health inequalities still exist.”*

However, comments also described GP services that made reasonable adjustments in accordance with people’s individual preferences when running annual health checks – this indicated a person-centred approach to the provision of care:

> *“The GP’s learning disability nurse will visit the service for any medication reviews or health reviews and vaccinations. They will visit our care home so the experience for the residents is more person-centred. This will also ease their anxieties.”*

> *“Essential visits, such as learning disability annual reviews, are maintained in the GP practice or at the service due to people’s preferences and requirements.”*

Independent Care (Education) and Treatment Reviews

In 2019, we published our interim report ahead of our Out of sight report, which focused on restraint, prolonged seclusion, and segregation for autistic people and people with a learning disability. In response, in November 2019, the then Secretary of State announced that all autistic people and people with a learning disability in long-term segregation would have their care independently reviewed, which led to the introduction of Independent Care (Education) and Treatment Reviews (IC(E)TRs).

IC(E)TRs are in-depth reviews of a person's care and treatment. They investigate whether:

- the person's rights are being upheld
- the Mental Health Act Code of Practice is being followed
- restrictions are being kept to a minimum.

They also aim to move people out of long-term segregation, as autistic people and people with a learning disability should not have to endure prolonged segregation.

In November 2023, the final report by Baroness Hollins recommended that the Department of Health and Social Care, NHS England and CQC should commit to funding and delivering interventions to reduce the use of solitary confinement and move people to the least restrictive setting and out of hospital as soon as possible.[79] The previous government asked us to take the lead on IC(E)TRs for 2 years, with reviews starting in May 2024. The following section describes our early findings of ongoing work and analysis based on 16 early IC(E)TR reports and a focus group with IC(E)TR panel chairs. In this analysis, we found that many reports noted changes which had not happened for people, often where recommendations from previous reviews had not been completed. However, we are already seeing the impact of our IC(E)TR programme to support people to leave long-term segregation.

Our analysis focuses on how people are supported to leave long-term segregation while highlighting factors that prevent this from happening soon enough. We also analyse the care and support people receive while in long-term segregation. The scope of IC(E)TRs means we cannot give a detailed understanding of preventing long-term segregation. To help address this, we are working with our external oversight panel to identify practices that help to prevent long-term segregation. We expect providers to have a culture that respects the rights of autistic people and people with a learning disability, provides skilled, trauma-informed therapy, follows the principle of least restriction, and promotes recovery.

Discharge planning

Discharge planning was viewed as an important aspect of supporting people to leave long-term segregation. Some review reports noted that there was no discharge plan in place and recommended that providers start to create a pathway for people to leave long-term segregation by working with other stakeholders, such as commissioners and local authorities. Reviews often recommended that these plans were developed in collaboration with the person and those who represent their best interests.

We also found that providers had not held discussions about discharge or leaving long-term segregation with some people:

> *"In half of the places that I've been recently, they weren't really having those discharge conversations. In two cases they were having lots of really positive conversations. They were recording what the person's views were, what they wanted when they moved out, what sort of place they wanted to live, where they wanted to live. They were in regular communication with that person's family."*
>
> (IC(E)TR Panel Chair)

IC(E)TR panel chairs told us about instances where providers did not have discharge plans for people, citing the 2 main contributing factors as:

- a lack of knowledge
- a lack of leadership and drive.

For example, some clinical teams lacked the knowledge and the expertise to work with autistic people and people with a learning disability, which could be a barrier to people moving out of long-term segregation. This included knowing how to support people's communication requirements and supporting them in ways that reduced anxiety around change.

A lack of leadership and drive could lead to a culture of 'stuckness' where, although staff might want to support someone to leave, a team might become collectively uncertain about how to do this.

By contrast, panel chairs said they had seen some effective interventions when stakeholders from external initiatives came into services to work with people and staff to reduce people's time in long-term segregation. These independent stakeholders provided the leadership and direction that was sometimes lacking internally. They often implemented a human rights-based approach and focused on staff building a good relationship with people in long-term segregation to better understand their wants and needs.

Providing joined-up care from services and professionals

Enabling people to leave long-term segregation cannot happen through the inpatient team alone. It requires joined-up care delivered between services and professionals, including:

- active involvement from the most appropriate specialist community teams in supporting a person's transition
- active involvement from the relevant integrated care boards and local authority
- commissioners working to remove barriers
- sharing skills and knowledge to support the person during the transition to life outside of long-term segregation.

Panel chairs told us about the key role of commissioners in progressing people out of long-term segregation, with some having seen "commissioners who are passionate about getting the person out". Where this was working well, commissioners knew the person, they were in contact with their family or supporters, and attended meetings. One example was of a commissioner who was quite firm and challenging with the provider, and really clear about what they wanted from the provider and the direction of travel. This showed that leadership from outside of the clinical team facilitated people's progression out of long-term segregation.

Another potential barrier noted to leaving long-term segregation was the complicated commissioning landscape. If someone's inpatient care is funded by the integrated care board, the commissioner is responsible for both the inpatient and community care along with the local authority. However, if the person is in secure care or mental health services for children and young people, then the provider collaborative is responsible for commissioning the inpatient stay.

The provider collaborative is not responsible for community provision, but needs to work closely with the integrated care board and local authority to effect discharge. This means that there are often difficulties in understanding who is best placed to discuss discharge planning with the person. This is because the professional who has the relationship with them often does not have enough information to discuss what is possible. This includes understanding the person's wishes for their future.

We were told that this difficulty in understanding was further hindered by an inability or failure of some commissioners to actively engage with other stakeholders in people's discharge planning while they were an inpatient. A chair told us this was sometimes made apparent during IC(E)TRs by a lack of engagement from integrated care board commissioners in the review process: "the integrated care board just refused to come to the IC(E)TR" citing reasons such as "we haven't got enough time to come to the IC(E)TR" or saying they "don't come to IC(E)TR on a matter of policy because the provider collaborative is involved".

The chair argued that this “is about the integrated care boards who are responsible for the discharge planning, being at the table”, which in their experience appeared to vary from review to review.

The level of involvement from community teams varied in preparing people to leave long-term segregation. One chair said they had not seen any occasions where the team in the community were already in place, and another noted times when there were challenges involving the social care team. They believed a lack of connection between services caused by moving people ‘out of area’ was a potential barrier here.

On the other hand, panel chairs also spoke about community teams going into hospitals to build up the knowledge, skills, and relationships to work with a person as part of their transition out of long-term segregation, which was thought to contribute to a more successful discharge.

Arrangements for future accommodation

Panel chairs said there were 2 main routes out of long-term segregation:

- reducing restrictions so the person is no longer being segregated from the rest of the ward
- enabling the person to live in the community outside of a hospital setting.

People in services that are unable to provide a suitable environment for step-down support could face longer periods in segregation. One review report noted:

> *“The person would need gradual stepping down of the restrictions. We were very concerned that there was no ward into which the person could be re-integrated.”*

Ongoing searches for appropriate accommodation were noted in several reports, with one saying a person was ready for discharge but that no suitable housing had been identified.

Positively, some reports also described adaptations to people’s next accommodation. In one instance, various stakeholders, including those responsible for funding, had come together to arrange a person’s future home, ensuring they identified a property close to the person’s family and had arranged the required adjustments and adaptations.

Are people’s rights and requirements supported?

People in long-term segregation required providers to implement personalised adjustments to help them transition out of segregation as soon as possible.

Adjustments included specialist equipment to meet sensory requirements, such as resources to help a person to sleep, which an occupational therapist at a service had implemented.

However, the IC(E)TR reports and panel chairs highlighted how some environments might contribute to the restriction of some human rights – including environments with limited privacy and access to appropriate outside spaces. The reviews also highlighted instances where people did not have access to equipment or environments that sufficiently met their requirements. For example, one review report highlighted that a person's specialised sensory equipment was lost for months, but no further action was taken to replace it.

In IC(E)TR reports, we found evidence that some people were not receiving assessments, and some people's assessments were being carried out in a way that did not properly identify their requirements. These issues meant that adjustments were not always made to enable them to progress out of long-term segregation. For example, one review report notes that "It had been long identified that the person needs a speech and language therapist assessment. However, the provider was not able to provide this due to funding".

IC(E)TR reports highlighted the value of staff who are able to adapt, which is needed to support people's changing needs (for example, sensory requirements and preferences, and mealtime preferences).

This demonstrates the importance of a personalised approach – rather than a standardised or prescriptive approach – to supporting people in long-term segregation. One panel chair underscored the need for people to be "supported by staff every day whom they know, who are passionate about getting them out and getting them to live their best life and reducing restrictions."

The IC(E)TR reports also included examples where staff made personalised adjustments for people after completing training on the best way to do so.

By contrast, the reviews showed that where staff had adopted a more inflexible approach, people did not receive person-centred support. This sometimes stemmed from avoiding positive risks that could improve people's experience. In one example, staff intended to move someone from their placement in long-term segregation to 3 different hospital-based settings in quick succession. The IC(E)TR report highlighted the "extremely detrimental" impact that this could have on the person and suggested that one move into more permanent accommodation would deliver an approach that centred more on the person's experience than on organisational process and protocol.

Focus groups also highlighted that, when providers were not aware of the circumstances in which a person was admitted into long-term segregation or about their lives outside it, it is difficult to have a holistic understanding of the cause of any trauma they may be experiencing. This means there is a risk of people being treated in an unhelpfully standardised way rather than being given effective person-centred care. Trauma within long-term segregation was also noted in Baroness Hollins' report where it was said that "Traumatised people are further traumatised by inappropriate hospital environments which do not make provision for their sensory and communication needs" and that some people were "further traumatised by the social and sensory deprivation they experience during lengthy periods of enforced isolation, as well as by the hospital routine and environment".

We will continue to analyse themes from our IC(E)TR reviews, including feedback from people and loved ones participating in the reviews as the programme continues.

Medicines support for autistic people and people with a learning disability in hospital

In 2024, our Medicines Optimisation team asked hospital pharmacy teams how they were supporting autistic people and people with a learning disability to access medicines while in their care. This was part of our annual engagement calls with chief pharmacists at 192 NHS trusts, including acute, mental health, ambulance and specialist tertiary centres.

Health and care passports for autistic people and people with a learning disability provide healthcare staff, including pharmacy staff, with the right information to help them give the right care and treatment.

We found that knowledge of these tools varied, with pharmacy staff from mental health trusts being more familiar with them than acute trusts. Passports that were kept updated were seen as a good opportunity to support conversations about each person's needs, especially before they are discharged.

The Reasonable Adjustment Flag is a national record that shows a person's needs and may include details about reasonable adjustments. NHS services need to be fully compliant in using it by 31 December 2025. Many trusts told us they did not use their pharmacy IT systems to identify autistic people and people with a learning disability, although a few described the advantages they had seen since using the flag. For example, in one trust, the flag alerted the appropriate staff when people are admitted so they could implement reviews and support at the right time. This made a positive difference for people.

Chief pharmacists were able to tell us about various ways they were helping staff to develop their knowledge and skills to support autistic people and people with a learning disability, for example:

- using bespoke training on learning disabilities
- developing a pharmacy learning disabilities champion role
- running a learning disabilities educational week.

We asked trusts if they had any examples of good practice in how their pharmacy teams had helped people during their admissions to hospital. Overall, where NHS organisations understood the people they cared for and worked collaboratively within the local system, access to medicines tended to be more seamless. However, good practice was not universal, and further work is needed to ensure that autistic people and people with a learning disability have a better experience with medicines while in hospital, and when their care is transferred to another service.

Black men's mental health

In last year's report, we shone a spotlight on the longstanding health inequalities that Black or Black British people face, and our specific concerns around Black men's mental health.

To develop our understanding of how Black men experience mental health care, we commissioned Queen Mary University (QMU) and University College London (UCL) to carry out a rapid review of what 'good' looks like in relation to access, experience and outcomes for Black men. As part of the review, the team carried out a literature review, which showed that Black people (that is, people of Black Caribbean and Black African heritage) continue to face stark and persistent inequalities in mental health care.

The literature review found that not only are Black people 3 to 5 times more likely to be diagnosed and admitted to hospital with schizophrenia compared with all other ethnic groups, they are also less likely to access care early. Inequalities affect Black people along the entire care pathway from access to diagnosis, assessment, treatment and recovery.

Members of the review team spoke with 23 people, including those with lived experience, family, carers, charities and advocacy groups, and providers of services to hear their experiences.

People described stigma as one of the main barriers to accessing mental health services – both in terms of the way communities often viewed mental illness as a sign of weakness or shame, and past experiences that have led to distrust in services. This was also reflected in the findings of the Ipsos survey, where professionals reported that cultural stigma can lead to a reluctance to seek help, disclose symptoms and engage with medicine. Differing cultural beliefs and practices related to mental health and wellbeing can also lead to misunderstandings and misdiagnoses.

Other key barriers identified by the QMU and UCL research included the availability of services and the lack of culturally appropriate models. Culturally appropriate care is sensitive to people's cultural identity or heritage. It means being alert and responsive to beliefs or conventions that might be determined by cultural heritage.

Tackling Inequalities in Health and Care was the theme for our engagement event with representatives from NHS trusts, community organisations, carers, and people who use services. Here, we heard that when people use services, they should feel culturally safe and connected to their identity, including having access to prayer spaces, cultural practices, and community. In addition, we heard that staff should demonstrate understanding of racial trauma and its impact on people who use services. Participants in the research by QMU and UCL felt that more work was needed to make people aware of the services available, reduce stigma regarding mental health problems and create a model centred on prevention, rather than treatment. One participant mentioned the use of satellite clinics embedded in the community and accessible to patients:

> *"Satellite clinics that support the surgery in the villages once a week… If you can't get to the surgery or you just need some advice, or you just want someone to talk to, or you know you're worried about something, 'just come and talk to us."*
>
> (Family member/carer)

People who use services and their families who participated in the research described 'good' care as care that was open and inclusive. They described the importance of involving Black men in both decisions about their care, as well as the design of services.

All interviewees agreed that care should be holistic and address all aspects, including mental, physical and emotional care. They described the importance of culturally appropriate care that is tailored to individual people's needs. One person who uses services explained how this affected them:

> *"Being aware, me feeling confident in the knowledge that the therapist I'm speaking to has been through cultural awareness training. Has good experiences of working with, you know, ethnic minority or marginalised clients. And you know, I think of all the things, I think it for me, it comes back to this one issue which is around feeling that these folks are culturally competent."*
>
> (Person who uses services)

The research participants described how care that was not holistic and was focused on medication could mean that the causes of the patient's mental health condition were not addressed and would probably continue to be there after the treatment ended. As one provider reflected:

> *"If I come to you asking for help and I'm saying I'm struggling with low mood, don't assume what could help. It might not be medication, it could be [help with] housing. I'm not saying 'give me a job' because I might be struggling with employment. However, it's not the medication [that would help]. It could be [referring me to] someone who can help me to get a job."*
>
> (Provider)

People felt that the ability of services to deliver holistic care was also affected by the current fragmentation of the healthcare system, where there were notable gaps in the communication between providers. One of the family members described the impact of this:

> *"You may see a nurse, an [occupational therapist], a psychiatrist, a psychologist… the multidisciplinary team sometimes is more challenging in the way that they communicate to each other. It shouldn't be our responsibility to take bits and pieces [of information] and make sure these are communicated."*
>
> (Family member/carer)

People also described the need for additional funding to deliver high-quality services, address gaps in staffing and scale-up initiatives that were having a local impact. There would also need to be additional investment to train more Black therapists to deliver care and integrate cultural competency training in practice:

> *"Funding is a key issue. The reason why more models are not being introduced is because the funding isn't there to sustain it, so things may happen at pilot level, but they're never scaled up and embedded permanently, so there's loads of [small scale] activity that happens and it's brilliant and then it's done [and] the funding's finished."*
>
> (Advocacy group)

Findings from the literature review show that staff must be properly trained to fight racism and support Black men with respect and understanding, and that services need to be held accountable when they fail to do the right thing.

