



The state of health care and adult social care in England

2025/26



Care Quality Commission

The state of health care and adult social care in England 2025/26

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
22 October 2026.

HC 691



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ISBN 978-1-5286-6803-3

E03678397 10/26

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	4
Summary	7
Evidence used in this report	15
Primary and community care	22
Adult social care	45
Mental health care	79
Secondary care	109
Health and care services for children and young people	146
Deprivation of Liberty Safeguards	158
Appendix: CQC ratings charts	174
References	191

Foreword

Over the past year we have continued to improve our operational performance, significantly increasing the number of our inspections. This has given us a clearer and more current picture of quality across the health and care system than we've had in recent years. There is still much to do, but this year's State of Care report is built on that stronger evidence base.

It finds a system under pressure, with a social care market in flux and changing shape at an unprecedented pace, while persistent inequalities mean people's experience of care remains fractured, too heavily dependent on where they live and who they are. Improvement and innovation are struggling to keep up with rising demand for care.

Demographics in England are shifting towards an ageing population, as well as a working-age population with increasingly complex needs. The number of people needing health and adult social care services continues to grow and, in many areas such as community mental health services, the complexity of that need is also increasing.

There are signs of real progress in how the system is responding, including more GP appointments, better use of digital solutions, and shorter waits for elective care. Throughout this report, we have highlighted examples of local innovation, including neighbourhood models and integrated teams, which are making it easier for people to access care.

But this progress risks being outpaced by people's increasing need for care, against a backdrop of persistent and localised inequality. Prevention, one of the key shifts identified in the 10-Year Plan, is widely recognised as a crucial part of the answer – reducing demand before it reaches crisis point and helping to tackle inequalities at source. Yet it too often lacks a clear strategy for delivery, or clear accountability for outcomes.

Our report this year finds substantial variation in access, quality, and outcomes across every part of the system we regulate.

In primary care, ratios of staff to registered patients vary considerably by area, which can affect the quality of care people receive. Uptake of annual health checks for people with severe mental illness varies widely by integrated care board (ICB) area, despite this group facing a significantly increased risk of premature death. In hospitals, our analysis found variation in maternal readmissions by ethnicity, reflecting entrenched disparities in maternal safety for Black women.

In children's health, hospital admission rates for conditions including bronchiolitis, asthma and diabetes with links to social deprivation vary sharply by region, and levels of tooth decay for children living in the most deprived areas are more than double those in the least deprived areas.

Overall, children and young people are experiencing some of the sharpest increases in need for care and waiting times across the system, even as some adult waiting times have improved. This is starkly illustrated in community health services where over 80,000 children and young people – almost 11 times the number of adults – have been waiting over a year for an appointment. At the same time, the number of children waiting for first contact with mental health services rose nearly a third in 2 years.

We also highlight inequalities not just for those using care, but those delivering it. A key strength of the health and social care workforce is its diversity – failure to support this diversity has consequences not only for staff but for the people who rely on them. Staff who feel valued and included are more likely to stay, delivering continuity of care and reducing the need for temporary staffing solutions, which can increase risk. Our inspections of the well-led key question look at how organisations are monitoring and managing equality, diversity and inclusion in their workforce. There is more work to do in this area, as NHS Workforce Race Equality Standard reporting shows, but trusts who take steps to ensure fairness for all staff are more likely to provide high-quality care.

Within adult social care, the market is changing rapidly. Underpinning much of this change is how well local authorities are equipped to shape and plan for the care their communities will need, and a funding model that remains fragile. This is leaving both providers and local authorities exposed to pressures that are contributing to a reshaping of the market largely by accident rather than by design. Homecare is fragmenting, with a growing number of small providers entering the market and significant variation in strategic commissioning by local authorities.

Care homes, meanwhile, are consolidating, with more of the available care home beds now located in large care homes and recent increases in institutional investors acquiring homes. These trends towards consolidation of property ownership by institutional investors and fragmentation of community-based provision seem likely to continue. We will continue to monitor quality to ensure these divergent trends do not have an impact on either the personalisation or accessibility of care.

Commissioning is one of the most powerful levers to drive quality, equity, and the sustainability of social care, as our local authority assessments have highlighted. But within this changing market, we have found that some local authorities are struggling to meet people's needs. Care providers are increasingly looking for people who can self-fund their care in order to remain financially viable. This risks reducing choice or capacity for people who rely on council-funded support, which is already subject to significant regional variation.

Pressures in one part of the system often compound others – and challenges in access to social care are also contributing to delays in hospital discharge, while gaps in community mental health provision, particularly for people being discharged from inpatient mental health care, are placing further pressure on community services.

This comes despite some improvements in social care staffing, with vacancy and turnover rates in social care falling slightly – although concerns about the impact of reductions in international recruitment remain. We have identified leadership as the area most in need of improvement – this is significant because well-led services deliver better care, which is true of all sectors. Despite significant pressures, we continue to see many excellent examples of high quality and compassionate care – a testament to the hard work of staff.

Ten years ago, we warned that adult social care was approaching a tipping point. Although the intervening decade saw a historically overlooked sector pushed into the public consciousness by the pandemic, successive governments have not resolved the long-term funding of social care. Now, this government’s renewed focus on social care offers an important opportunity for meaningful solutions in social care that improve outcomes across the whole health and care landscape – but only if reform addresses workforce, funding, commissioning, prevention, and inequalities together.

In addition to the sustainable funding solution we have consistently called for, work to improve commissioning across the system is needed to design care purposefully around people’s needs. It is also vital that clearer national standards are set so that people who use adult care services, and their carers, know what they can expect. If a National Care Service is to deliver real change it must address these issues.

We are committed to playing our part – working with providers, commissioners, stakeholders and, most importantly, people who use health and social care – to assess quality, drive improvement and keep people safe.

We will also seek to encourage innovation and collaboration across the system, including working with partners to understand and support the safe implementation of technology and AI to improve care.

The measure of success for all of us who regulate, commission, lead or work in health and social care is not how well each part of the system performs on its own. It’s how well those parts work together for the people who need them, regardless of who they are or where they live.



Kay Boycott
Interim Chair



**Baroness
Julia Neuberger DBE**
Chair



Dr Arun Chopra
Interim Chief Executive

Summary

Our 2025/26 report presents a mixed picture across health and adult social care services that people in England use every day.

The demand on health and adult social care services in England continues to grow and in some areas, including community mental health services, people who need care have increasingly complex or advanced needs. However, there are some green shoots of recovery. We see improvements in how the system responds to demand – for example, a better experience of contacting GPs, benefits of digital solutions, and shorter waits for elective care.

But it is difficult for this improvement to keep pace with the increased need for care – and this is set against a backdrop of persistent and localised inequality. Where you live can make a big difference to the quality of care you might experience, especially for those living in relatively deprived places.

We are concerned for children and young people where we see rapidly increasing levels of demand and people having to wait longer – especially for community health services. While the length of waits is improving overall for most adult services, the opposite is happening for children’s services.

Workforce pressures can affect people’s access to care – and the quality of care. Although we have seen some improvement in the stability of the workforce in the adult social care sector, we remain concerned about the potential impact on reductions in international recruitment for the sector. Our inspections of adult social care show that where staffing is well managed, with the right skill mix, people are more likely to receive safe, person-centred care. However, from the 6,294 inspection ratings for adult social care services that we have published under our current assessment framework, the area needing greatest improvement is under our well-led key question.

Gaps in staffing within GP services can lead to challenging workloads and less capacity to care for people, as well as less time for staff to complete the right training and upskilling. In community health services, we continue to see a decline in the number of health visitors and school nurses.

While the move towards greater community provision and prevention activity is recognised as necessary, we have heard from some integrated care board leaders who are concerned about the feasibility of these shifts. Across care pathways, we are concerned about how people move between services and the effects of delayed discharges from hospital into community and care services.

There is increasing concern about the fragility in the funding model for local authority provision in adult social care services – and the market in which they operate. Our programme of local authority

assessments has highlighted variation in both the quality and practice of commissioning in adult social care services across England.

While the overall number of care homes is reducing, large care homes are making up more of the market, which means the market is becoming more consolidated. However, in homecare, the market is fragmenting, with more smaller providers being established. What – if any – impact these divergent emerging trends in social care have on the quality of care is a question that will need careful attention.

Access to care

Access to health and adult social care services remains a serious problem for many people who need care – and is a challenge for the services providing care. The issue of access to care is probably the most persistent problem throughout the years that we have reported to Parliament on the state of care in England. This is evident in 2025/26 in all the sectors we regulate.