In October 2023, NHS England launched the Patient and Carer Race Equality Framework (PCREF). This is the first anti-racism framework for mental health trusts and mental health service providers, which sets out to improve access, experience and outcomes for people from ethnic minority groups.

We support PCREF as a practical tool to tackle racism and dehumanisation. We continue to encourage services to embed the approach through our regulatory and monitoring activity, and will be checking how services use the framework as evidence to inform our assessments. This includes how mental health services embed equity into their shared vision and ensure equity in experience and outcomes for people from ethnic minority groups. In our MHA monitoring visits we have found poor awareness of and lack of training about PCREF in mental health inpatient settings. We will discuss these findings in our upcoming Monitoring the MHA report.

As a regulator and monitoring body, it is important that we do not hold others to account for actions we are not taking ourselves. We stand against racism, violence, aggression and abuse in all forms. We are currently adopting the principles for an anti-racist organisation set out by the NHS Race and Health Observatory. Our approach will focus on how we address the effects of structural, institutional, and interpersonal racism. This includes addressing racism in our external regulatory work for people using services and providers, as well as internally for our colleagues in CQC.

Health and care services for children and young people

Community health services for children and young people

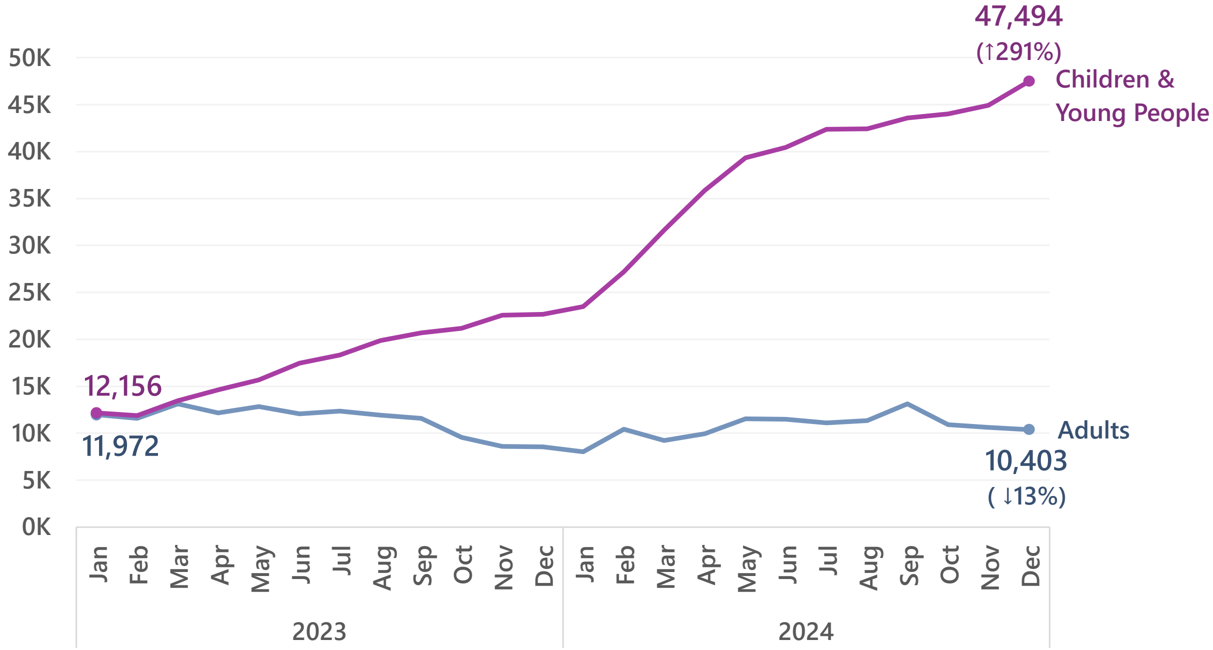
In last year's State of Care report, we highlighted the sustained decline in the number of qualified health visitors who provide support and advice for families with children up to 5 years of age.

This year, we turn our spotlight more widely on community health services for children and young people, which, as well as health visiting, deliver school nursing, speech and language therapy, and community paediatric services. The latter services provide care for children who need diagnostic assessments and initial support for complex and ongoing physical and mental health issues, including neurodivergent conditions, such as attention deficit hyperactivity disorder (ADHD) and autism.

According to NHS England data, between January 2023 and December 2024, the number of children and young people waiting to access community health services increased by 26%. This is higher than the 19% reported for adult services.

But the most glaring difference lies in the number of people waiting over a year for community health treatment. From January 2023 to December 2024, waiting lists for adults have reduced by 13%. By contrast, the number of children and young people on these waiting lists increased almost threefold (by 291%), from 12,156 to 47,494 over the same period (figure 20).

Figure 20: **Number of people waiting over a year for community health service treatment in England – children and adults, January 2023 to December 2024**



Source – CHS Sit Reps. Definitions of service types included in the reporting changed in February 2024, and February to April represent statistical outliers compared with the preceding monthly pattern. The higher levels reported from this point have nevertheless persisted above the expected range through to December 2024.

As at December 2024, the majority of people waiting over a year for community health treatment are those waiting for community paediatric services. They make up 85% of the community healthcare waiting list, compared with the next most-awaited service – speech and language therapy – which accounts for 10%.

A personal story – waiting for an ADHD diagnosis

Charlotte and her husband first started to notice a decline in their daughter Izzie's mental health when she was 14 years old. Once she had turned 16, these signs became more apparent, and Izzie's boyfriend suggested that she might have ADHD.

Izzie's GP asked her to complete an online test, which showed that she was extremely likely to have ADHD. Her GP therefore added her to a waiting list for a formal assessment.

While waiting, Izzie's mental health rapidly worsened. She started to hurt herself and retreated into her own bubble. She stopped going out. She even had to quit education.

At 17, Izzie finally received a formal diagnosis of ADHD. On receiving it, she burst out crying because she finally felt seen. She felt validated. She was offered medication, which has helped her to manage the impact of ADHD on her day-to-day life.

Izzie now plans to focus on navigating life with ADHD, while her parents help her to get the help that she needs.

(Interview with a member of the public)

The backlog of children and young people waiting for community paediatric services varies by region. As at December 2024, nearly half (45%) of children and young people in the South West of England were waiting over a year for treatment from community paediatric services, compared with 14% in the South East. To put these figures into context, the National Institute for Health and Care Excellence states that people with possible autism should have their diagnostic assessment initiated within 3 months of their referral.[80]

Protecting children from serious youth violence

The report on our joint targeted area inspections discussed how some groups of children are particularly vulnerable to being affected by serious youth violence, including children with special educational needs or disabilities – especially those with neurodivergent conditions, such as those mentioned above.[81]

Joint targeted area inspections are carried out by CQC, Ofsted, His Majesty's Inspectorate of Constabulary, Fire and Rescue Services, and His Majesty's Inspectorate of Probation (HMI Probation). They look at how local partnerships and services, including health services, respond to children and their families when children are affected by serious youth violence.

The report says how children with special educational needs or disabilities are having to wait too long for their needs to be assessed, and how there are delays in children being able to access services, as reflected above. This is making some children more vulnerable to serious youth violence, as needs can increase while they wait for an assessment or support. Waiting times are especially long for children who need a neurodevelopmental assessment, including for ADHD and autism. Out of the 6 areas we visited, 3 areas had waits of at least 2 years for a neurodevelopmental assessment. In one area, children then had to wait a shocking 10 years to access support following a diagnosis, by which time some of them would be adults.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) form an important part of the Mental Capacity Act 2005. DoLS can be applied in care homes and hospitals where a person aged 18 or over does not have the mental capacity to consent to the arrangements made for their care or treatment, and they need to be deprived of their liberty. The safeguards are designed to protect people's human rights, aiming to make sure that any restrictions are necessary to prevent harm, are proportionate and in the person's best interests.

If a person is deprived of their liberty, they are not free to leave the premises on a permanent basis, for example to live where and with whom they choose to, and they are subject to continuous supervision and control. This means they are monitored or supervised for significant periods of the day, and they are not allowed to make important decisions about their own life.

We have raised serious concerns about the safeguards and the need for system-wide reform for a number of years. Applications to authorise the deprivation of a person's liberty have continued to increase significantly over the last decade – far beyond the levels expected when the safeguards were designed. This puts pressure on local authorities, who are responsible for authorising standard DoLS applications, and often results in lengthy delays in processing applications. In turn, it affects health and care staff, who need to balance keeping people safe with protecting their rights while waiting for an application to be granted.

People in need of a DoLS authorisation are often among those least likely to have their voices heard. In a system struggling to cope, many people subject to DoLS authorisations are not having their rights upheld in the way that the system intended. In our last State of Care report, we called for urgent action to ensure that the system does not fail people in the future. We remain concerned that the current system is not effectively protecting the rights of many people who use health and social care services. Added to this, the level of understanding among staff of how and when to apply the safeguards, and the need to review restrictions regularly to ensure they remain relevant, continues to vary across both adult social care and hospital settings.

People at the heart of the system

Longstanding issues with the DoLS system can significantly affect people who are assessed as needing to be deprived of their liberty, their family, friends and carers. While DoLS aim to offer important safeguards, many of the issues we raise risk infringing people's rights or even contributing to abuses of individuals' rights. For example, this includes people being deprived of their liberty without legal protection while waiting for an authorisation. To better understand the experiences of staff using DoLS in hospitals, this year we surveyed Mental Capacity

Act leads for hospitals and heard from staff at over 40 NHS trusts. One hospital provider told us:

> *"DoLS is resource/admin heavy and as a result, we have created a system that rather than protecting people's human rights, leaves them vulnerable to unlawful deprivations and no recourse to public funds to challenge. Those that work within the world of DoLS are demoralised working in a broken system that no-one has the appetite to fix."*

It can be particularly challenging for families and carers in situations where people may feel distressed and do not understand the restrictions placed on them. We heard some positive examples from hospital providers, where working closely and maintaining good communication with family members enabled staff to respect people's choices while keeping them physically safe. Another provider noted how positive engagement with a family helped to minimise risk for a patient who was found to lack capacity to consent to being admitted.

However, a small number of providers commented on families' lack of understanding of the DoLS process, which can result in stress, a lack of trust in the clinical team and complaints. The Mental Capacity Act Code of Practice is clear that for standard DoLS applications, staff at hospitals and care homes should tell the relevant person's family, friends, carers and advocates about applying for an authorisation, unless there are valid reasons for not doing so. Anyone engaged in caring for the person or interested in their welfare should have opportunities to input their views.

Jane's experience highlights the need for good communication about DoLS.

A personal story: The need for good communication

Jane's husband, Andrew, experienced memory problems for around 3 years but initially did not want to see a doctor. When Jane convinced him to see the GP, he was referred for an urgent MRI scan. The following week, Andrew woke up early with no idea where he was, searching for the couple's children, who were all in the house. Jane took him to A&E immediately.

At the hospital, Andrew's state of confusion continued. A CT scan revealed he had a cyst on his brain, but Jane and Andrew were then left waiting in A&E for a further 11 hours. Jane described the constant battle to keep Andrew in A&E as he did not know where he was and wanted to return home. By the early hours of the following morning, Jane spoke to staff, and Andrew was admitted to an observation area.

At this point, DoLS was mentioned for the first time as Andrew was found not to have the mental capacity to consent to being in hospital. Staff did not explain the process to Jane or outline what it meant for her husband’s rights. Although the observation area was behind closed doors, Jane received a call early the next morning to say her husband had gone missing. Jane felt that the urgent DoLS authorisation did nothing to safeguard him.

While the hospital security team watched CCTV footage to try to track Andrew’s movements, it was Jane who eventually located him using the ‘find my phone’ app. Jane described a dangerous situation where he crossed a dual carriageway opposite the hospital, thinking he was on his way to work. She insisted someone from the hospital should meet him to ensure he returned to hospital safely. During his hospital stay, Andrew would try to leave the hospital with Jane every time she went home, and she received distressed phone calls from him every night.

Doctors at the hospital carried out a general cognitive assessment, asking Andrew questions about his name, the date and the people around him. Jane recalled a doctor making a blanket statement about her husband no longer having capacity, who added that they were “taking that away from him”.

[It is important to clarify that, legally, there is no such thing as ‘taking away’ a person’s capacity. The starting point must always be to support individuals to make their own decisions. If they are still unable to make a decision even after all practicable steps have been taken, then the Mental Capacity Act is there to ensure that any decisions are made in the person’s best interests. This potential miscommunication may have added to Jane’s confusion about the process.]

Andrew was then moved between numerous wards over the following 5 days. Jane felt she needed to talk to staff on each ward about her husband’s mental capacity, as it was not always mentioned in handovers and she worried for his safety if staff were not aware. He was moved to a high dependency ward for people with dementia, with specialist staff who were better equipped to meet his needs. Jane felt this ward was safer as he was unable to leave.

Andrew was waiting for a bed to become available at a different hospital, and Jane mentioned being told by staff that they were “babysitting” him and there was no further treatment they could offer. It was only when Andrew was discharged that Jane found more information about DoLS in discharge notes. During his time in hospital, she had not seen any paperwork such as a formal urgent authorisation, and there was no explanation about the legal framework to keep him safe, nor any communication about her husband’s wishes or feelings.

Jane said an occupational therapist put together a helpful pack with some information about care at home and phone numbers to call for support, but the overall lack of information about DoLS meant she was unsure if the authorisation remained in place at home. She told us that the experience could have been significantly improved for both her and her husband if staff had explained their choices and rights. Ultimately, she does not feel the DoLS authorisation kept her husband safe.

(Interview with member of the public)

We expect providers to deliver person-centred, rights-respecting care. All providers have a duty to ensure that they provide care and treatment with the consent of the relevant person, and when a person lacks mental capacity to make an informed decision or give consent, staff should act in line with the requirements of the Mental Capacity Act 2005. Providers also have a duty to ensure people are not deprived of their liberty for the purpose of receiving care and treatment without lawful authority. We are also clear that care that does not respect and promote human rights is neither safe nor high-quality.

We were encouraged to hear examples of services supporting people to take part in decisions about their daily routines and care plans from some hospital providers. A number of NHS trust staff who responded to our survey also acknowledged that a DoLS authorisation does not remove a person’s right to have a voice or to object. While there was recognition of the need to document and respect such objections, a few staff expressed mixed feelings when these objections conflicted with what was deemed to be in the individual’s best interests. In some cases, this led to a sense of tension or conflict as staff navigated the fine balance between respecting individual autonomy and ensuring safety and appropriate care.

We continue to hear how issues with the DoLS system may disproportionately affect certain groups of people. Last year, we heard from a local authority national DoLS lead that while some people with a learning disability or living with dementia meet the requirements for a DoLS authorisation, the use of screening tools means their applications often do not meet the prioritisation criteria.

This year, several respondents in our survey specifically mentioned older people, including those with dementia. One respondent noted that because of the nature of their care needs, certain groups of people such as older people and people with dementia are more likely to require a DoLS authorisation. As a result, they may be disproportionally affected by the current DoLS processing times and the delays to the implementation of the LPS. Another suggested that local authorities do not always regard older people as a priority if they have complex care needs, including a dual diagnosis. We also heard from a respondent in a different trust that ‘most patients’ are never assessed by their local authority partners, and that patients either regain their capacity, are discharged or die before they are assessed.

Sarah’s story demonstrates how, when implemented correctly, a DoLS authorisation can benefit people with dementia and their families.

A personal story: DoLS as a safeguard during transitions

Sarah’s father, Michael, had been living with dementia for around 5 years when she started to see a noticeable deterioration in his health. Michael was usually well dressed when leaving the house and people may not recognise that he has dementia, but he would go for walks and not remember where he was going. On one occasion, Sarah had to share a post on Facebook asking friends to look out for her father.

A few weeks later, in the early hours of the morning, Sarah received a call from a paramedic to say Michael had been found in a large park on the other side of town, confused about where he was. Along with dementia, Michael also has some physical health conditions. He was taken to hospital and given a full assessment.

Michael was assigned a social worker, and after a mental capacity assessment they concluded that he lacked capacity to make decisions about where he lived and that it was not in his best interests to continue living independently. He had to wait in hospital for a suitable care home placement. During this time, his dementia became worse and the hospital staff told Sarah they were going to apply for DoLS authorisation to keep him in hospital. Sarah said the hospital and local authority worked effectively together and kept her well-informed. They explained what it meant to have a DoLS authorisation, how they came to the decision to apply and the process for an authorisation. Sarah became her father's representative, which enabled her to represent his wishes. She explained that although the situation was "daunting and upsetting", the family felt relieved that the DoLS was in place to keep her father safe.

Eventually, the social worker informed the family that an appropriate care home had been found. Sarah was able to talk to staff at the home about what they could offer Michael and ask questions. The family agreed that the home would be suitable and Michael moved in. Having support from the hospital and the care home meant the move went very smoothly. The home worked with the local authority to put a new DoLS authorisation in place. The assessments took place promptly and as her father's representative, Sarah was involved in this process and was also given information in writing. The authorisation is reviewed regularly, with Sarah and her sister invited to attend meetings and provide input.

Reflecting on her experience of the DoLS process, Sarah said, "I have zero complaints about how the DoLS was put in place. They've given him his dignity, looked at his preferences. They have put his best interests first and made sure he's safe."

(Interview with member of the public)

Processing DoLS applications

Applications to deprive a person of their liberty must be authorised by a 'supervisory body'. In England, the role of a supervisory body is undertaken by local authorities, who are responsible for arranging assessments to make sure that a deprivation of liberty is only authorised if certain requirements are met. Standard authorisations can last for up to a year. Where a care home or hospital has made a request for a standard authorisation (or is required to make a request to the supervisory body for a standard authorisation), but believes that the need for a person to be deprived of their liberty has now become so urgent that a DoLS authorisation needs to begin before the request is dealt with by the supervisory body, they may grant an urgent DoLS authorisation. These can last up to 7 days and can be extended for a further 7 days if necessary, but not beyond this.

Providers are required to formally notify CQC when they know the outcome of an application for a deprivation of liberty, including withdrawn applications. This must be done without delay for applications made to both the Court of Protection and under DoLS. It includes when an authorisation has not been granted, or the application has been withdrawn. Since April 2020, we have seen year-on-year increases in the number of notifications we receive.

In 2024/25, we received over 185,000 notifications, a 15% increase on the previous year.

Last year, we reported on the wide variation in how local authorities were managing DoLS applications. In 2024/25, our assessments of local authorities show a similar picture. While some local authorities reported not having any DoLS backlogs, others were struggling to meet demand and a few hospital providers told us that local authorities were not completing timely assessments or providing adequate feedback on the application process. According to the Association of Directors of Adult Social Services (ADASS) Spring Survey, directors have the least confidence that their adult social care budgets will be sufficient to meet their legal duties in relation to DoLS in 2025/26, compared with other legal duties.[82] Local authorities with no waiting lists for DoLS applications or renewals told us about investing resources to cover the increase in applications in recent years and ensure levels of Best Interest Assessors were sufficient.

In our last report, we also highlighted that many local authorities cited the ADASS screening tool as a way of helping to prioritise DoLS applications. This year, we continued to see local authorities adopting risk-based approaches to triage and prioritise applications, and some local authorities had processes in place to regularly review their waiting lists.

While tools can help to identify applications that need urgent attention, local authorities have a statutory 21-day timeframe to process all standard applications. Unfortunately, many people face significant waits for DoLS authorisations, far beyond the statutory timeframe. For example, staff at one local authority outlined that lower risk assessments could take 2 to 3 years to complete. This poses a significant risk of people being unlawfully deprived of their liberty while they wait years for an authorisation. It may also increase inequalities for people who are more likely to be deemed lower risk, such as people with a learning disability or those living with dementia, as we highlighted in our 2023/24 report.

Several hospital providers cited this issue when responding to our survey. One described the "anxiety" felt by clinical staff when patients do not have a standard DoLS authorisation in place and an urgent authorisation lapses, meaning people are kept in hospital in their best interests without a legal framework in place. A different provider said their "biggest concern" is "patients being unlawfully deprived of their liberty because [local authorities] are unable to meet their legal obligations."

We also heard how a lack of consistency in how local authorities process DoLS applications can be difficult for providers to navigate. In our survey, one hospital provider expressed frustration about the different formats and platforms that local authorities use, while another described the challenge of having to use 11 different local authority portals, which are all different. This can cause uncertainty about the correct procedure, resulting in staff being less confident in making applications and following up on them. However, some providers reported productive working relationships with local authorities, explaining how regular contact enabled them to check the status of referrals and highlight more urgent cases.

Staff understanding and application of DoLS

Another issue we have raised consistently in many State of Care reports is the variation in the way staff understand and apply the safeguards. This year, we continued to find examples of staff not properly understanding when DoLS is needed or failing to recognise and review restrictions appropriately.

Many respondents to our survey of Mental Capacity Act Leads raised the need for improved training to enhance understanding of the Mental Capacity Act, and therefore protect people's rights. One noted the "poor application of knowledge to practice" even when this training forms part of the provider's mandate for all staff. Examples like this one show that training alone is not enough, and it is important that staff can demonstrate that they understand what the requirements of the Mental Capacity Act and DoLS mean for the people they are caring for and are confident in applying this learning in their role. We have also found evidence of these challenges in our inspection activity.

These issues manifest in a variety of ways, and we continue to see examples in our inspection activity of providers not reviewing restrictions regularly to check if these remain proportionate. This could mean that people receive overly restrictive care or may remain deprived of their liberty for longer than they need to. Reviews could also show that a person needs enhanced safeguards. Not only does this represent a missed opportunity to improve care, but it also contradicts the principles of the Mental Capacity Act and means people's human rights may be affected. However, when we analysed a small sample of our DoLS notifications from providers, many mentioned the need to regularly review the care arrangements to ensure they remain responsive to people’s changing needs and emphasised the need to inform the local authority if there is a change in circumstances that could require a review of the DoLS authorisation.

A standard authorisation can last for a maximum of 12 months. When providers review people’s care arrangements, they may find that a DoLS authorisation is still needed. To ensure that people are not restricted without the required safeguards in place, we expect providers to apply for renewals in a timely way using the correct process, but we continue to find examples in our inspection activity of this not happening. On the other hand, when responding to our Mental Capacity Act Leads survey, some hospital providers expressed frustration about the time it takes for their local authority to process renewals. Again, this risks people being deprived of their liberty without the appropriate legal framework in place while waiting for a renewal authorisation.

We have also seen cases where staff did not always recognise restrictions, such as locked bedroom doors or people not being able to leave where they live without support from staff. When services stop recognising restrictions there is a risk that they become part of the culture. At one adult social care service, we observed staff applying restrictions on multiple residents without lawful justification:

> *“One person was walking with purpose and appeared content when they were repeatedly physically redirected to sit in a chair. There were no supporting assessments, consent forms, or best interest decisions in their care records to justify this practice. Multiple people were routinely kept in bed throughout the day and night with no recorded rationale or any indication this was people’s own choice. Two members of staff and multiple relatives told us they had raised these concerns with the registered manager, but no action was taken.”*

At the service, while some members of staff demonstrated a sound understanding of DoLS, others were unable to explain what this means for people in their service. One member of staff simply said “I don’t know” when asked about DoLS. In this assessment, inspectors identified multiple areas of concern and issued 6 Warning Notices for improvements to be made in areas including the need for consent.

At another service, inspectors found that staff and the manager lacked adequate knowledge of the Mental Capacity Act and DoLS. We were concerned that some people were subject to control or restraint that may not have been proportionate to the risk of harm. For example, one resident’s clothes were locked in a cupboard outside of their bedroom, with no evidence that this decision had been consented to or made in their best interest following a mental capacity assessment.

The wider policy landscape

The wider policy landscape in health and social care is changing, and this could have implications for the DoLS system. The Mental Health Bill is currently progressing through parliament and will bring about important safeguards for people who are detained under the Mental Health Act (MHA). This could have a knock-on effect on the DoLS system.

In our recent Monitoring the Mental Health Act report, we raised concerns about autistic people and people with a learning disability staying in hospital for prolonged periods when this does not meet their needs. We welcome the ambition to change this situation, which is reflected in the proposals of the Bill to exclude being autistic or having a learning disability from the scope of civil detention under the MHA. This means that being autistic or having a learning disability alone cannot be a reason to detain a person for longer than 28 days.

However, without suitable community-based alternatives, there is still a risk that people may be detained under other legal frameworks, such as DoLS, placing additional pressure on an already struggling system that is not always effectively protecting people's rights.

Another pending area for change is the move from DoLS to Liberty Protection Safeguards (LPS). Introduced through the Mental Capacity (Amendment) Act 2019, LPS were intended to replace DoLS. They were designed to be more streamlined than DoLS, operating alongside care planning. It was intended to ensure that people could access key legal protections more quickly. It also extended to 16 and 17-year-olds and those deprived of their liberty in settings other than care homes and hospitals.

The implementation of LPS has been postponed multiple times: first in 2020 because of the COVID-19 pandemic, and again in 2023 it was paused without giving a reason. In successive State of Care reports, we have expressed concerns about implementation delays and uncertainty around the future of the LPS.

Chronic, longstanding issues with the current DoLS system mean many people are still not getting the important safeguards they need, and many of the issues we raise in this report are not new. We welcome the government's recent announcement that it intends to take forward the consultation on LPS. We recognise that the sector will need time, resources and support to prepare for the introduction of the new system, and we will work with key stakeholders as part of this process. We look forward to the publication of an updated Code of Practice, as clear guidance will help health and social care staff with the practical application of the MCA and is essential to support the implementation of the reforms. During this process, it will be vital that the human rights of people affected by the current DoLS system remain a focus.

Chapter 3
Local systems

Local systems

Key findings

- Integrated care systems (ICSs) continue to face challenges in addressing health inequalities, shifting care closer to home, and supporting older populations.
- Leadership and shared vision appear strong, with clear accountability and shared understanding of priorities across most ICSs, though aligning funding with these priorities remains a challenge.
- Financial constraints remain the dominant barrier to progress – systems cite insufficient funding and competing national priorities as limiting capacity for transformational change.
- Partnership working with voluntary, community, faith and social enterprise (VCFSE) organisations has strengthened, particularly in addressing health inequalities.
- Data capabilities have improved in the last year but remain inconsistent, with ongoing challenges in data sharing and linkage across partners.
- There is some caution in confidence to deliver the 'three shifts' in the government's 10 Year Health Plan – more than half of respondents to a survey of ICS leaders were moderately confident and around a quarter expressed no confidence at all.
- From our local authority assessment programme, we can see work to increase and improve capacity in homecare services through reviews and new approaches to commissioning. We also see partnership working to try to make sure people are safely discharged from hospital and improve flow in the system, as well as proactive approaches that often involve community and voluntary sectors.

Integrated care systems

Introduction

For over 10 years, we have reported on the challenges for services in providing equality of access, experience and outcomes for people who need care. We know that better care and better outcomes are possible when services work together in local systems – and we have reported on people's experiences when they have good care that is joined up across a local area.

In 2025, for the second year running, we have worked with the Nuffield Trust to find out more about the way local health and care systems are trying to help people who need care. The aim of integrated care systems (ICSs) throughout England is to improve health and care services – with a focus on prevention, better outcomes and reducing health inequalities.

In 2024, our findings on health inequalities showed that integrated care boards (ICBs) were struggling on finance, planning and workforce matters. They told us they were focused on tackling health and care inequalities, but they did not always understand their populations sufficiently – and there were competing priorities. Responsibility for tackling health inequalities is not the sole responsibility of ICBs – local government also has a role to play, so our local authority assessments help us to gain an understanding of this.

CQC has a duty to assess ICSs under s.48B of the Health and Social Care Act 2008. Although this work is currently paused, we acknowledge that these systems are pivotal in health services that people use. As such, we have sought systems' own views of their own progress across 3 priority areas identified as critical to system transformation in 2024/25:

- reducing health inequalities
- shifting services into the community
- supporting older and frail populations.

For health inequalities specifically, the focus is on their progress in what is known as the Core20PLUS5, a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level.

The findings are based on an independent survey conducted by the Nuffield Trust of 49 respondents from 30 ICS areas (representing 71% of all ICSs) and 8 interviews with senior leaders who have strategic responsibilities from 6 NHS regions. The research examines progress, barriers and the future outlook among ICSs. We also wanted to collect and highlight examples of activities and good practice from across different systems, as well as understand the barriers they encountered in 2024/25.

Some things are working well. Across the 3 priority areas we asked about, systems reported similarities in what is going well and the factors that are supporting this progress:

- We heard about successes in data-driven, place-based understanding of local populations and their needs, strong relationships with voluntary, community, faith and social enterprise (VCFSE) organisations, and bringing proactive multidisciplinary teams focused on prevention to the communities who could benefit most.
- Systems told us about innovations in service delivery using one or more of these aspects, which resulted in progress across the 3 priorities we asked about. For example, bringing together both medical and non-medical services at a community hub, making healthcare more accessible to the local population by providing it nearer to home, at the same time as tackling health inequalities through addressing wider determinants of health.

Shifting care into the community

Most progress in shifting care into the community is described as moving hospital-based expertise, diagnostics and screening into community settings. But there are reported barriers to moving care closer to home, with insufficient funding being the most frequently cited issue. There were also significant disagreements within systems about how to shift resources to prioritise community services.

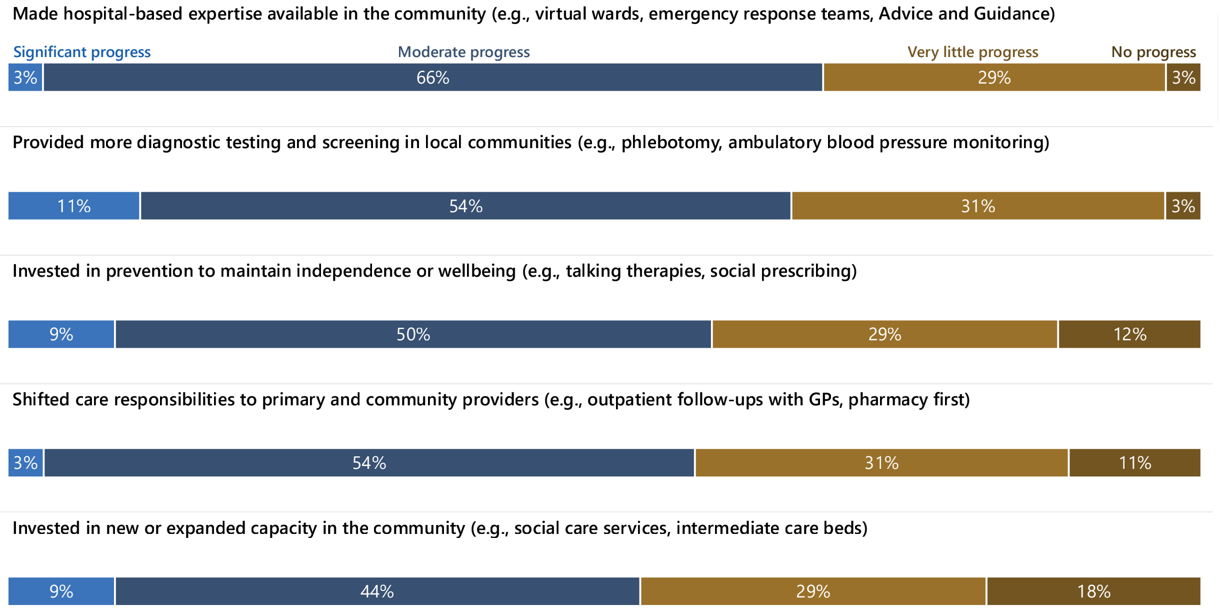
Moving care out of hospitals and into communities is one of the 3 main shifts proposed in the government's 10 Year Health Plan for England, bringing care closer to the people who need it through 'neighbourhood health services' that bring teams together around shared needs rather than specialisms. We heard that systems are already strategically prioritising care provided in local communities and piloting innovative solutions within constrained resources.