In adult social care, fewer and fewer people are eligible to receive fully state-funded care. At the end of 2024/25, it was estimated that around 223,000 fewer adults were receiving long-term council-funded social care support compared with 20 years ago.

The financial means test to receive state-funded care has been capped at £23,250 for the last 15 years and many people must either try to fund care themselves, count on support from unpaid friends and family, or go without. For 70% of new requests for council-funded social care and support no further action is taken, beyond providing information.

There is pressure on mental health services across the care pathway and demand continued to rise in 2025/26. In community mental health, the number of people in contact with services has increased by 34% over the last 3 years. This pressure is compounded by a rise in the number of people with severe mental illness who are accessing care.

In the hospital sector, urgent and emergency care services remain under sustained pressure. In 2025/26, there were just under 19.9 million calls to NHS 111, nearly 14 million 999 ambulance calls, and 28 million attendances to urgent and emergency care services – this is over 608,000 more attendances than in 2024/25.

The operation of Deprivation of Liberty Safeguards (DoLS) over the last decade has been characterised by an increasing volume of applications and sustained backlogs. Our notifications data suggests a continued increase in the use of DoLS in 2025/26.

Problems with getting access to care affect people's experience of care. And long waits for care remain common for many people – there is unmet need across the system, and those who need care often rely on unpaid carers who provide billions of pounds' worth of care every year.

A growing number of people are waiting for community health services. The number of adults waiting over a year has reduced, but

the number of children and young people who have been waiting over a year increased by 129% in the 2 years to March 2026. The majority of these very long waits are for community paediatric services, including diagnosis of neurodevelopmental conditions, such as autism and attention deficit hyperactivity disorder (ADHD). Our joint inspections with other agencies have shown the profound impact that delays in assessment and care are having on children and their families.

More children and young people need mental health care, and we are also concerned about the long waiting times for these mental health services. Between 2023/24 and 2025/26, the number of children waiting for their first contact with services at the end of the reporting period rose by 31% from a monthly average of 237,590 to 311,070.

People in crisis are struggling to access the mental health care and support they need. Only 25% of very urgent referrals are receiving care within 4 hours. And those seeking help from urgent and emergency care services are facing long waits for assessment by psychiatric liaison services, although this has improved over the last 2 years.

A lack of community placements, incomplete information sharing, or poor representation from social care at planning meetings are creating challenges with discharging patients from secondary mental health services into the community. This can lead to delayed discharge, longer inpatient stays, relapse or readmission, and increased pressure on the whole system.

In 2025/26, the number of people waiting 4 hours at type 1 emergency services to be either admitted to hospital, transferred or discharged, has improved slightly with 60.9% of attendances (10.4 million) seen in under 4 hours. However, more people who need to be admitted to hospital are facing long waits, with more than 1,500 people a day on average waiting longer than 12 hours from the decision to admit to actual hospital admission in 2025/26. Our urgent and emergency care inspections show how this is creating significant operational challenges for emergency departments, with some people facing prolonged waits.

Bed availability, hospital processes and challenges in the wider system can all affect patient flow through the hospital, and we continue to see ongoing challenges with hospital discharge delays. On average, on any given day in 2025/26, nearly 13,000 people remained in hospital when they were ready to be discharged. This is up from 12,700 in 2024/25.

Year-on-year, the average number of incomplete pathways for elective care or treatment has fallen: in 2025/26, the average size of the waiting list stood at 7.3 million, down from 7.5 million incomplete pathways in 2024/25. Most people are also receiving a diagnosis or having cancer ruled out within 28 days of referral. But we remain concerned for the people waiting too long to start treatment once they have a diagnosis of cancer. In 2025/26, 69.4% people with an urgent referral started their treatment within 62 days – the target is 85%.

For some people, access to services appears to be improving. In primary and community care services, since the requirement from October 2025 for GP practices to keep online consultation tools open during core hours, there has been a significant rise in the use of online consultation systems by patients (a 67% increase in online requests per 1,000 patients between March 2025 and March 2026).

More patients are finding it easier to contact their GP practice: 73% of people described their last experience of contacting their GP as ‘good’, compared with 70% in 2025 and 67% in 2024. This coincides with an increase in people saying they contacted their practice online. Across the key questions that we use to assess how effective, caring and responsive services are, we have rated over 9 out of 10 GP practices as either good or outstanding.

The health and care workforce

Workforce pressures affect people’s access to care as well as the quality of care. We have seen that where staffing is well managed, people are more likely to receive safe, person-centred care.

There is considerable regional variation in workforce numbers across integrated care board (ICB) areas. For example, in GP practices, the number of GPs per 100,000 patients ranges from 38 to 56, and for nurses it is between 13 and 45. Among GP practices, London has some of the lowest staffing rates, while the South West has some of the highest.

We see the impact of persistent gaps in staffing at GP practices that are rated as requires improvement and inadequate – including increased workloads for existing staff, an inability to keep up with important training and longer waiting times for appointments.

While staff vacancy and turnover figures continue to reduce in the adult social care sector, they remain high. Our assessments of services rated as inadequate for the safe key question identified issues around recruitment processes and ensuring a safe and sufficient level of staffing – this resulted in breaches of regulations and had an impact on the delivery of safe, high-quality care as well as on staff wellbeing.

International recruitment has played a vital role in reducing staff vacancy and turnover pressures in adult social care. However, as the numbers of staff recruited internationally continues to reduce, the stability of the workforce is a key concern. As a result, more work is needed to strengthen recruitment and retention strategies.

Staff training and qualifications are also an area of concern. Our assessments of adult social care services rated as inadequate for the safe key question found that they did not always ensure staff had the necessary skills, knowledge or competence to safely meet people’s needs. Social care employers responding to the adult social care workforce skills survey highlighted the cost and time to train staff as the most common barriers to investing in developing their skills.

Through our joint inspections with Ofsted of services across education, health and care for children and young people with special educational needs and disabilities, we saw how health visiting and school nursing services remain central to early identification of needs, safeguarding and access to wider health support. Despite demand growing for these services, staffing levels continue to decline with the added pressures of an ageing workforce.

Inequalities

Inequality pervades across health and adult social care in England in 2026. Where you live influences whether you can access care, how long you might wait for care, the quality of care you receive and the outcomes from it. People living in more deprived areas often experience poorer access and outcomes.

Primary and community care services play a vital role in the clinical areas highlighted in NHS England's Core20PLUS5 approach. This aims to support the reduction of health inequalities at both national and system level, including severe mental illness (SMI), which includes schizophrenia and bipolar disorder, and hypertension.

For adults living with SMI, the risk of dying prematurely is almost 5 times higher compared with others. There is huge variation in annual health checks for people on an SMI register by ICB area – ranging from only 53% of people to 81%.

In March 2026, 80% of people aged 14 and over who were on their GP's learning disability register had received a health check in the previous 12 months. These figures also vary by ICB area, from 70% to 86%. But, as at March 2024, it was estimated that only around a quarter of the 1.3 million people with a learning disability in England were recorded on their GP's learning disability register.

As demand increases for mental health services, we continue to see that people who live in the most deprived areas and people from ethnic minority groups have greater levels of need and contact with community mental health services. But not everyone is able to access the care they need when they need it.

In hospitals, we have been clear about the need for a faster pace of improvement nationally in maternity services, particularly around the safety of services and the inequalities faced by certain groups of people with protected equality characteristics.

Our analysis of maternal readmissions this year highlights variation in rates of maternal readmission within 6 weeks of birth. The highest rates are for women from Black ethnic groups.

Our focus on health and care services for children and young people shows that where people are born and where they live can have a dramatic influence on their health outcomes. There are large variations depending on the area and levels of deprivation. The Core20PLUS5 for children and young people includes asthma, diabetes and oral

health as 3 of its clinical areas of focus. Although hospital admission rates for diabetes in children and young people have been reducing, there is regional variation – the North East and Yorkshire have higher rates of admissions for diabetes in children and young people, while rates in London have been consistently lower than the England average since 2013/14.

Among examples of variation is the condition of bronchiolitis – a common cause of hospitalisation in children under 2 years. Although admission rates for bronchiolitis have reduced slightly in the last 2 years, rates in 2024/25 remain over 50% higher than a decade earlier. There is also a distinct national divide – regions in London and the South East have lower admission rates than regions in the North.

Oral health outcomes for young children continue to show substantial geographic and socioeconomic variation across England. Children living in the most deprived communities experienced, on average, more than twice the level of tooth decay compared with those living in the least deprived communities.