Of the options provided in the survey (figure 21), systems reported most progress in making hospital-based expertise available in the community (3% significant progress and 66% moderate progress) and in expanding diagnostic and screening services in the community (11% significant progress and 54% moderate progress).

Reported progress was most varied regarding investment in new or expanded capacity in the community.

Examples of progress included hospital-based expertise in community and primary care settings, such as diagnostic and screening services, with GPs taking on some dermatology and gynaecology services. We also heard examples of innovation in strengthening proactive, preventative and urgent community services.

Figure 21: **Perceived progress in strengthening community services in the last 12 months**



Note: Questions about moving care closer to home were answered by 38 out of 49 survey respondents (78%). The denominator for each sub-question varied here, as some respondents (between 3 and 4) selected ‘not applicable/unsure’ and these responses were excluded.

Example of a multi-agency care and co-ordination team (MACCT)

Aim: To identify adults living with frailty or a complex long-term health condition who would benefit from proactive care support to stay well, work towards their goals and reduce avoidable hospital attendances or crises. For example, people at risk of falls, people with dementia, people affected by polypharmacy issues, and unpaid carers.

Input: A multi-disciplinary team includes social workers, mental health workers, occupational therapists, physiotherapists, community matrons and a GP. In addition, team members are drawn from: Haringey Council (adult social care); North London NHS Trust, and voluntary sector agencies, to create a wider multi-agency, multi-professional team.

Activities: The team works with local GP practices to identify patients who would benefit from the service – and works with patients to set goals and create personalised care and crisis plans.

Outcomes: MACCT works with over 2,700 people a year, of whom 95% are aged 50 and over, and 60% living with moderate or severe frailty. In subsequent evaluation, 94% of patients reported that the service was ‘very good’ or ‘good’ and 70% reported that they had met or progressed towards their agreed health goals. Two-thirds reported that the service had reduced their fear of falling. An analysis of secondary care activity for the 12 months before and after the start of the MACCT service showed a 30% reduction in emergency department attendances and non-elective admissions for its patients.

Haringey MACCT

Example of an acute response team service

Aim: To provide holistic care support to frail patients in their homes and in care homes, enabling hospital avoidance and community-based interventions through collaborative multidisciplinary working.

Input: Team of GPs, nurses, paramedics, allied health professionals, and geriatricians operating from 8am to 8pm (extended from 8am to 5:30pm during COVID-19). Serves 61 care homes with around 1,500 residents in Thanet district.

Activities: Daily monitoring of frail patients, responding to ambulance calls, remote hospital ward rounds, A&E assessments, face-to-face assessments, medication management, end-of-life care support, and fortnightly multidisciplinary knowledge-sharing webinars.

Outcomes: Around 1,000 professionals engaged across Kent and Medway and issues resolved within days that were previously unsolvable for year, enhanced collaboration between services, and demonstrable significant qualitative and quantitative impact, leading to consideration for ‘business as usual’ implementation.

East Kent: Sharing knowledge for a different mindset in health and social care

We also heard feedback about actions that strengthened community-based infrastructure:

> *“We have been able to use small amounts of capital funding to turn administrative space into clinical rooms, use those clinical rooms for additional primary [and] community care services. In towns where there aren’t acute hospitals, people have been able to get treatment and screening, and things that they don’t need to go to hospital for, provided in their health centres closer to home.”*

Supporting older or frail populations

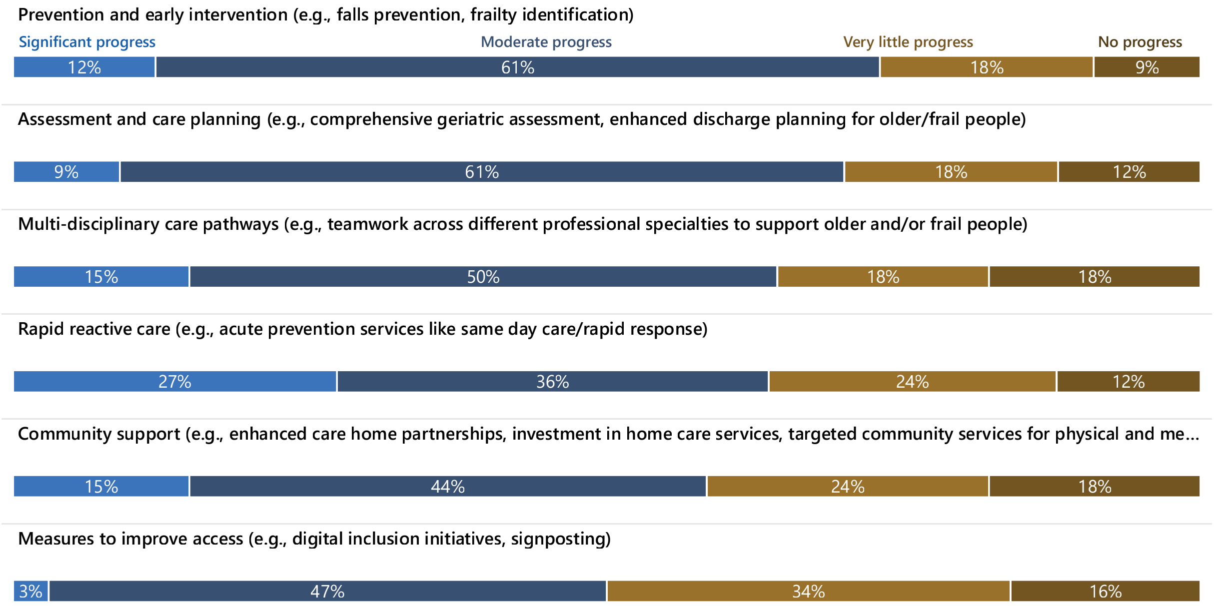
When asked about efforts to support older and frail people, systems reported having made most progress in:

- prevention and early intervention (12% significant progress and 61% moderate progress)
- assessment and care planning (9% significant progress and 61% moderate progress)
- multi-disciplinary care pathways (15% significant progress and 50% moderate progress)
- rapid reactive care, for e.g. rapid response services (27% significant progress and 36% moderate progress)(figure 22).

Relative to reported barriers in reducing health inequalities and shifting care into the community, workforce challenges were more frequently listed as a barrier (41% compared with 21-32% in other areas), though this research did not ascertain the drivers of those workforce barriers.

The areas of focus about supporting older and frail people were reflected strongly in interviews as people frequently cited work that identified and addressed the risk factors of ill-health among older and frail people.

Figure 22: **Perceived progress in supporting older and/or frail people in the last 12 months**



Note: Questions about actions to support older and/or frail people were answered by 34 out of 49 survey respondents (69%). The denominator for each sub-question varied here, as some respondents (between 1 and 2) selected ‘not applicable/unsure’ and these responses were excluded.

From the interviews, we heard about several key approaches for supporting older and/or frail people, focusing on preventative, joined-up and place-based approaches.

Systems are increasingly using data and information systems to proactively identify people at risk of ill health and injury. For example, they are using single care records to predict people's risk of falling, and monitoring respiratory rates for early intervention in care homes that have nursing. We also heard about community-based multidisciplinary teams that provide proactive outreach to address these risk factors and prevent unnecessary admissions to hospital.

Example: eFalls pilot programme in Wigan

Aim: Help GPs to identify older adults who are at moderate risk of falling in the future, so they can receive early support to prevent injuries and maintain independence.

Input: NHS Greater Manchester data team uses the eFalls tool to search GP systems, using indicators such as frailty scores, falls history, medicines, and long-term conditions, and classifies patients into risk categories.

Activities: Patients identified are invited for a health check and offered a place on a Falls Management Exercise programme, to help improve strength, balance and confidence. Patients can be referred for onward services, such as eyesight checks.

Outcomes: The team is monitoring outcomes to assess the programme's impact.

Greater Manchester Integrated Care Partnership

This proactive approach extended to expanding access to early diagnosis and preventative care through initiatives like advanced care planning in end-of-life care, as well as technology-enabled care to support people to stay connected, monitor falls, and reduce social isolation and loneliness.

To deliver these services effectively, we heard how some places have sought to break down traditional silos, through joint commissioning arrangements with GP practices and local authorities, establishing multi-disciplinary teams that take holistic approaches to care, and extending clinical expertise into community settings through innovations such as geriatrician hotlines and frailty fellows supporting care homes.

Interviewees described the development of integrated neighbourhood models as central to delivering more proactive care and support in the community for older and frail people.

Reducing health inequalities

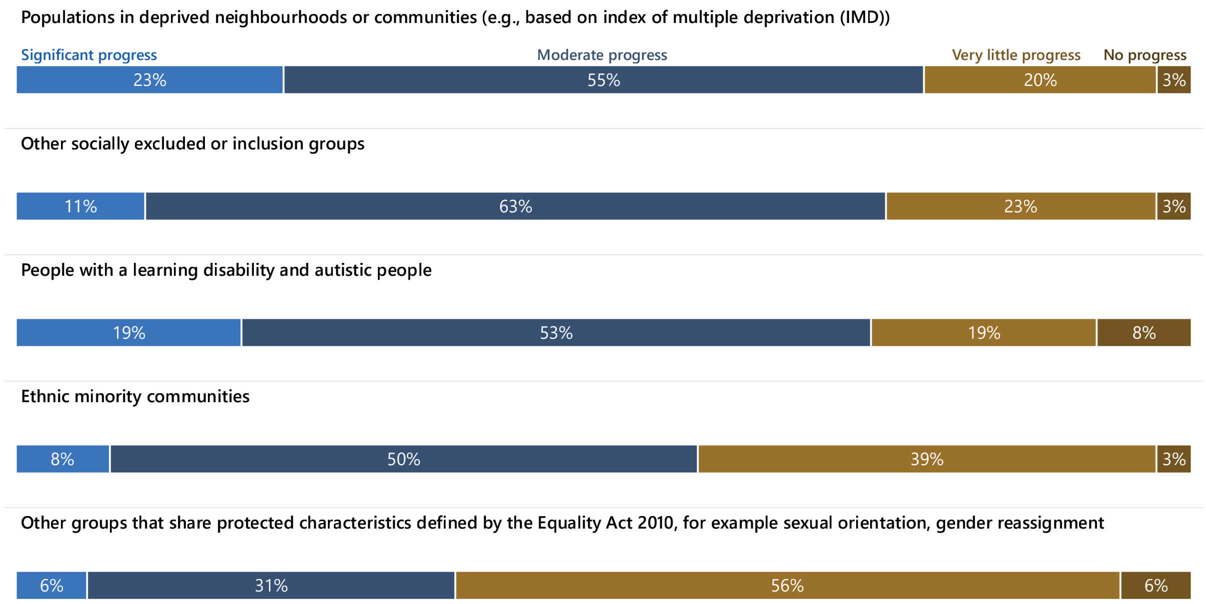
Systems described being in a strong position to use evidence to identify population groups and clinical areas affected by health inequalities. Clinical areas included specifics such as maternity, severe mental illness, early cancer diagnosis and more. Often, they were able to identify effective interventions to address these issues, although data-sharing remains difficult. However, they reported not having sufficient financial or human resources to make effective change, and they described persistent difficulties in efforts to re-allocate resources from hospital services to address longer-term goals.

Although we heard that systems are committed to addressing health inequalities, with the same strong leadership and shared vision seen in the previous 2 priority areas, the picture of progress is more complex and variable. This was attributed in part to the variety of health inequalities in need of remedy, their entrenched nature requiring long-term solutions, and the importance of non-health system drivers such as housing and employment.

This variability can be seen in differences in how respondents to the survey viewed progress by population and health condition. Around three-quarters of respondents perceived that progress had been ‘significant or moderate’ in addressing Core20PLUS5 health inequalities among populations in deprived neighbourhoods (78%) and socially excluded or health inclusion groups (74%).

By contrast, two-thirds of respondents reported making ‘little or no progress’ in reducing health inequalities for groups with other protected characteristics (63%) and around 2 in 5 respondents reported making ‘little or no progress’ for ethnic minority communities (42%). There are mixed views on progress in addressing health inequalities in people with a learning disability or autism with 72% reporting ‘significant or moderate’ progress but 8% reporting no progress – the highest across the 5 groups (figure 23).

Figure 23: **Perceived progress in addressing inequalities in CORE20PLUS 5 population groups in the last 12 months**



Note: Questions about addressing inequalities in Core20PLUS5 population groups were answered by 38 out of 49 survey respondents (78%). The denominator for each sub-question varied here, as some respondents (between 2 and 10) selected ‘not applicable/unsure’ and these responses were excluded

We heard how specific groups were prioritised through better use of population health data and local intelligence (35 respondents, 83%), and the importance of partnerships with VCFSE organisations (36 respondents, 86%) and local authorities in understanding health inequalities in local areas and designing interventions that meet people’s needs. Just over half of respondents (55%) reported undertaking action to address the wider determinants of health that contribute to inequalities, such as deprivation, housing, or fuel poverty. This was further reflected by interviewees:

> *“Local authorities [are helping to] provide us with really good cutting-edge data analytics so we can [best] target our interventions. They have helped us to target specific households in [the area] that are more likely to be at risk of fuel poverty, more likely to have people who are unable to heat their homes, and therefore more likely during winter to find themselves in A&E. And we’ve been able to do some very targeted intervention including with the support of [the energy sector] to improve insulation in those homes to keep people well at home and out of hospital.”*

> *“We have a fantastic VCSE sector… what I feel we’ve really [reflected on] is how much VCSEs put into our local communities and the level of knowledge and experience they have. What we have put a lot of effort into is trying to understand the full breadth of VCSEs out there… There’s some really small VCSEs that are [representative of particular populations], but don’t have the infrastructure in place to be able to demonstrate the impact they’re making. One of the things we’ve tried to do is really tap into that resource, and take time to understand who is out there, what populations they’re representing, and to put time into listening to them in a way that doesn’t always fit neatly into a template.”*

Co-production, co-design, and engagement with people who use services and local communities was also reported as a key strategy to address health inequalities (34 respondents, 81%).

Other systems focused on specific clinical conditions where inequalities were most pronounced (such as hypertension and diabetes among certain ethnic groups), as described by interviewees:

> *“One of the areas that we use the health inequalities funding for was around hypertension, so how you identify and then manage the target around hypertension. We use the funding to design a local incentive scheme, really targeting specific areas, specific practices, and how they were identifying patients.”*

ICSs were asked about the government’s Core20PLUS5 priority areas, which are 5 key health conditions where there are recognised inequalities. Heart disease and stroke prevention saw the strongest progress in terms of significant advancement, with 20% of respondents reporting significant progress in this clinical area. While severe mental illness had a slightly higher overall positive response rate (73% reporting moderate or significant progress), only 3% reported significant progress – the lowest rate across all 5 areas, with most progress described as moderate (70%).

Overall, more ICSs reported making progress than not across all 5 health conditions. However, the perception of progress varied significantly between different population groups and health areas, with some seeing more progress in the last 12 months than others.

Vulnerable mothers

Example of services that aimed to reduce health inequalities.

Aim: Provide better support for vulnerable mothers who are more likely to experience poor maternal outcomes and access to care, including refugees and new arrivals, and women who are isolated with no support.

Input: Local volunteers are trained to become community doulas.

Activities: The community doulas provide practical and emotional support for women 6 weeks before birth, during labour, and 6 weeks after birth. Support can be delivered within the home, community or at a mutually agreed location.

Outcomes: In the final quarter of 2022/23, 26% of the women supported were of Black ethnicities, 48% South Asian and 12% Arab; a third were asylum seekers. Women living in temporary accommodation identified barriers to positive breastfeeding outcomes, which led to work to improve communication from health visitors.

Furthermore, 64% of the trained volunteers said they had gained transferrable skills and 29% said that volunteering had informed their choices for onward study or employment.

Bradford District and Craven ICS

Enablers and barriers

There are different perceptions among ICSs about the presence of enablers and supportive factors, or barriers in the systems to progress on the 3 priorities (addressing health inequalities, shifting care closer to home, and supporting vulnerable populations).

For enabling factors, respondents were most likely to agree that, across the 3 priority areas:

- leaders have a shared understanding of priorities (54-62% of respondents agree or strongly agree)
- there is clear accountability for a given area (51-67% of respondents agree or strongly agree).

Across all 3 priorities, respondents were least likely to say they agreed with the statement “Leaders agree on how to shift resources to prioritise this work” (17-23% agree or strongly agree).

Respondents also reported similar barriers across the 3 priority areas, and were most likely to select:

- insufficient funding for relevant initiatives (selected by 56-71% of respondents)
- conflicting and/or competing national priorities (selected by 32-52% of respondents)
- limited capacity to operate beyond core service delivery (selected by 42-52% of respondents).

Respondents more frequently reported workforce challenges, for example recruitment and retention, as a barrier to supporting older and frail people (selected by 41% of respondents), when compared with the other 2 priority areas.

Systems consistently reported a struggle to balance national priorities with local transformation efforts across all areas. The focus on acute sector metrics, such as A&E waiting times and elective recovery, creates perverse incentives that work against community-focused, preventative approaches. Some systems reported a tension between national pressure for rapid results and the need for a long-term approach in addressing health inequalities:

> *"Some of the national policy frameworks don't really help, if I'm honest. When we have the annual planning round with NHS England, 90% of that is focused on the hospital sector. That's where the attention of the system gets pulled. […] There's very little on community-based neighbourhood work in primary care. Inevitably, people's attention gets drawn to the hospital bit of the system."*

> *"These are the kind of things that we need to plan over the next 5 to 10 years for them to actually show some tangible benefit. But you don't get funding year after year, and every year you have to fight to keep that funding going. That is really quite disheartening for people."*

These issues are exacerbated by additional systemic barriers, including the concentration of funding within acute trusts and difficulty in shifting resources to community services and difficulties in demonstrating impact with the same level of confidence as acute sector interventions.

> *"… I still see health inequalities discussed separately to saving the NHS or looking at how we reduce acute costs, and it should be described as health inequalities because that's what it is. Culturally, we need to see it more as how do we get best use out of this resource? Sometimes people understand that more if you talk about it in the language of emergency admissions and the differences you see there."*

Looking forward

ICSs have offered some perspectives on future activity and their confidence in delivering against the government's 3 ambitions for the health sector.

Confidence levels on the '3 shifts'

More than half of survey respondents expressed being moderately, very, or extremely confident in their system's ability to deliver the government's 3 strategic shifts:

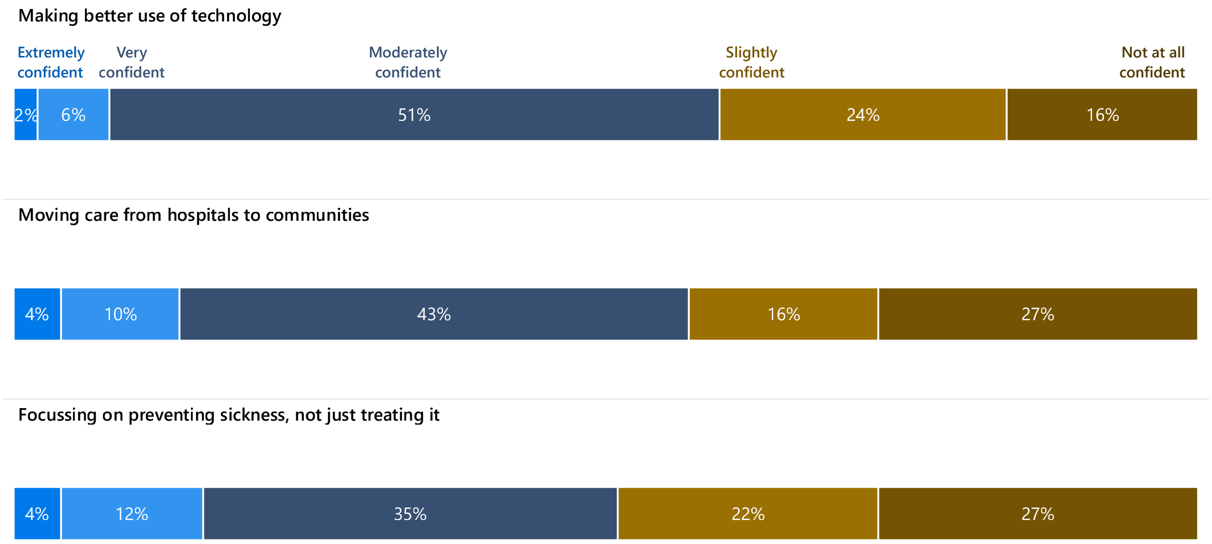
- moving care from hospitals to communities (57%)
- making better use of technology (59%)
- focusing on prevention. (51%)

Just over a quarter of respondents (27%) expressed no confidence at all in delivering community care and prevention shifts.

Confidence was highest for making better use of technology, with 84% of respondents reporting at least slight confidence, compared with 73% for prevention and community care (figure 24).

Interview participants identified several areas where national support could help progress. They emphasised the need for clearer guidance on implementation and success metrics, as well as financial mechanisms to support resource re-allocation. Additionally, they called for support in capacity building during transformation periods and recognition of the long-term nature of the required changes.

Figure 24: **Confidence in ability to deliver the 3 shifts**



Note: Questions about confidence in their systems' ability to deliver each of the 3 shifts were answered by 49 out of 49 survey respondents. No respondents selected 'not applicable/unsure' and therefore no responses were excluded.

Local authority assessments

Introduction

In 2022, CQC was given new responsibilities to assess how local authorities meet their duties under the Care Act (2014). In December 2023, we started an assessment programme for all 153 local authorities in England with adult social care responsibilities, to be assessed within a 2-year period.

This year, we have analysed a sample of 27 published local authority assessment reports to explore how local authorities are ensuring good quality care and support for older people, especially those who may be frail. Of our assessments:

- 1 was rated as outstanding
- 15 were rated as good
- 11 were rated as requires improvement.

Our analysis also included reports for 5 pilot assessments, 4 of which have an indicative rating of good and 1 had an indicative rating of requires improvement.

We sought to understand the role of a local authority in prevention and early intervention, and how they work to support hospital discharge and enable people to recover and live independently in the community. The importance of effective system working was evident.

The 2025 Spring Survey from the Association of Directors of Adult Social Services highlighted that many local authorities had reviewed their data and revised their systems, partly in anticipation of CQC assessment, helping to improve how they manage waiting lists. It is encouraging to see that anticipation of our regulatory activity is driving change.

Summary findings

Prevention

- Local authorities are working closely with public health to provide targeted interventions, to prevent future care needs and avoid hospital admissions.
- Assistive technology and digital solutions, occupational therapy, and support to carers are used to support older people's independence and prevent the need to use services. Digital examples include the use of falls sensors, tracking and monitoring technology, and telecare.
- Reablement was used proactively by some local authorities to support admission avoidance strategies and prevention work. Where it was applied most effectively, local authorities had been successful in reducing or almost eliminating their waiting lists for a Care Act assessment.

Discharge from hospital

- Hospital discharge focused on a discharge to assess and ‘home first’ approach. This ensures that people who are medically ready to leave hospital are discharged promptly – to their own residence where possible – with assessment for long-term care fully completed following a short period of recovery.
- Partnership working across integrated teams and including voluntary partners was key to aiding smooth and timely discharge. However, waiting lists and a lack of capacity in homecare caused delays. To address this, some local authorities provided bridging services.
- People with more complex needs requiring specialist care, for example people with dementia, were harder to place, more likely to experience delays or be placed out of their local area so they could get the care they needed.

Reablement

- Reablement was a key strand of hospital discharge pathways. Local authorities worked in integrated teams with health to provide free reablement support for usually 6 to 8 weeks. Care models varied – they were led by occupational therapists, in-house authority provision or private homecare providers – and this was usually supported by the Better Care Fund.
- Successful reablement supports people to return to their own homes – and effective partnership working between hospital staff and local authority social work teams is essential to achieving good reablement outcomes.
- Barriers to effective reablement included reablement capacity in some authorities, a lack of skill and capacity in private homecare services, delays and workforce shortages in occupational therapy, and the impact of Care Act assessment waiting times.

Homecare

- Local authorities had worked to increase and improve their homecare capacity with reviews and new approaches to commissioning.
- Homecare capacity and capability remains an issue. Shortages of skilled staff coupled with a lack of homecare service providers in some areas meant they struggled to address long delays and waiting lists, which affects people’s health and wellbeing. This was especially the case in rural areas.
- Good homecare commissioning needs to take population diversity and intersectionality of needs into consideration.

Prevention

The government's 10-Year Health Plan for England outlines 3 shifts to make the NHS fit for the future, one of which is a focus on prevention. How local authorities prevent, reduce and delay the need for care is an element of our local authority assurance assessments.

Many local authorities that we assessed recognised the importance of prevention and maintaining a healthy population, with prevention a major theme in their strategies. Some took a preventive approach to addressing health concerns that commonly affect older people, for example by focusing on falls prevention and blood pressure monitoring.

We also saw a proactive approach to prevention by working closely with public health bodies and using public health data to provide targeted interventions, which can prevent future need and avoid hospital admissions.

For example, one local authority used data from a joint strategic needs assessment (JSNA) to understand local need and inform commissioning priorities. The JSNA had identified an ageing population with a likelihood of people living longer and developing more complex needs or frailty. Staff told us about initiatives around falls prevention that were aligned to priorities in the JSNA.

Early intervention to avoid hospital admission – as well as to prevent, reduce and delay the need for care – is a fundamental element of local authority duties. Partnership working is important in this context. We saw examples of information sharing and 'no wrong door' approaches to support and identify those most at risk of being admitted to hospital. Several local authorities had care projects that delivered these levels of support, and particularly for older people.

The most common prevention approaches included reablement services, voluntary services, assisted technology, occupational therapy and home improvements and support to unpaid carers – all intervention options that could support people in their own homes. These often used a multi-agency approach, with health and social care staff working together.

Partnership working with community and voluntary organisations is an important strand of prevention work, particularly for those with non-eligible care needs (needs that do not meet the criteria to receive care and support following a Care Act assessment). Some local authorities commissioned a variety of community and voluntary sector organisations to support this work.

Signposting to third-sector organisations is one way in which local authorities can support people with non-eligible care needs and there were some good examples of this, where funding was rooted in the identified need for the area. However, we also saw evidence of voluntary partners struggling with funding, leading to gaps in provision.

Additionally, some local authorities use reablement to support admission avoidance strategies and prevention work. We saw that where it was applied most effectively, local authorities had been successful in reducing or almost eliminating their waiting lists for a Care Act assessment.

One authority had a well-established therapy-led reablement service that was meeting the needs of the local community. This community approach avoided people unnecessarily being admitted into care homes or hospitals.

Another local authority gave an example where a person was referred from their GP following a serious injury and was put on the reablement pathway to reduce the risk of a hospital admission. Structures were in place to help prevent unnecessary admissions and promote independence.

However, this was mixed and in some assessments we found gaps in early prevention services for older people, and it was unclear what was being done to resolve these. Measuring impact and outcomes for people was a challenge for most local authorities when evaluating the effectiveness of their prevention approaches.

Hospital discharge

Our analysis showed that when a person needs to be admitted to hospital, local authorities work in partnership with the right teams to get them discharged back to their own homes or offer an appropriate alternative as quickly and safely as possible.

They did this using either a ‘home first’ approach or a ‘discharge to assess’ approach. Close collaboration between local authorities and hospital discharge teams was essential for this to be effective.

In one example from an assessment, we saw that a fully integrated hospital discharge team started working together a year ago and is achieving positive outcomes for people being discharged from hospital. The team worked closely with the other services available for people who required varying levels of support when discharged from hospital. This varied from a voluntary service providing transport and shopping, to the reablement team providing longer-term support.

The local authority’s data, as well as national data, showed that the support had enabled increased numbers of people to return home and remain at home rather than requiring longer-term support such as residential care.

In another example, hospital discharge was led by the Homesafe social care teams based in each of the acute and community hospitals. The Homesafe team was made up of social workers and social work support assistants who worked closely with occupational therapists and discharge nurses, employed by the trust as part of a wider transfer of care hub.

From research we commissioned through National Voices we know that a ‘home first’ approach is preferred by people leaving hospital. The vast majority of older people responding to the survey told us they had been discharged home and that this was their preferred outcome. The main things that could have improved their discharge experience were better planning and communication of those plans.

In some local authority areas, hospital discharge teams were co-located – this helped with joined-up working and led to more effective communication.

We also found that partnership working across integrated teams – including voluntary partners – can aid smooth and timely discharge. The voluntary and community sector was an important partner for local authorities, especially for people with non-eligible care needs. Other important partners included physiotherapy and occupational therapy teams. We saw how they worked in a joined-up way to ensure that people were assessed and had the aids and adaptations they needed to return to their own homes.

However, there were also challenges with hospital discharge. Where our assessment reports highlighted issues, these related to:

- communication and integrated ways of working
- a disparity in assessed care needs
- homecare capacity – especially for people with more complex needs.

Our analysis showed that there are gaps in services for people with more complex care needs, which can lead to delays in access to care home beds and out-of-area placements.

In some areas virtual wards or reablement beds were used to meet more complex needs. One authority described adjusting its in-house residential services to provide long-term specialist dementia beds. Another authority showcased its use of contingency planning to support those most in need:

> In this assessment, staff shared an example of contingency planning, where they worked with care home managers to assess people in hospital and develop rehabilitation, with the view that if risks became unmanageable after discharge home, they could move directly into the care home rather than return to the hospital. Throughout the home access visit, the rehabilitation bed remained open and available for the person to return to, if risks became too high to manage at home.
>
> (Assessment example)

Local authorities told us how a lack of capacity in homecare directly affected hospital discharges.

Some local authorities had developed a bridging service to decrease this pressure on homecare, and one local authority told us how it had worked closely with homecare providers to clarify expectation around response times and delivery, as well as offering support to overcome geographical and workforce challenges. This helped to improve capacity and flow within the system.

Reablement

Looking at local authority assessment reports, we found that reablement is an important element of hospital discharge pathways. Successful reablement services for people supports people to return to their own homes with a short-term care package in place, delaying or removing the need for permanent long-term care. Services aimed to be strengths-based and person-centred. Local authorities worked in integrated teams to provide free reablement support, usually for 6 to 8 weeks.

A homecare reablement short-term service called Home First worked used ‘strength-based’ practice to promote people’s independence by focusing on their own qualities and resources. Senior staff told us 80% of people did not require ongoing care following this service.

Reablement services work well when there are strong partnership working networks between hospital staff and local authority social work teams. For example, there is often a specific team within the local authority that supports this work, and they maintain effective links to occupational therapy teams and third-sector organisations.

These teams ensure that people have the aids, adaptions and community support to help them stay independent in the community for longer. We saw good examples of where this support had worked well for people, but in some areas there were long waiting lists for occupational therapy assessments and subsequent aids and adaptations. This can stall people’s recovery.

We also found that effective partnership working between hospital staff and local authority social work teams is essential to achieving good reablement outcomes.