Improving access to children and young people’s mental health services for 0 to 17-year-olds is one of the 5 clinical areas of focus in the Core20PLUS5 approach for children and young people. Our work with the Nuffield Trust to find out more about the work of ICBs to improve health and social care services found that mental health was most consistently rated as a clinical priority for children and young people, as 11 out of 13 ICB leaders who responded to a survey said it was a high priority.

Variation is also evident in the way health and adult social care services apply and understand Deprivation of Liberty Safeguards (DoLS). We have identified issues around how services manage training for staff and record-keeping, as well as recognising and reviewing restrictions.

Systems

Local health and social care systems are focused on the ‘three shifts’ encouraged by the government in the 10 Year Health Plan for England, including a drive to move care closer to people’s homes and local neighbourhoods – from hospital to community.

We have seen that GP appointment rates have increased – appointments per 100,000 patients rose by 2.4% in 2025/26 since the previous year, and by 9.7% since 2022/23.

The social care market is changing shape – it is moving towards a more diverse and fragmented community-based sector, and the care home market is consolidating, with more of the available care home beds now located in large care homes. There is also an increase in institutional investors acquiring homes.

We are seeing an increase in the number of homecare hours delivered, which can lead to better experiences and outcomes for those able to access services – more people supported to live in their own homes

and communities. But there are risks. Fragmentation can lead to more complex commissioning processes, and can present challenges for care providers.

Local authorities have a pivotal role and influence on people's experience of adult social care – and we now have a strong view about the way they are working to meet their legal duties under Part 1 of the Care Act (2014). Our assessments allow us to provide independent assurance and our first report on local authorities, in 2026, provides a baseline view.

We found that local authorities are broadly performing well in the face of significant challenges, with 59% rated as good, 37% rated as requires improvement, 3% rated as outstanding and 2% rated as inadequate.

In this State of Care report, we have drawn on those findings and highlighted the importance of the quality of partnerships in an area – and how some people will be experiencing the positive benefits of living in a place where the importance of adult social care is valued and understood. But in too many instances, people wait too long for their care to be negotiated, and for assessments, reviews, services and equipment to be arranged. Nationally, 1 in 8 delays in discharging people (who had been in hospital for 14 days or longer, in 2025/26) came from delays completing transfers between hospitals and social care services.

There are examples of local innovation, including neighbourhood models and integrated teams. There is also some good use of population health data – and outreach to communities affected by inequalities.

In particular, we have seen changes in the way community mental health services are commissioned and delivered. Through our engagement events held with mental health providers, we heard positive examples of providers working more closely with the voluntary, community, faith and social enterprise sector to remove barriers and deliver care in the community. However, providers at our events also raised issues about a lack of guidance around safe staffing levels, medicines management, caseload management, and a lack of focus on a proactive and longer-term approach to preventative care and recovery.

Findings from the State of the Provider Sector Survey, from NHS Providers, and feedback from attendees at our provider engagement event have pointed to concerns around funding and the need for investment in order to scale up successful pilot projects. Figures from the NHS Providers Survey show that 19% of mental health providers have deprioritised spending on transformation initiatives, and a further 32% are considering doing so because of financial pressures.

We are also concerned about what happens to some people with mental health needs following discharge from hospital. Some people with complex needs and who present with a high risk of harming themselves or others, including specific groups of people who are more

likely to disengage with services or are seldom heard, are being lost in the system and not receiving appropriate support.

As well as our findings from inspections, this report reflects what we hear from people who use services. We use our Experts by Experience programme and we take feedback from Share for Better Care.

People's voices are an essential part of our insight and we continue to use all the networks we can – everything from our own surveys to social media – to ensure our work is well-informed. The feedback helps us focus on issues that matter to people.

Throughout the year, we have continued to use our unique position to influence improvement for people who need health and social care services. We provide examples of this in this report, including our ongoing commitment to encouraging services to embed the Patient and Carer Race Equality Framework, and checking how services use the framework as evidence to inform our assessments. And we have encouraged services to learn from one another by promoting the successes we have seen – there are real examples of excellence, identified through our day-to-day work.

In March 2026, we published research on what good practice looks like in caring for people living with dementia, highlighting the importance of having staff who know about dementia and know how to provide proactive support. From here, we will co-produce statutory guidance for providers across health and social care on delivering care for people living with dementia. And we will continue to voice our concerns for people who are subject to restrictive practices – particularly autistic people and people with a learning disability. Our Independent Care (Education) and Treatment Reviews will continue for a further 2 years, highlighting the importance of person-centred, trauma-informed care, and how the skills and knowledge of staff can have a direct impact on the quality of care that people receive.

While we have improved our operational performance and the number of our inspections over the past year, there is much more to do. We are determined to not only maintain this progress but to accelerate it, drilling down into the areas that give us cause for concern, drawing on what we see through our regulatory work and what we hear from people who use health and care services, and their families and carers.

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 2025/26.

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

This report is also based on our review of and analysis of external data, research and evidence. 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 and for better readability we have rounded many of these figures.

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, inspectors, 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 about the evidence used in this report.

People's experience and what they have told us

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

- Adult inpatient survey 2024
- Adult inpatient survey 2025
- Community mental health survey 2025
- Maternity survey 2025.

For the hospital sector, we analysed 1,377 free text comments from the NHS Adult inpatient survey 2024. The sample was drawn from patients who had stayed as an inpatient at any of the 21 hospitals where we inspected emergency departments during the winter of 2025/26 (see Regulatory and strategic projects below for more information).

For mental health, we reviewed all free text comments from the 2025 Community mental health survey from people who also had a stay in hospital as an inpatient in the last 12 months that lasted 7 or more days. We identified quotations that helped to illustrate themes identified through other analyses included in the mental health chapter.

We looked at comments submitted through our online Give feedback on care service about people's experiences in both the adult social care sector and the primary and community services sector.

For adult social care, we sampled and reviewed 145 comments submitted between 1 April 2025 and 24 July 2026. For the primary and community care sector we sampled and reviewed 630 comments submitted between 1 April 2025 and 31 March 2026. We identified relevant experiences from people that would help to illustrate themes identified through other analysis for each sector in this report.

Providers of health and care services

We conducted targeted analyses of:

- information from our provider information returns for adult social care services
- adult social care market trends using our Health and Social Care Act Directory.

We have also drawn on findings from a sample of our published inspection reports of registered providers during 2025/26 and used the data and insight gained through our routine engagement with these providers.

For mental health, we analysed a total of 85 inspection reports, including:

- 41 inspection reports for mental health services published between April 2025 and March 2026. These included the services: acute wards for adults of working age and psychiatric intensive care units, wards for people with a learning disability or autism, and child and adolescent mental health wards. Inspection reports were for services rated as either requires improvement, inadequate, or outstanding.
- 15 inspection reports from our adult community mental health inspection programme, for community mental health services for adults of working age, and crisis services and health-based places of safety, published between April 2025 and April 2026. These reports were analysed to understand patient safety in services.
- 20 inspection reports for mental health services published between April 2025 and March 2026, where we looked at both outstanding and poor practice around the environment. As well as the service types described above, we also included wards for older people with mental health problems and residential substance misuse services.
- 9 additional inspection reports for community mental health services for adults of working age, and crisis services and health-based places of safety, published between April and August 2026. We reviewed these to look at evidence of implementing the Patient and Carer Race Equality Framework.

For the other sectors, we analysed:

- 48 inspection reports for GP services published between April 2025 and May 2026, which were for providers rated as either requires improvement or inadequate, and where we found a breach of regulations.
- 9 inspection reports for community health services for children, young people and their families, which were published between 2023 and 2025.
- 25 inspection reports for urgent and emergency care services published between April 2025 and June 2026, for services rated as either outstanding, good, requires improvement, inadequate and no approved rating.
- 47 inspection reports for adult social care services published between April 2025 and March 2026, which we reviewed for the ‘safe’ question, where providers were rated as either inadequate or outstanding.

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 types of services we regulate are provided in the data appendix of this report. Some ratings data is also used in the body of the report. The ratings data are from inspection reports published under our current assessment framework, as at 4 August 2026. We began implementing our current assessment framework in January 2024, so the ratings in the appendix, for more than 8,400 services and providers, shows our growing picture of the quality of care under the current framework from that point in time.