Local authorities made use of the Better Care Fund (BCF) for a variety of initiatives with a core purpose to reduce admissions to hospital, improve hospital discharge and provide more integrated services. Coupled with knowledge of hospital admission data, local authorities were able to use the BCF to adapt their reablement to meet their needs and areas of focus.

Some local authorities sought to build capacity and enhance their reablement services in partnership with private homecare providers. Sometimes, they met with capacity challenges in the private sector.

More generally, local authorities sought to work with reablement providers and the NHS through investing in training to upskill staff when caring and providing support for older people with complex needs. Upskilling staff helps the delivery of good quality care - and the greater understanding of specific needs can also help providers to reduce admissions to hospital and improve discharge from hospital.

We found that some local authorities face barriers to effective reablement. These include reablement capacity in some authorities, a lack of skill and capacity in private homecare services, delays and workforce shortages in occupational therapy and the impact of Care Act assessment waiting times.

Despite examples of effective and efficient reablement services, some local authorities had challenges with these services, as they were not yielding the positive results expected in terms of hospital discharge and reducing and delaying care needs. Workforce issues, such as staff shortages and recruitment, were the most frequently highlighted challenge for reablement services.

Homecare

We found that local authorities have worked to increase and improve their homecare capacity. Inspection reports noted how new approaches and reviews of homecare commissioning had led to improvements.

Examples included moves to a more neighbourhood or zone-based method of commissioning. This allowed for a more consistent staffing team, less travel time between calls and, for one authority, we heard this had meant they were able to increase pay for care staff.

Despite this work, homecare capacity remains an issue. Staff shortages, coupled with a lack of homecare agencies in some areas, means some local authorities struggle to address long homecare delays and waiting lists. This has an impact on people's health and wellbeing.

Staff skill levels in the homecare workforce also pose challenges to reablement and promoting people's independence. This is particularly the case in rural areas. Focus groups we ran in April 2025 with experts by experience underlined this point where we heard about the impact that living in rural areas can have on people's choice of homecare provider. One participant said:

> *"If you were in a rural area and you're lucky enough to have an agency who really is good then that's great. But if you have an agency that is poor very often, there is no other care facility and therefore you either have poor care or no care."*

Local authorities are creating strategies to tackle this problem. Some local authorities have embraced using assistive technology to delay the need for homecare and reduce demand on homecare workforces.

For example, one authority used assistive technology to reduce the reliance on formal care visits, with such technologies acting as a prompt and motivator to encourage independent living. Another authority introduced an electronic monitoring system, free of charge to all its homecare providers.

Other evidence of authorities improving the quality of care was seen in work to improve diversity in the care that was available. This included multiple language options or providing support in line with religious needs.

In practice, readers and staff demonstrated they had considered the impact of how their plans and services would impact on people with different protected characteristics. Action had been taken in areas where inequalities had been identified. For example, a specific home care contract was in place with an organisation who delivered care to people in culturally diverse communities.

However, there was little outcome evidence for people included in the reports. And commissioning in some local authorities had not considered diversity, which can lead to inequity.

References

1 NHS England, Patients Registered at a GP Practice, March 2025
2 NHS England, General Practice Workforce, April 2025
3 Royal National Institute for Deaf People, Still Ignored: The Fight For Accessible Healthcare, June 2025
4 Royal College of General Practitioners, Continuity of Care work at RCGP, September 2021
5 NHS Race and Health Observatory, Patients report alarming lack of trust in NHS primary care providers, March 2025
6 Healthwatch England, Access to NHS dentistry 2024 – findings, November 2024
7 Department of Health and Social Care, Faster, simpler and fairer: our plan to recover and reform NHS dentistry, February 2024
8 NHS England, How tackling health inequalities in Suffolk and north east Essex is the first step to make NHS dental care available to all, July 2024
9 Healthwatch England, Your right to an NHS dentist, April 2025
10 Office for Health Improvement & Disparities, Short statistical commentary for hospital tooth extractions in 0 to 19 year olds 2024, February 2025
11 NHS England, Fit for the Future: 10 Year Health Plan for England, July 2025
12 The Kings Fund, Understanding quality in district nursing services, August 2016
13 Department of Health and Social Care, Road to recovery: the government’s 2025 mandate to NHS England Policy paper, January 2025
14 Queen’s Nursing Institute, District Nursing Today, The View of District Nurse Team Leaders in the UK, June 2024
15 The Commission on Palliative and End-of-Life Care, Palliative Care and End-of-Life Care, May 2025
16 Equality and Human Rights Commission, New guidance on AI and equality available to public sector bodies, September 2024
17 The King’s Fund, Key facts and figures about adult social care, July 2024
18 Institute for Government, Adult social care across England: Performance Tracker Local Examining the care gap in England, June 2025
19 Association of Directors of Adult Social Services, ADASS Spring Survey 2025, July 2025
20 Care Quality Commission, Tackling workforce inequalities in health and adult social care, June 2025
21 Association of Directors of Adult Social Services, ADASS Spring Survey 2025, July 2025
22 Health and Social Care Committee, Adult Social Care Reform: The Cost of Inaction, May 2025

23 Care Quality Commission, An introduction to Dr Arun Chopra and reflections on the power of community in mental health care, May 2025
24 NHS England, Mental Health Act Statistics, Annual Figures, September 2025
25 Children's Commissioner, Children's Commissioner calls for urgent action to tackle waiting times and inequality in mental health care for children, May 2025
26 Royal College of Psychiatrists, Bed occupancy across mental health trusts, May 2022
27 Home Office, Department of Health and Social Care, NHS England, College of Policing, Agreement to support mental health care and free up police time, July 2023
28 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, July 2025
29 National Institute for Health and Care Excellence, NICE guideline NG10: Violence and aggression: short-term management in mental health, health and community settings, May 2015
30 Pharmaceutical Press, Common mental health medications, October 2024
31 Care Quality Commission, Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2, August 2024
32 National Institute for Health and Care Excellence, Clinical guideline CG76: Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence, January 2009
33 Department of Health and Social Care and NHS England, New services for patients under record pharmacy funding deal, March 2025
34 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, July 2025
35 NHS England, First NHS round-the-clock mental health unit opens under 10 Year Health Plan, July 2025
36 NHS England, Urgent and emergency care plan 2025/26, June 2025
37 UK Parliament, Plan for Change: Milestones for Mission-led Government, Hansard, Volume 841
38 NHS England, Urgent and emergency care plan 2025/26, June 2025
39 NHS England, 2025/26 NHS Standard Contract
40 Office for National Statistics, Association between time spent in emergency care and 30-day post-discharge mortality, England: March 2021 to April 2022, January 2025
41 Royal College of Emergency Medicine, An alarming threat to patient safety' – over a million older patients endured 12-hour waits in England's A&Es last year, May 2025
42 National Institute for Health and Care Research, Frailty: research shows how to improve care, October 2024
43 British Geriatrics Society, Introduction to Frailty, Fit for Frailty Part 1, June 2014

44 Royal College of Emergency Medicine Quality Improvement Programme, Care of Older People 2023 - 24 Interim Report, May 2025
45 Royal College of Emergency Medicine, RCEM Acute Insight Series: Crowding and its Consequences, May 2022
46 Royal College of Nursing, Corridor care: unsafe, undignified, unacceptable, June 2024
47 Care Quality Commission, Under pressure: safely managing increased demand in emergency departments, May 2018
48 National Audit Office, Report by the Comptroller and Auditor General: Discharging older patients from hospital, HC 18 Session 2016-17, May 2016
49 Nuffield Trust, Improving length of stay: what can hospitals do?, September 2015
50 Nuffield Trust, Delayed discharges from hospital, September 2025
51 NHS England and NHS Improvement Board, Diagnostics: Recovery and Renewal, Board Paper
52 The King's Fund, What are diagnostics, and how are diagnostics services performing?, June 2024
53 The King's Fund, Waiting times for elective (non-urgent) treatment: referral to treatment (RTT), May 2024
54 Nuffield Trust, Elective (planned) treatment waiting times, May 2025
55 NHS England, Referral to treatment
56 Royal College of Paediatrics and Child Health, Children's organisations call for greater ambition in government's plans to reduce waiting times for young people, January 2025
57 Cancer Research, Why is early cancer diagnosis important?, March 2023
58 Hesgrove, B, Zebrak, K, Yount, N *et al,* Associations between patient safety culture and workplace safety culture in hospital settings, BMC Health Serv Res 24, 568 (2024)
59 NHS England, Safety culture
60 Nuffield Trust, Safety culture in the NHS, December 2024
61 Kwame, A, Petrucka, PM, A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward, BMC Nurs 20, 158 (2021)
62 NHS England, Good communication with patients waiting for care, October 2023
63 https://www.nhsconfed.org/articles/nhs-needs-confront-serious-problem-racism-within-service
64 NHS Confederation, The NHS needs to confront the serious problem of racism within the service, August 2024
65 NHS Race and Health Observatory, Independent Review Explores the Cost of Racism to the NHS, March 2025
66 NHS England, NHS Workforce Race Equality Standard
67 Hospice UK, Extending Frailty Care, accessed July 2025

68 Finlay, I., Richards, M., Maskell, R., et al, Palliative Care and End-of-Life Care: Opportunities for England (Volume 1), The Commission on Palliative and End-of-Life Care, 2025
69 Care Quality Commission, Safety, equity and engagement in maternity services, May 2022
70 Department of Health and Social Care, New ambition to halve rate of stillbirths and infant deaths, November 2015
71 Perinatal Mortality Review Tool, PMRT Sixth Annual Report, December 2024
72 The All-Party Parliamentary Group on Birth Trauma, Listen to Mums: Ending the Postcode Lottery on Perinatal Care, May 2024
73 Royal College of Midwives, How to fix the midwifery staffing crisis, February 2024
74 Royal College of Midwives, Latest NMC report reveals concerning snapshot of why midwives are leaving the register, June 2025
75 MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), Maternal mortality 2021-2023, September 2025
76 Department of Health and Social Care, Code of Practice on statutory learning disability and autism training, June 2025
77 UK Parliament, Inequalities in healthcare and employment for people with a learning disability and autistic people, May 2024
78 Mencap, Why annual health checks are so important for people with a learning disability, accessed July 2025
79 Department of Health and Social Care, Baroness Hollins' final report: My heart breaks - solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people, November 2023
80 National Institute for Health and Care Excellence, Quality statement 1: Diagnostic assessment by an autism team, January 2014
81 Ofsted, Care Quality Commission, HM Inspectorate of Constabulary and Fire & Rescue Services, His Majesty's Inspectorate of Probation, Multi-agency responses to serious youth violence: working together to support and protect children, November 2024
82 Association of Directors of Adult Social Services, ADASS Spring Survey 2025, July 2025

Appendix: CQC ratings charts

The data in this section are from ratings published under CQC's single assessment framework, as at 1 August 2025. We began implementing the single assessment framework in January 2024, so these ratings show our growing picture of the quality of care under this framework from that point in time.

The rating charts in this appendix are not directly comparable with previous years because:

- Our assessment activity during this time has been based on risk to people using these services so they are unlikely to be representative of all services in a sector. This means that we have prioritised assessing services where our data indicated there may be greater risk to quality and safety for people.
- For some services, the numbers of assessments completed using the single assessment framework are still too low to be representative of all services in that sector.
- Alongside the introduction of the single assessment framework, we also made changes to some aspects of our assessment methodology. One of these changes was differences in the levels at which we rate providers. You can read the full detail of the different levels of ratings on our website. We provide more detail on whether the level of assessment has changed for specific services or providers at the top of each section.

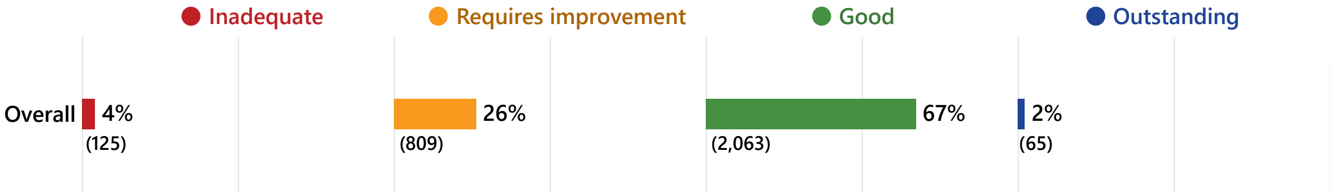
Our website provides data for all current ratings.

Adult social care

The charts in this section show the 3,062 ratings for adult social care services that we have published under the single assessment framework. There are 20,467 adult social care services with current ratings from our previous frameworks.

As part of the changes introduced with the single assessment framework, individual adult social care services are now rated separately as individual services at a location. For example, where a care home and a homecare agency are provided from the same location, we will publish 2 ratings. Ratings under our previous frameworks were only published for the location. For this reason, adult social care ratings published from assessments under the single assessment framework should not be combined with or compared with those under previous frameworks.

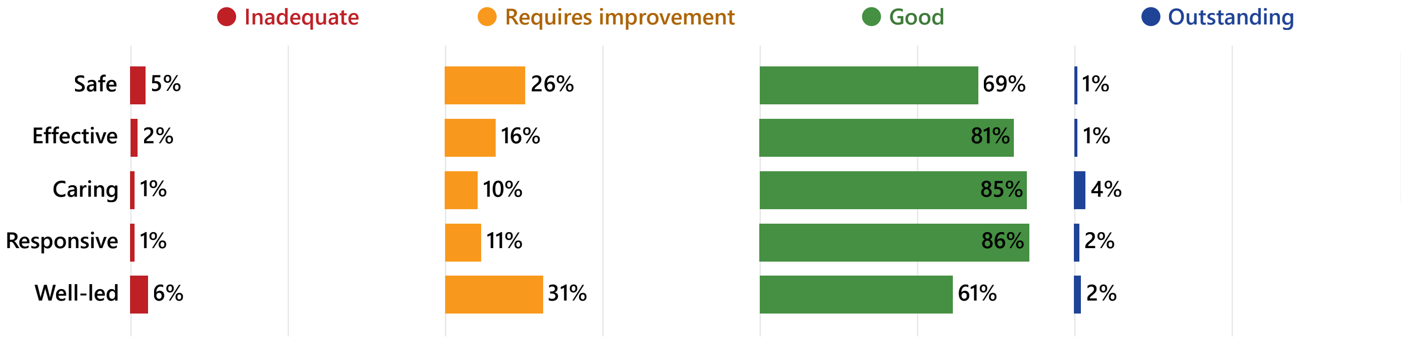
Figure A1: **Adult social care, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

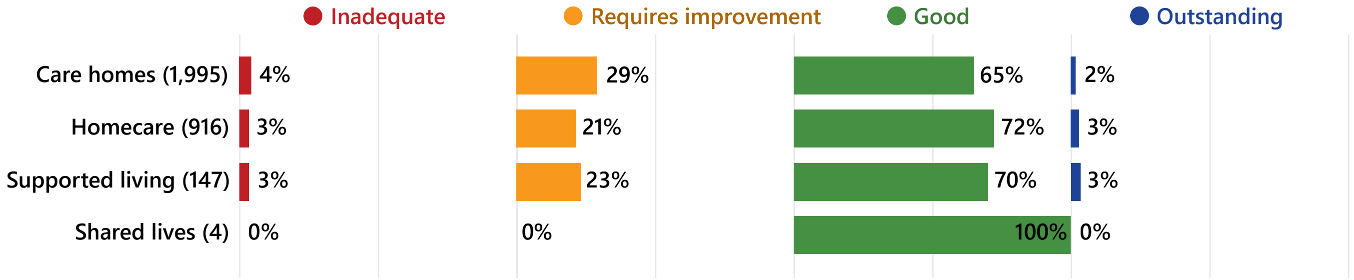
Figure A2: **Adult social care, key question ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A3: **Adult social care, overall ratings by assessment service group, 2025**



Source: CQC ratings data, 1 August 2025

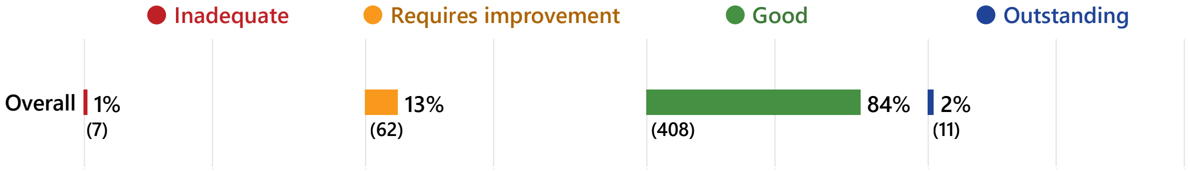
Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

GP services

The charts in this section show the 488 ratings for GP services that we have published under the single assessment framework. There are 5,638 GP services with current ratings from our previous frameworks.

As part of the changes introduced with the single assessment framework, specific primary medical care services are now rated separately as individual services at a location. For example, where a GP practice and an out-of-hours GP service are provided from the same location we will publish 2 ratings. Ratings under our previous frameworks were only published for the location. For this reason, GP ratings published from assessments under the single assessment framework should not be combined with or compared to those under previous frameworks.

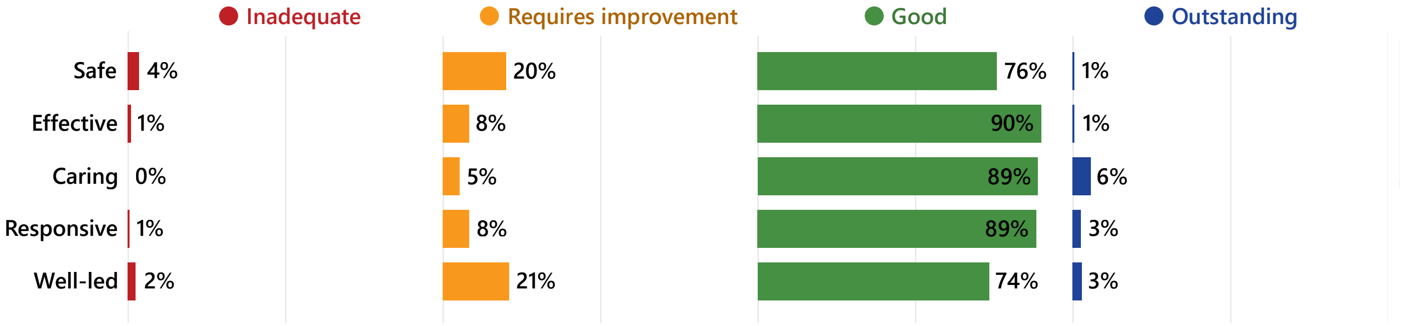
Figure A4: **GP services, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A5: **GP services, key question ratings, 2025**



Source: CQC ratings data, 1 August 2025

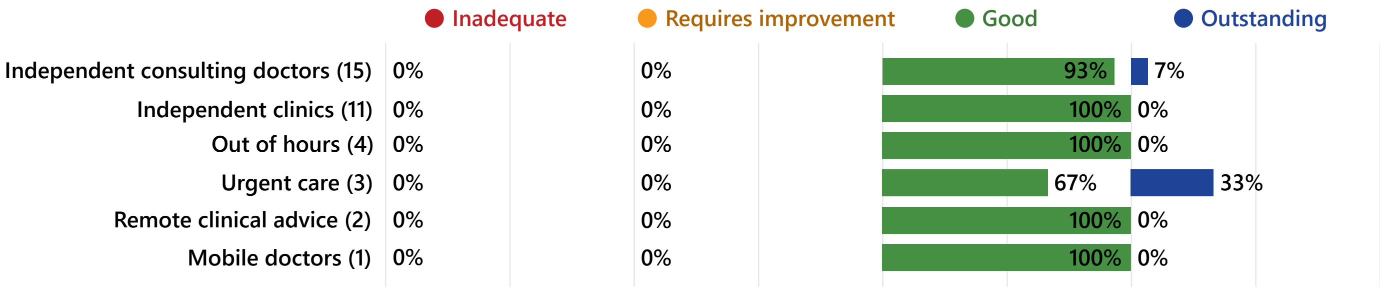
Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Other primary medical services

The charts in this section show the 36 ratings for other primary medical services that we have published under the single assessment framework. There are 1,054 other primary medical services with current ratings from our previous frameworks.

As part of the changes introduced with the single assessment framework, specific primary medical services are now rated separately as individual services at a location. For example, where a GP practice and an out-of-hours GP service are provided from the same location we will publish 2 ratings. Ratings under our previous frameworks were only published for the location. For this reason, other ratings published from assessments under the single assessment framework should not be combined with or compared with those under previous frameworks.

Figure A6: **Other primary medical services, overall ratings, 2025**



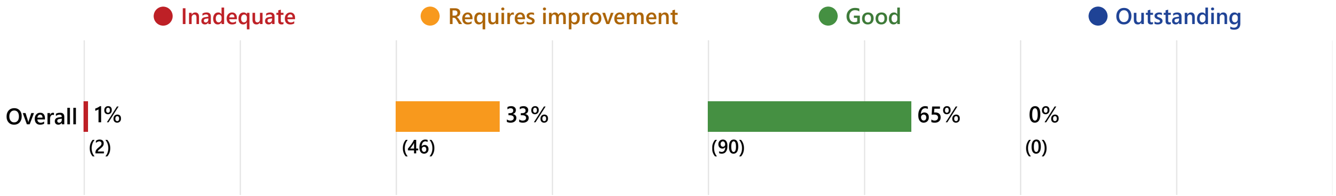
Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

NHS and independent mental health services

The charts in this section show the 138 ratings for mental health services that we have published under the single assessment framework. There are 916 mental health services with current ratings from our previous frameworks.

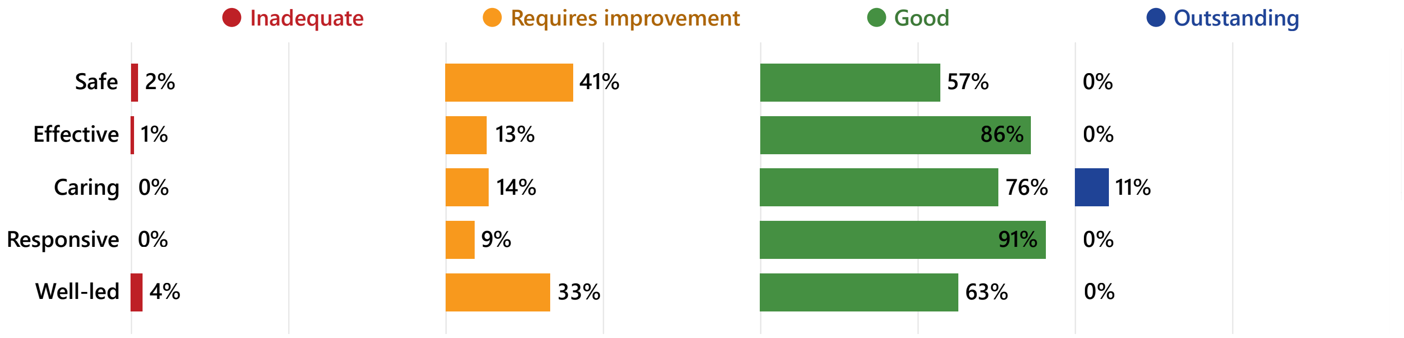
Figure A7: **NHS and independent mental health services, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

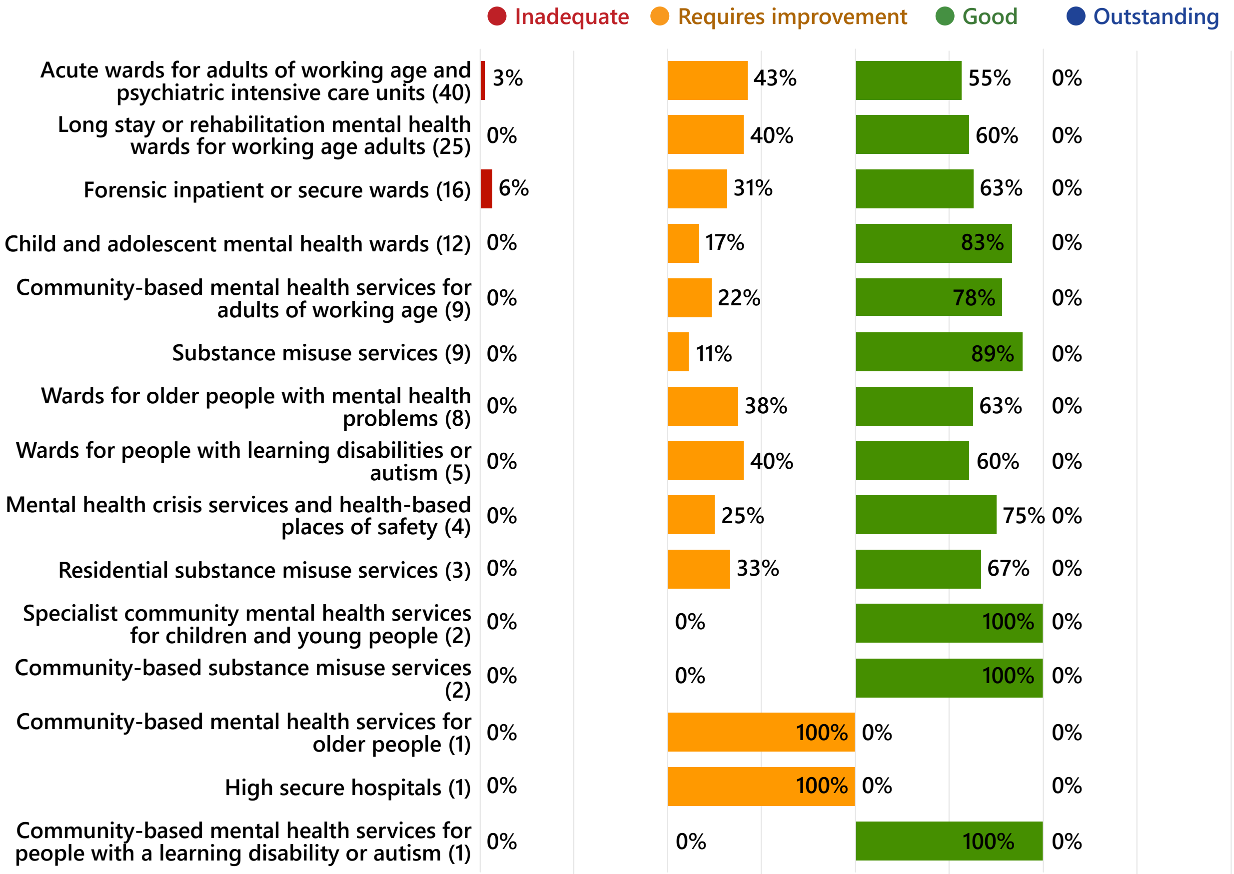
Figure A8: **NHS and independent mental health services, key question ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A9: **NHS and independent mental health assessment service groups, overall ratings, 2025**



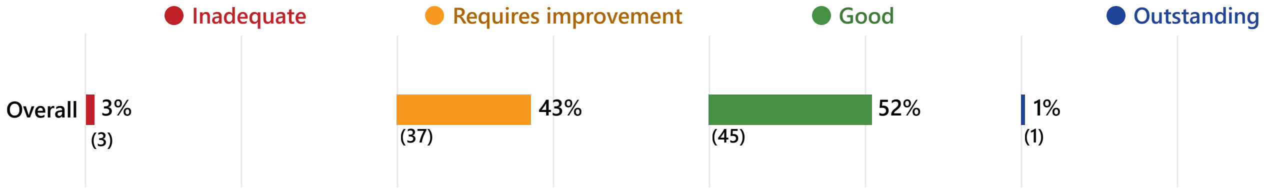
Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

NHS acute hospitals

The charts in this section show the 86 ratings for NHS acute hospital services that we have published under the single assessment framework. There are 1,603 NHS acute hospital services with current ratings from our previous frameworks.

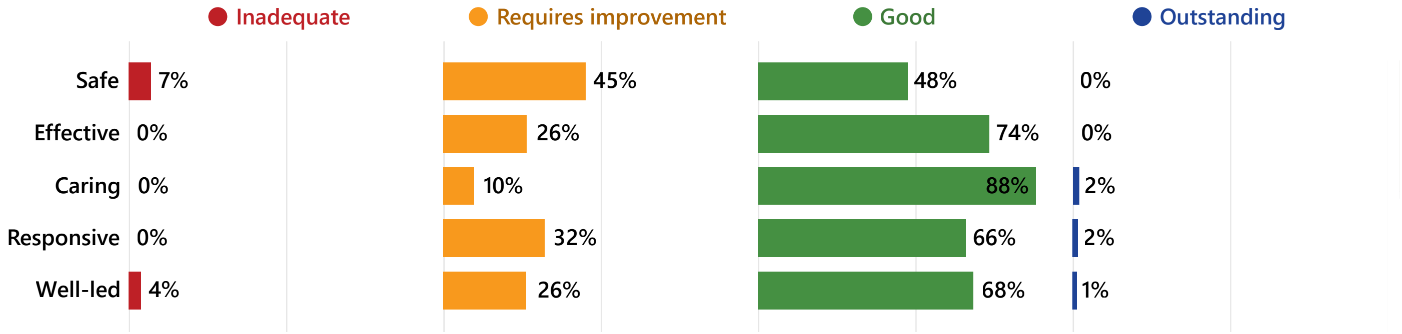
Figure A10: **NHS acute hospital services, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

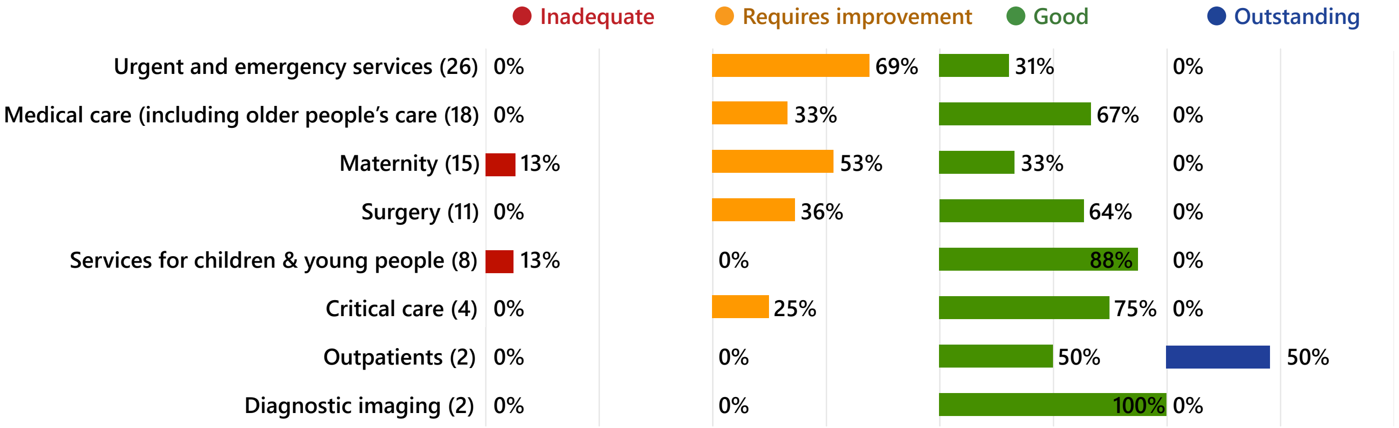
Figure A11: **NHS acute hospital services, key question ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A12: **NHS acute hospital assessment service groups, overall ratings, 2025**



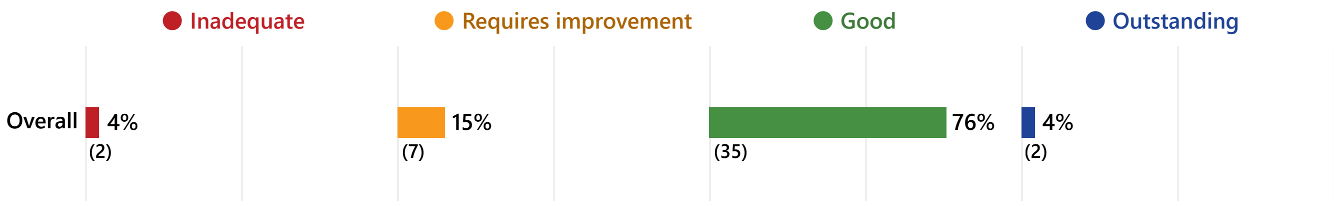
Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Independent acute hospitals

The charts in this section show the 46 ratings for independent hospital acute services that we have published under the single assessment framework. There are 790 independent hospital acute services with current ratings from our previous frameworks.