Throughout the report and ratings appendix, we do not compare current and previous ratings for the following reasons:

- Our assessment activity during this time has been predominantly 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 the quality and safety of people’s care.
- For some services, the numbers of assessments completed using the current assessment framework are still too low to be representative of all services in that sector.
- Alongside the introduction of the current assessment framework, we also changed some aspects of our assessment methodology, including the levels at which we rate providers. Read the full detail of the different [levels of ratings](#) on our website.

In the section on adult social care, we also used our internal data systems to analyse scores for quality statements that underpin the well-led key question.

Our report includes analysis of NHS consultant-led referral to treatment waiting time data. This data presents monthly counts of incomplete pathways at the end of each month. Our analysis includes annual averages of this data to present a high-level picture of waits across the year. It should be noted that as the NHS data is a count of incomplete pathways on one day in a month, the average is a simplification. There will be variation within each month that is not seen in the data. The same pathway may appear in multiple months of data.

We also include analysis of published demographic data from the Waiting list minimum dataset. This data is considered management information and is therefore subject to less validation than an official statistic.

We used a variety of methods to better understand safety in maternity services.

We used responses to the NHS Staff Survey from midwives and our ratings for the safe key question for maternity services to explore whether there is a relationship between measures of staff experience and safety ratings for maternity services. To do this, we used descriptive statistics to compare results from midwife respondents at each NHS trust with our ratings for maternity services at that trust. Where a trust has more than one maternity service at different locations, the staff survey represents the experience of staff across those locations as one value.

However in reality, staff experience at different locations may vary. By applying that trust-level staff survey score to the different maternity service locations in that trust, we are assuming that single score is a relevant comparison to the rating for each location. This is a simplification, and we plan to improve our analysis further over time. Additionally, because we used descriptive statistics, it can only relate to the relationship between these specific survey responses and ratings, rather than inferring a relationship for all midwives and all maternity services.

We also used Hospital Episode Statistics (HES) to analyse changes in maternal readmissions within 6 weeks of discharge from hospital, and how these have changed over time, by mode of delivery and by the mother's ethnicity. The analysis uses a long-standing CQC indicator based on HES. For this report, NHS England's maternity analysis team reviewed the code, which led to minor changes with no material effect on the results. Our analysis uses data from the first quarter of 2022/23 up to, and including, the first 2 quarters of 2025/26 (April to September 2025). This was the latest data available to us during the analysis period for this report, and we note that the data for 2025/26 is still provisional.

Figures from this analysis are not directly comparable with maternal readmission rates published by the National Maternity and Perinatal Audit (NMPA). Unlike the NMPA indicator, our analysis does not exclude planned readmissions or transfers, or readmissions lasting less than one

day. Where combinations of ethnicity and delivery method resulted in counts of 8 or fewer deliveries or readmissions, these were suppressed, meaning they were not included in the data and subsequent analysis. Although suppressions do have an impact on analysis results, they are important to protect people's privacy. To simplify presentation of the analysis we have excluded 'Not known' and 'Not stated' ethnicity values from our analysis. Instrumental deliveries, for example using forceps, and breach deliveries have been excluded from the ethnicity and delivery method analysis because the rates per 1,000 deliveries were low for some groups, and therefore volatile.

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 2025 and 31 March 2026 on the outcome of an application to deprive a person of their liberty under DoLS in hospitals and care homes. Due to changes in our systems, we cannot exclude applications made through the 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, we conducted a qualitative analysis of 130 comments received through our online Give feedback on care service received between April 2025 and February 2026. Using a targeted keyword search, we identified and analysed comments relating to people's experiences of DoLS.

We also conducted focus groups with 19 CQC adult social care inspectors in April and May 2026. Discussions explored levels of understanding and identification of DoLS among staff, care planning and risk management, and the impact of waiting times and wider system pressures.

In addition, we analysed inspection reports across adult social care, urgent and emergency care, and mental health services, published between April 2025 and March 2026. We used a targeted keyword search to identify reports that referenced DoLS and to explore common themes and issues.

We drew on insights from the local authority assessment programme, including analysis of 32 assessment reports, to examine issues relating to delays and waiting times, record management, and staff knowledge and understanding of DoLS.

To provide further context for these findings, we analysed the Department of Health and Social Care's DoLS data for 2024/25 (the most recent data available). This enabled us to explore regional variation in the number of DoLS applications and associated waiting times.

Regulatory and strategic projects

Over 2025/26, we have continued our programme of assessing all 153 local authorities in England that have adult social care responsibilities. We have also conducted focused regulatory work on:

- urgent and emergency care services
- adult community mental health services
- Independent Care (Education) and Treatment Reviews (IC(E)TRs).

Insight gathered through these projects has informed our reporting in 2025/26, alongside research commissioned from the Nuffield Trust on priorities for integrated care boards (ICBs).

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.

The recently published report, [Local authority assessments 2023 to 2026: Emerging themes and findings](#), drew on a combination of both quantitative and qualitative evidence generated through our local authority baseline assessment activity, which is described in the Context section of that report.

Urgent and emergency care

During the winter of 2025/26 we carried out inspections in 21 hospitals to look at the emergency departments and medical wards within these providers. We also conducted patient pathway tracking interviews across 16 of these sites. 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 data from patient pathway tracking interviews for 9 out of the 16 sites. We also analysed free text responses from patients who attended the 21 hospitals and who responded to the Adult inpatient survey 2024. We triangulated outputs from these with the 25 inspection reports for urgent and emergency care services, referenced in Providers of health and care services above, to draw out themes about the quality and safety of care in these services.

Senior members of our staff who specialise in mental health supported 14 out of the 21 inspections. Following these inspections, we conducted 10 telephone interviews with leaders in mental health services to discuss the adult acute pathway flow. We used this evidence to establish themes around the care provided to people with mental health needs presenting at emergency departments, and to understand the pressures on adult acute mental health pathways.

We also conducted a qualitative analysis of a sample of reports from the Learning from Patient Safety Events service, which records patient safety incidents. These reports related to liaison psychiatry and people with mental health needs presenting at emergency departments, submitted by the providers that were part of the urgent and emergency care inspections and associated mental health work. The sample consisted of 356 reports that were submitted by 31 providers, between 1 April 2025 and 31 March 2026. This analysis has also been used to inform our work around adult community mental health services.

Adult community mental health care

In 2024, our rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) highlighted specific concerns about the systemic issues within community mental health care. In 2025 we started a comprehensive programme of inspections of community mental health services for working-age adults, and crisis care (including health-based places of safety). To date, we have inspected over a third of community-based mental health services for adults of working age as well as mental health crisis and health-based places of safety.

We have continued to gather evidence to support this programme of work and held 2 engagement sessions with providers in November 2025. These explained our inspection programme and explored how services have been designed and implemented differently across providers, specifically with the aim of meeting the needs of those with severe mental illness and more intensive needs. Representatives from 35 providers of community mental health services for adults of working age and crisis care (including health-based places of safety) participated.

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

Between May 2024 and March 2026, we carried out 88 IC(E)TRs. Our recently published report, [Learning from Independent Care \(Education\) and Treatment Reviews \(IC\(E\)TRs\) in 2024 and 2025](#), shares findings from these reviews. DHSC has asked us to continue to run these reviews for a further 2 years, which we started in April this year.

The published report is based on analysis of a range of both qualitative and quantitative evidence sources, including national data, IC(E)TR reports, focus groups with subject matter experts and follow-up evidence from individuals, providers and families. Full details are described in the report.



Primary and community care



State of Care

Primary and community care

Key points

- More than 4 out of 5 (87%) GP practices assessed under our current assessment framework are rated as good. A further 3% are rated as outstanding. The remaining GP practices are rated as requires improvement (9%) or inadequate (1%).
- GP appointment rates have increased: in 2025/26, the number of appointments per 100,000 patients rose by 2.4% over the previous year, and have increased by 9.7% since 2022/23.
- Following the requirement for GP practices to keep online consultation tools open during core hours from October 2025, the volume of requests to GP practices using online consultation systems per 1,000 patients increased by 67% between March 2025 and March 2026.
- As online contacts have increased, patients who responded to the GP patient survey are finding it easier to contact their GP practice, with 73% of people describing their last experience of contacting their GP as 'good' compared with 70% in 2025 and 67% in 2024.
- There is considerable variation in the number of GP practice staff per 100,000 patients in different integrated care board (ICB) areas. This ranged from 38 GPs to 56, and from 13 nurses to 45. London has some of the lowest staffing rates, and the South West region some of the highest.
- Inspection reports for GP practices rated as requires improvement or inadequate showed persistent gaps in staffing, which could result in increased workload for existing staff, reduced ability to complete required training, and longer waits for appointments.
- Levels of NHS dental activity continued to recover in 2025/26, although remained below the level of treatment delivered in 2019/20. There is considerable regional variation in the number of dental practices per 100,000 people, with the highest numbers in London and the South East, and the lowest in mainly rural areas. We are concerned about the potential for this disparity to produce further inequalities in access to dentistry and oral health outcomes.
- A growing number of people are waiting for community health services, including care provided in people's homes and community clinics, as well as health promotion services such as health visiting. Although the number of adults waiting over a year has reduced, the number of children and young people waiting over a year has increased by 129%, with the majority of these very long waits for community paediatric services.
- Primary and community care plays a vital role in reducing health inequalities. We have seen how some providers are committed to reducing these inequalities. However, there is a 27 percentage

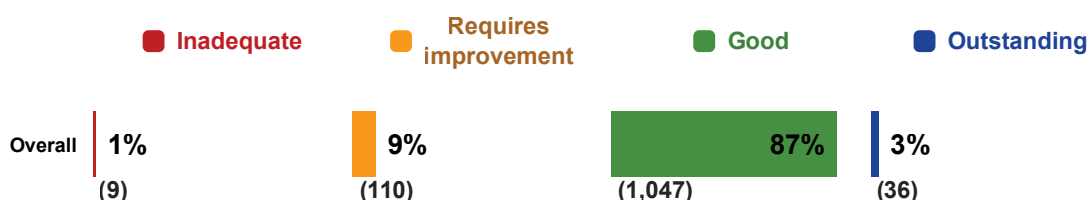
point difference in the proportion of adults living with severe mental illness who receive annual health checks by ICB area, autistic people and people with a learning disability continue to be less likely to describe their experience of their GP practice as good, and there is variation by age, ethnicity and across ICB areas in the proportion of people receiving effective treatment for lowering blood pressure.

GP practice ratings and patient satisfaction

As at August 2026, 87% of the 1,202 GP practices assessed under our current assessment framework, from January 2024 onwards, are rated as good. A further 3% are rated as outstanding. The remaining GP practices are rated as requires improvement (9%) or inadequate (1%) (figure 1). For most of these assessments, we have prioritised assessing services where our data indicated there may be greater risk to the quality and safety of people’s care. However, since March 2026 we have been carrying out assessments of NHS GP practices that we consider to be lower risk under our Returning to good and outstanding programme, as a direct response to feedback from the sector for proportionate regulation.

Figure 1: **Most GP practices are rated as good overall**

GP services, overall ratings, August 2026

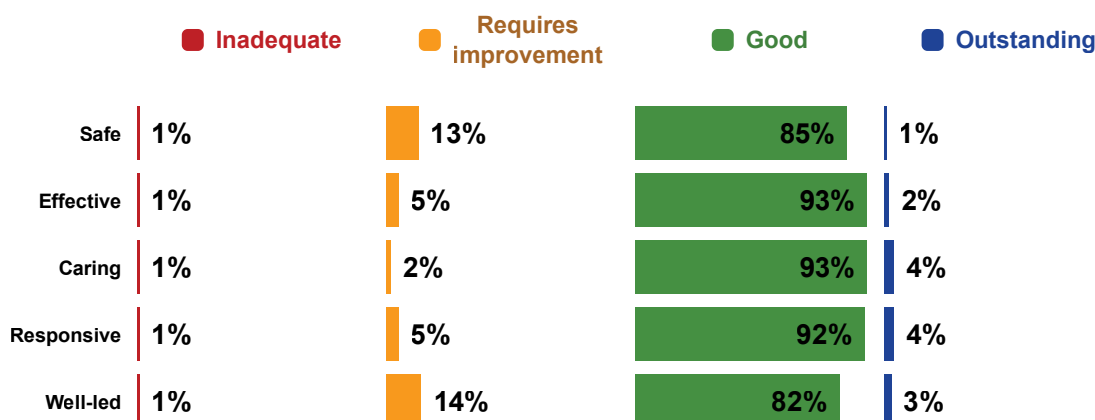


Source: CQC, ratings data

Where we see poorer performance, it is usually under the safe key question (13% requires improvement and 1% inadequate) or well-led key question (14% requires improvement and 1% inadequate). Across the effective, caring and responsive key questions, we see 95-97% of practices rated as either good or outstanding (figure 2).

Figure 2: GP performance is weaker under the safe and well-led key questions

GP services, key question ratings, August 2026



Source: CQC, ratings data. Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

The latest British Social Attitudes Survey, presented in a [report by the Nuffield Trust](#), showed people's overall satisfaction with GP services was at 35% and dissatisfaction was 45%.¹ This is the highest level of satisfaction since 2021 and ends the downward trend of the past few years.

The survey also shows that respondents aged 65 and over were more likely (43%) to be satisfied with GP services than the 18-64 age group (33%). Those aged under 35 were the least satisfied group, with just 31% 'very' or 'quite' satisfied.

An increase in overall satisfaction is also reflected in the [GP Patient Survey 2026](#), with 77% of people describing their overall experience as 'good' compared with 75% in 2025 and 74% in 2024.²

People living in the most deprived areas are less likely to report a good overall experience of their GP practice than people living in the least deprived areas (74% and 79% respectively). People with dementia or Alzheimer's disease and those who have had cancer in the last 5 years (83%) are most likely to say they have a good overall experience of their GP practice.

The most recent [National Cancer Patient Experience Survey](#) reported that 78% of respondents who had contacted their GP practice said they only spoke to a healthcare professional once or twice before they received their cancer diagnosis. 68% said that the referral for diagnosis from their GP practice was explained in a way they could completely understand, which is an improvement since the 2024 survey.

There has also been an improvement in how easy it is for people to contact their GP practice, with 73% of people describing their last experience of contacting their GP practice as 'good' compared with 70% in 2025 and 67% in 2024. Older people are more likely to report

a better experience when contacting their GP practice than younger people (69% of 16-24 year-olds report 'good' compared with 81% of those aged 85 and over). However, people living with frailty are less likely to report their experience of contacting their GP practice is good, as well as autistic people and people with a learning disability.

When asked how they last contacted their GP practice in 2026:

- most people (54%) used the telephone – a decrease from 62% in 2025 and 68% in 2024
- more people (31%) used online methods such as a practice website, NHS app or other online method – an increase compared with 22% in 2025 and 17% in 2024.

We discuss online methods more in the next section on patients' needs.

Patients' needs, and capacity in GP services to meet them

The new Quality strategy for NHS-funded care in England seeks to ensure people receive high-quality care consistently across all NHS-funded services by providing a new structured approach to making quality the organising principle for all NHS activity in England over the next decade.³

The strategy points out that attention has tended to focus more on hospitals, secondary care services and individual organisations than on primary, community, mental health settings or whole care pathways. This is despite general practice delivering almost 380 million appointments each year – around 1.5 million every working day – making it the part of the NHS with which most people have contact. A recent report from The Health Foundation also highlights that the share of the NHS budget for general practice declined from 8.8% to 8.3% between 2015/16 and 2024/25, and advises that a clear multi-year commitment is needed to increase this share to shift care into the community.⁴

As well as improving health outcomes and patient satisfaction, we welcome the aims of the Quality strategy to reduce health inequalities, as we discuss in the Core20PLUS5 priority groups later in this section.

Improving people's health and care outcomes and reducing health inequalities are also key aims of the Neighbourhood health framework, which follows on from the 3 shifts to reinvent the NHS in the 10 Year Health Plan for England. One of these is a shift from hospital to community care through a neighbourhood health service.

Neighbourhood health is an approach to organising health and care services around local communities, with a strong emphasis on integration, prevention, community-centred approaches and care delivered close to home. Integrated neighbourhood teams bring together partners in primary, community, mental health, and social care, with voluntary sector partners to deliver co-ordinated, proactive

support for local populations. Neighbourhood health centres serve as the physical and operational hubs for these teams, offering a single, accessible point for people to access a wide range of services. We share some examples of these neighbourhood health approaches across this report.

Patients' needs

Nationally, the total number of GP appointments recorded on GP and primary care network systems has been increasing. From April 2025 to March 2026, 379,497,308 appointments were made. This is an increase of 2.8% since 2024/25, and an increase of 12.9% since 2022/23.

This is clearly linked to a growth in patient numbers. According to NHS England GP workforce statistics, the number of patients registered at GP practices in England has also been steadily increasing over the last decade – with a 12% increase from September 2015 to March 2026.