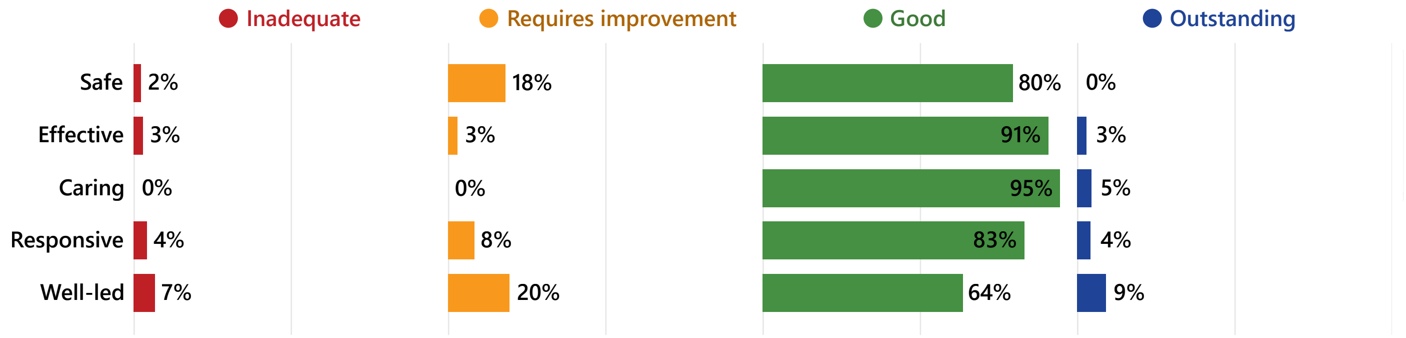
Figure A13: **Independent acute hospital services, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

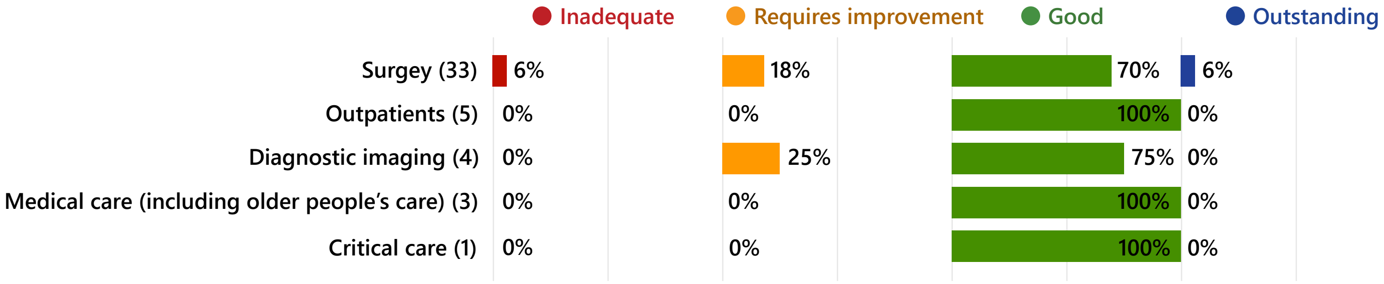
Figure A14: **Independent acute hospital services, key question ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A15: **Independent acute hospital assessment service groups, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

NHS ambulance trusts

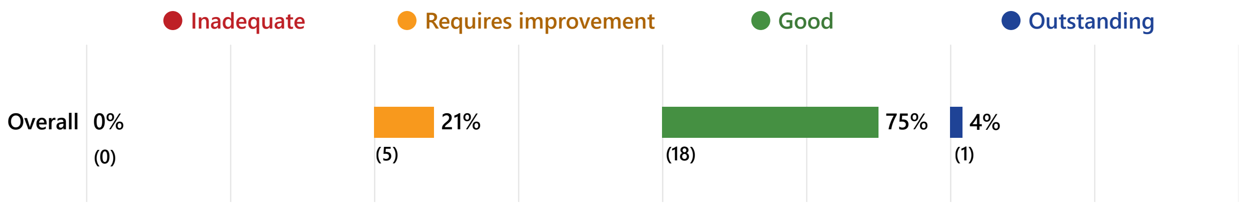
There have been no published ratings for NHS ambulance trusts under the single assessment framework. There are current ratings for 10 NHS ambulance trusts under the previous framework as follows:

- Good, 6 (60%)
- Requires improvement, 3 (30%)
- Inadequate, 1 (10%)

Independent ambulance services

The charts in this section show the 24 ratings for independent ambulance services that we have published under the single assessment framework. There are 187 independent ambulance services with current ratings from our previous frameworks.

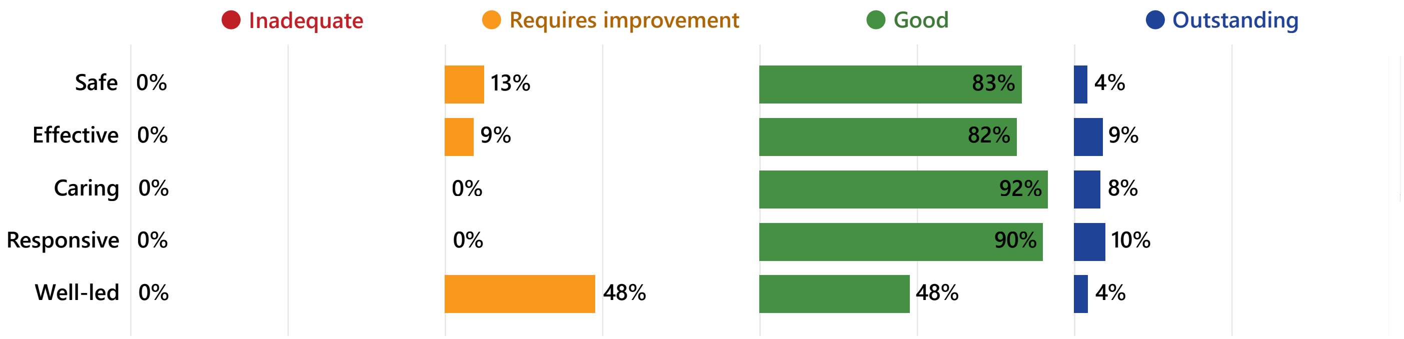
Figure A16: **Independent ambulance services, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A17: **Independent ambulance services, key question ratings, 2025**



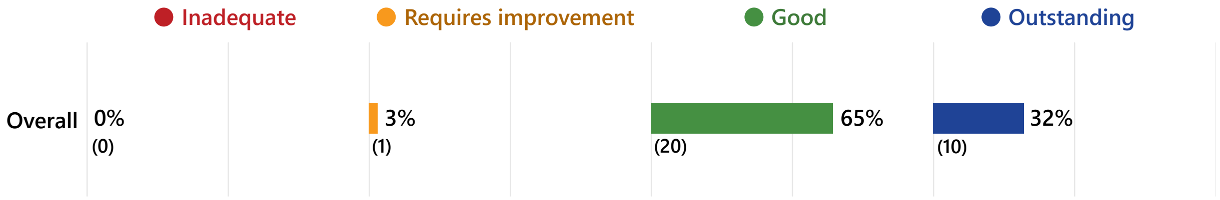
Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Hospice services

The charts in this section show the 31 ratings for hospice services that we have published under the single assessment framework. There are 91 hospice services with current ratings from our previous frameworks.

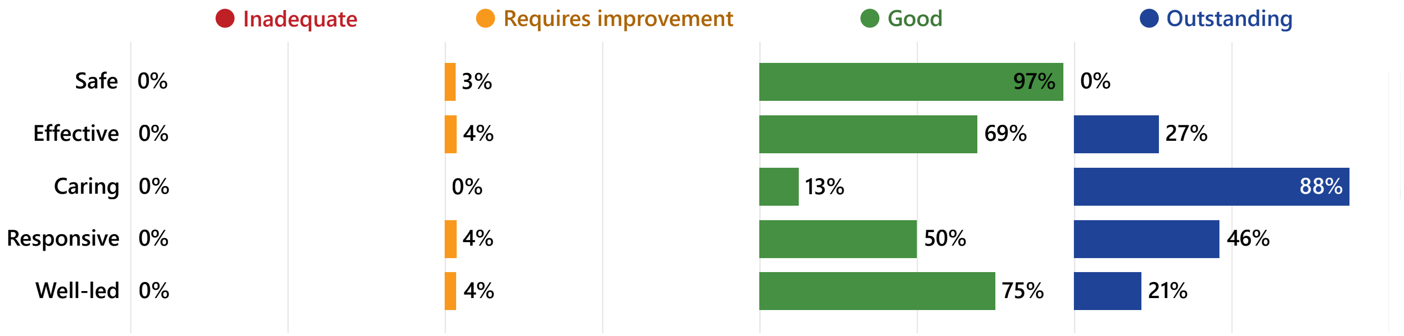
Figure A18: **Hospice services, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

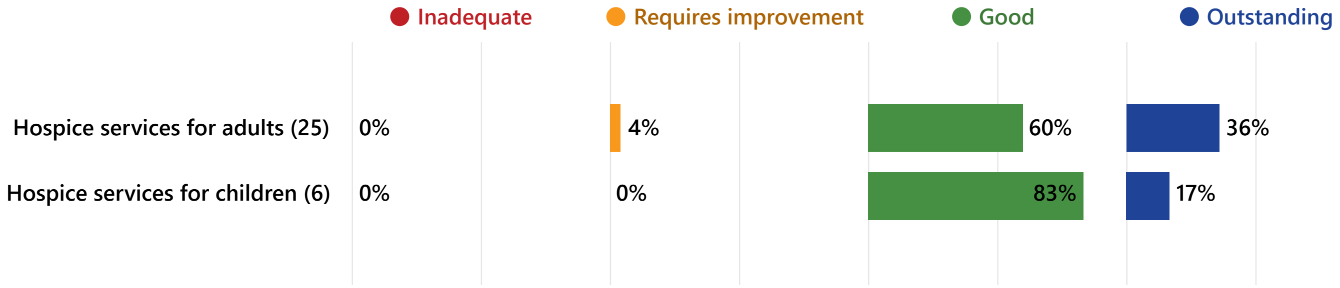
Figure A19: **Hospice services, key question ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A20: **Hospice services, assessment service groups, overall ratings, 2025**



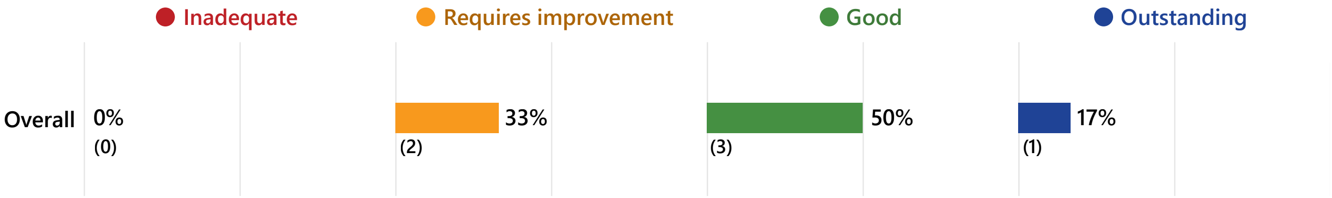
Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Community health services

The charts in this section show the 6 ratings for community health services that we have published under the single assessment framework. There are 527 community health services with current ratings from our previous frameworks.

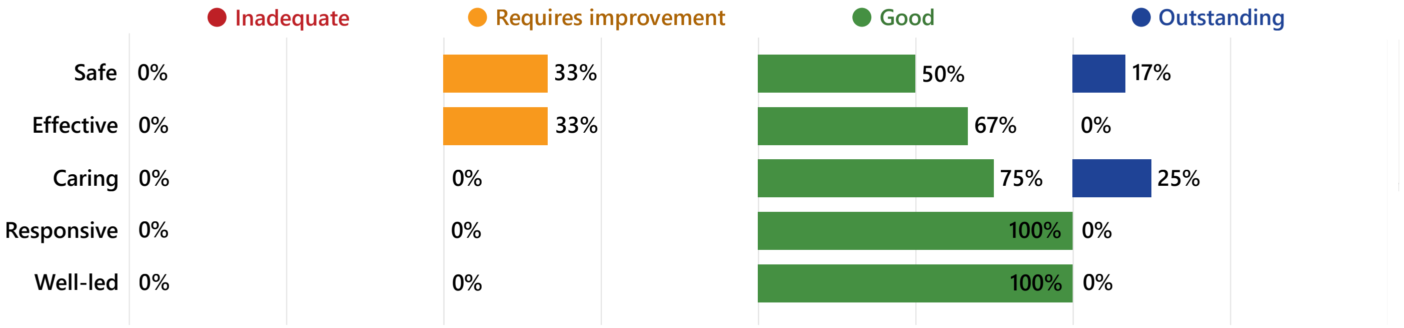
Figure A21: **Community health services, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

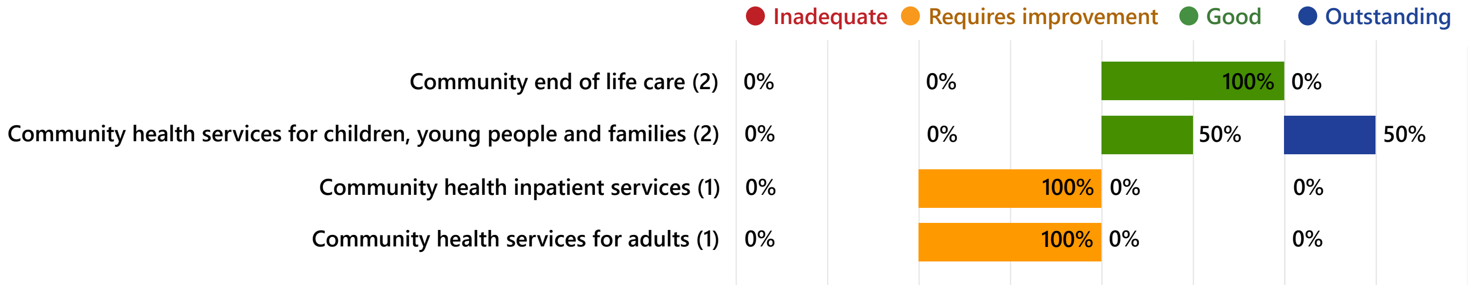
Figure A22: **Community health services, key question ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A23: **Community health services, assessment service groups, overall ratings, 2025**



Source: CQC ratings data, 1 August 2025

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

How to contact us

Call us on 03000 616161
Email us at enquiries@cqc.org.uk
Look at our website www.cqc.org.uk

Write to us at
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Find us on LinkedIn, Facebook and Instagram by searching Care Quality Commission.

Read the summary and download this report in other formats at
www.cqc.org.uk/stateofcare

Please contact us if you would like this report in another language or format.

CQC-491-15-102025

E03451258

978-1-5286-5993-2