This increase is also reflected in the rate of appointments per 100,000 patients: in 2025/26 the rate rose by 2.4% from the previous year, and by 9.7% since 2022/23. Rates of appointments per 100,000 patients varied across integrated care board (ICB) areas. In March 2026:

- the highest rate was 68,284 appointments
- the lowest rate was 40,368 appointments.

Nationally, the 5 areas with the lowest rates of appointments were all urban and with areas of high deprivation. They also generally have younger populations compared with the England average and we know that older people tend to use GP services more frequently. This may therefore partly explain the lower appointment rates, although other local factors are also likely to contribute.

To understand more about the scale of patient need for GP services, and to learn more about patient use of digital tools to engage with healthcare services, we looked at new data about the number of requests made by patients to practices using online consultation systems. These are for patients to request appointments, and to send medication queries and administrative requests such as for fit notes or referrals.

The aim of online request triage is to reduce the '8am rush' of people telephoning their GP practice to make it easier for people with the most urgent needs to get through by phone. Triage can also allow for more flexible appointment planning using other members of the GP practice team, as well as directing people to the most appropriate care provider and prioritising care based on need. We flagged in last year's State of Care, that, where online booking systems have been implemented well, we hear that this can support people to access services. However, practices must ensure that, as stated in [NHS England's guidance](#), the "introduction of these systems is balanced against the nature of the local population to avoid introducing additional inequalities".

“The online triage system works really well and is a much more efficient way of contacting the practice for same day urgent care than calling at 8am. They respond to it very quickly and offer a telephone or face-to-face appointment most times I’ve used this service.”

(Online submission through Give feedback on care, commenting on a GP practice)

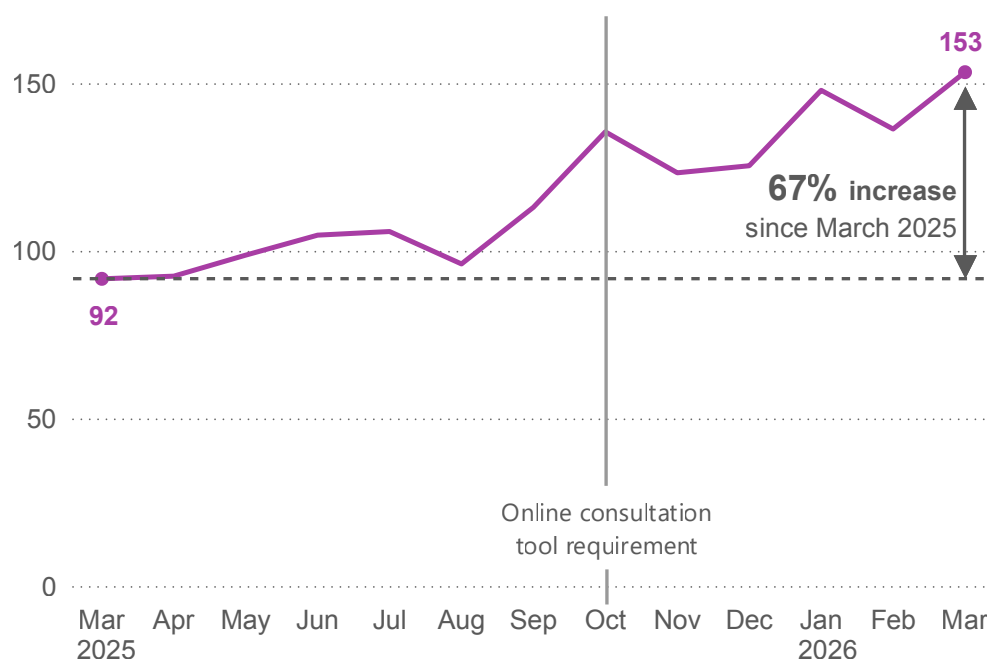
There has been an increase in the volume of online requests to GP practices, which increased notably after the requirement from 1 October 2025 for GP practices to keep online consultation tools open during core practice hours.

In March 2026 there were 9,617,628 online requests – an increase of 69% since August 2025, before the October requirement, when there were 5,690,082 requests.

The rates of online requests per 1,000 patients have also increased. In March 2026 there were 153 online requests per 1,000 patients – an increase of 67% since March 2025 (figure 3).

Figure 3: **Online request rates increased by 67% in one year**

Monthly online requests per 1,000 patients, March 2025 to March 2026



Source: NHS England, [Submissions via Online Consultation Systems in General Practice](#)

Example of commitment to access and digital inclusion – an outstanding GP practice

The GP service demonstrated a highly effective patient-centred approach to ensuring its population had access to services. The practice had consciously moved away from a “one problem per consultation” model to promote continuity and holistic care with standard consultation times of 15-20 minutes to enable meaningful engagement with patients. Reception staff had received enhanced training, which included effective communication skills, ensuring delivery of “right care, first time.” These initiatives helped the practice to deliver 650 appointments per 1,000 patients over a 3-month period, which was significantly above the England benchmark of 481 appointments.

To improve equity of access, the practice had a comprehensive digital inclusion policy, supported by dedicated Digital Inclusion Champions who helped patients with accessing and using digital services such as the NHS App, online forms, and messaging systems. Practical support included providing free SIM cards, referral pathways for patients who needed access to digital devices, and help in finding local digital literacy initiatives. This was further strengthened by keeping a record of patients who were experiencing digital inequality, which recorded 140 patients at the time of our inspection. This enabled the practice to implement reasonable adjustments and engage with these patients to ensure they were not disadvantaged by digital first models of care, improving their access to services, and their confidence in using them.

This fed into wider system development, with the practice contributing to programmes led by its local integrated care board, including digital transformation, workforce development, access improvement, and reducing health inequalities.

(From a CQC inspection report)

Last year’s State of Care report also included a focus on artificial intelligence (AI) in general practice, which was mainly being used for administrative purposes including scheduling appointments, note taking and triage. We welcome the launch last autumn of the National Commission into the Regulation of AI in Healthcare, established by the Medicines and Healthcare products Regulatory Agency to review current regulations, and welcome the recommendations for a new regulatory framework for AI in health care. We have published a position statement on our role, expectations and plans in regards to AI in health and social care.⁵ We encourage the use of innovative technologies, including AI, where the technology benefits people and results in more effective and efficient services, and will continue to explore the implications of providers’ use of AI for how we regulate, for example, how we register, assess, rate and encourage improvement.

Capacity in GP services

Capacity in GP practices to meet the increasing patient need is a complex picture.

General Practice and Primary Care Network (PCN) workforce data shows the number of fully qualified GPs per 100,000 patients has been increasing over the last few years. In 2025/26 there were on average 46 fully qualified GPs per 100,000 patients – a 4.1% increase on the previous year.

Two years ago, we pointed out in State of Care that the Department of Health and Social Care had announced that from October 2024, practices would be allowed to use funding from the Additional Roles Reimbursement Scheme (ARRS) to recruit newly-qualified GPs. Data shows that in March 2026, 1,777 full-time equivalent (FTE) GPs were funded through the ARRS scheme.

The number of GPs in training has also increased. As at March 2026, there were 10,058 FTE GPs in training – an increase of 1.7% since last year, and a large increase of 93% since March 2016.

But having more GPs in training doesn't necessarily convert into more GP jobs. Although NHS England's [NHS Jobs Adverts in General Practice](#) data does not capture all advertised vacancies, it provides an indication of the job market. In 2025/26, there were 29% fewer FTE GP job adverts recorded in GP practices in England compared with 2022/23 when the data collection started.

Looking at the wider practice workforce, including GP practice staff employed by PCNs, 2025/26 saw a similar rate of nurses working in GP practices compared with 2024/25 at 28 nurses per 100,000 patients. But the number of staff providing direct patient care, including healthcare assistants and clinical pharmacists, has increased. In 2025/26, there were on average 67 staff per 100,000 patients, which is a 2% increase from 2024/25 and a 9.5% increase from 2023/24.

There is considerable variation in the number of FTE GPs, nurses and direct patient care staff per 100,000 patients between ICBs areas (figure 4). The extremes in March 2026 were:

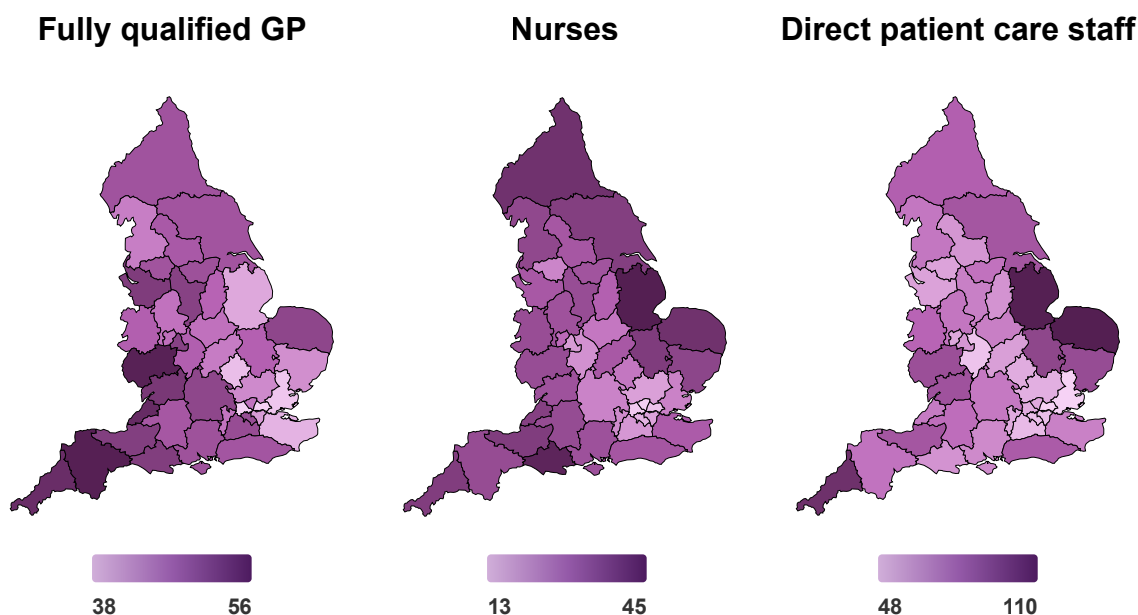
- fully qualified GPs per 100,000 patients ranged from 38 to 56
- nurses per 100,000 patients ranged from 13 to 45
- direct patient care staff per 100,000 patients ranged from 48 to 110.

London ICB areas have some of the lowest staffing levels per 100,000 patients. The 5 London ICBs have the 5 lowest rates nationally for FTE nurses per 100,000 patients. Two of these ICBs also have the lowest rates of GPs per 100,000 patients while 3 London ICBs are in the bottom 5 ICBs nationally for direct patient care staff.

By contrast, areas in the South West have some of the highest rates of staffing: 2 ICB areas are among the 10 with the highest staffing levels for fully-qualified GPs, nurses and direct patient care staff per 100,000 patients.

Figure 4: **Workforce rates vary substantially between ICB areas**

GPs, nurses and direct patient care staff per 100,000 patients by integrated care board area, March 2026



Source: NHS England, [General Practice Workforce](#) and NHS England, [Primary Care Network Workforce](#)

From inspection reports for GP practices rated as either requires improvement or inadequate, we see that practice staff have raised concerns that staffing levels were not always sufficient to deliver care that meets the needs of the patient population. In some services there were persistent gaps in staffing, particularly in relation to shortages of GPs and nurses, a reliance on locum or agency staff, as well as unplanned absences and inadequate cover arrangements.

These pressures could result in increased workload for existing staff and reduced capacity to provide timely care for people. For example, services reported that gaps in staffing led to longer waiting times for appointments or meant that clinicians had to take on additional tasks outside their usual roles.

The reliance on locum staff, while helping to maintain service delivery, introduced additional risks when appropriate governance was not in place. In several cases, there was limited evidence that locum staff had received appropriate induction, supervision, or that their competencies and training had been adequately reviewed.

Workforce pressures also had an impact on the experience of staff. Staff reported high workloads and difficulty managing demand, insufficient cover for sickness or annual leave, limited protected time to complete training and, in one case, being unable to take breaks during shifts.

Independent doctors

We have used our registration data to look at year-on-year changes in the number of independent healthcare locations whose main activity is 'independent consulting doctors', to give a snapshot view. These locations cover a large range of different services, including independent GP practices and health clinics, cosmetic clinics, weight management services, and condition or life-stage specific clinics.

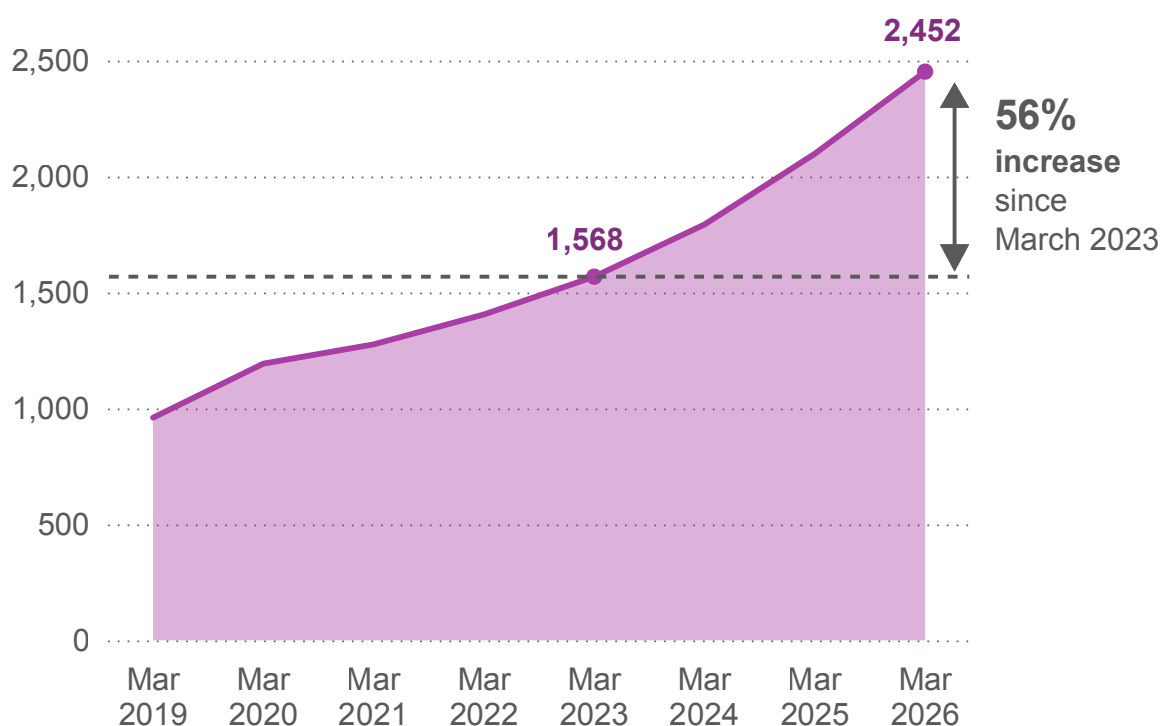
On 1 March 2026, there were 2,452 independent consulting doctor locations registered with CQC. This represents increases of:

- 17% since March 2025
- 37% since March 2024
- 56% since March 2023 (figure 5).

Looking further back, there has been a 155% increase since March 2019.

Figure 5: **Independent consulting doctor locations have increased by 56% since 2023**

Independent consulting doctor locations registered with CQC, March 2019 to March 2026



Source: CQC, Health and Social Care Act register

There are much higher numbers of independent consulting doctor locations registered in London than in other regions over the last 5 years.

Activity, workforce and provision in dental services

Activity and provision

According to [NHS Business Services Authority data](#), NHS dental activity continued to recover in 2025/26, although levels remain below those seen before the COVID-19 pandemic. In 2025/26, there were 37.6 million NHS courses of treatment delivered in England, an increase from 35.4 million in 2024/25. However, activity remained below the 38.8 million courses of treatment delivered in 2019/20.

There is substantial variation across ICB areas in the proportion of people who have been seen by an NHS dentist in the previous 2 years. For adults, this ranged from a quarter of people (25%) in one area to over double that in the highest performing ICB area (53%).

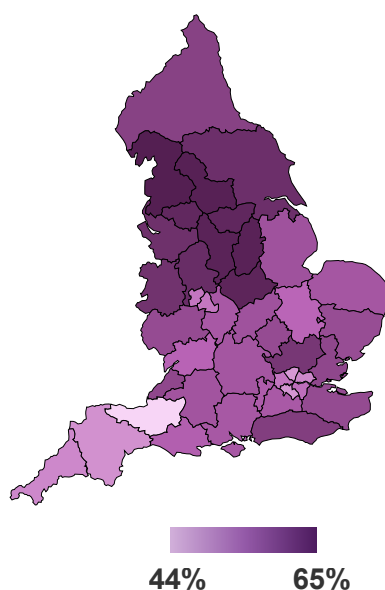
In 2025/26, nearly 7.2 million children were seen by an NHS dentist within the previous 12 months, representing 60% of the child population in England. As with adults, access to an NHS dentist varied substantially across ICB areas – the gap between the highest and lowest performing systems was 21 percentage points (figure 6).

We have noted different approaches to improving access to dental services for children and young people. For example, one practice opened on Saturdays for a month to enable working parents to register their children for NHS treatment. The scheme proved very popular and was extended for a further month.

Analysis of CQC registration data shows considerable variation in density of dental provision. The 5 ICB areas with the highest numbers of CQC registered dental locations are all in London and parts of the South East, with the highest at 37 locations per 100,000 people.

Figure 6: Access to NHS dentistry for children and young people differs markedly between ICB areas

Percentage of children and young people seen by an NHS dentist in the 12 months to March 2026, by integrated care board areas



Source: NHS Business Services Authority, [NHS Dental Statistics for England](#)

In ICB areas with lower provision, there are several predominantly rural or mixed rural areas, with the lowest at 15 registered dental locations per 100,000 people. We are concerned about the potential for this disparity to produce further inequalities in access to dentistry and oral health outcomes.

Together, these findings show a complex picture of the availability of dental services across England. The numbers of dental service locations are also highest in the least deprived ICB areas and lowest in mid-range areas of deprivation, showing that both geographic and socio-economic factors continue to shape the distribution of dental services.

Person-centred care at a dental practice

The dental practice had developed its own ‘social story’, which included photos of the inside and outside of the practice and all its staff, which it could send to patients who have additional needs, such as people with a learning disability or autistic people. The practice also offered non-treatment visits so that patients could explore the reception and waiting area and both treatment rooms, to help them become familiar with a dental practice. This led to a reduction in referrals to the local community services, and most patients completed their treatment at the practice.

(From a CQC inspection report)

Improving access to dental services for under-served communities

A programme supporting people experiencing homelessness to access dental care is helping to narrow healthcare inequalities in an area. In general, people experiencing homelessness have poorer dental health and experience higher levels of tooth decay and gum disease. They can also face particular challenges in accessing health care, particularly dental care services.

Dental public health and dental commissioning teams worked with dental care providers, local homelessness charities and other partners to establish 2 designated ‘homeless friendly’ dental practices offering dedicated sessions for those experiencing homelessness. As part of this, local charities work with the practices to book appointments for patients and support them to attend.

During the first 4 months of the programme nearly 70 people experiencing homelessness have received dental care.

([NHS England: Narrowing oral healthcare inequalities](#))

Dental workforce

In 2025/26, the number of NHS dentists recovered to 2019/20 levels, following a 4% decline between 2019/20 and 2020/21. While this shows a positive trend in the dentist workforce, the increase in the number of dentists has not matched the growth in population. In 2025/26, there were 43 dentists per 100,000 people, which remains slightly below the 2019/20 rate of 44 dentists per 100,000 people. However, there is local variation: the number of dentists per 100,000 people ranged from 34 to 69 across ICB areas in 2025/26. In the year preceding this, 7 ICB areas saw a decline of between 0.2% and 2.7% in the number of dentists per 100,000 people, while 34 ICB areas saw increases of between 0.35% and 11.5%.

This suggests that pressures on the NHS dental workforce are characterised by redistribution and uneven local sustainability, rather than sustained changes to the national workforce as, although most areas appear to be strengthening workforce capacity through improved recruitment and retention, some continue to experience a declining workforce.

Good development opportunities for staff can help them feel valued and respected. At one dental practice assessed this year, we saw that newly appointed members of staff had a structured induction process that was tailored for each role. For example, one of the dental hygienists had developed a comprehensive training programme for new hygienists. This programme helped new hygienists feel confident to fully contribute to patient care as part of a multi-disciplinary team.

NHS and private care

Analysis of data from the General Dental Council on working patterns shows that the proportion of dentists providing NHS-led care, defined as 75% or more of the care they provide, was only slightly greater than those providing predominantly private care.

In 2026, 38% of dentists reported working fully or predominantly within NHS dental care, compared with 37% within fully or predominantly privately led care. A further 23% reported delivering a mixed model of NHS and private care.

Access to community health services

Community health services cover a wide range of services and provide care for people of all ages in their homes, as well as in community hospitals and clinics. Services also include health promotion services such as school health services and health visiting services.

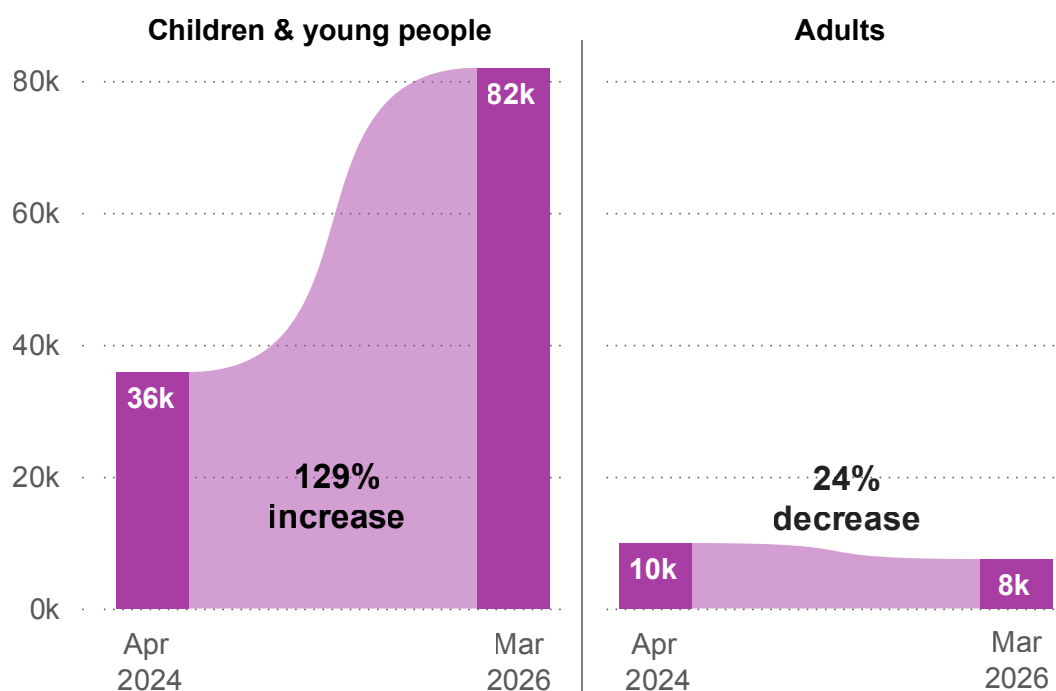
A great number of people are waiting for community health services and that number is growing. The total number of adults waiting for an initial appointment with community health services following a referral has increased by 12% from 795,270 in April 2024 to 892,435 in March 2026.

However, the number of children and young people (under 18 years) waiting for an appointment with community health services increased by a larger proportion, increasing by 14% from April 2024 (282,244) to March 2026 (321,817).

This difference is even more stark when looking at waits of over a year (figure 7). Although the number of adults waiting over a year for a community health service appointment has fallen by 24% from April 2024 to March 2026 (from 9,929 to 7,502), the number of children and young people waiting over a year has increased by 129%. As at March 2026, there were 81,986 children and young people waiting over a year (almost 11 times the number of adults), and nearly two-fifths of these (39%) were waiting more than 2 years.

Figure 7: There are almost 11 times as many children and young people waiting over a year for community health services as adults

People waiting over one year for a community health service appointment, April 2024 to March 2026



Source: NHS England, [Community Health Services waiting lists \(SitRep\)](#)

In March 2026, of the children and young people who were waiting, the vast majority (92%) were waiting for community paediatric services. These services provide diagnosis and support to infants and children with a wide range of physical and mental health issues, including diagnosis of suspected neurodevelopmental conditions, such as autism and ADHD. We also discuss waiting times for children and young people's mental health services in the section on Health and care services for children and young people.

Long waits for community paediatric services are also generating additional pressure on other services that support families, such as health visitors, which we focus on later in this report.

Insight from our joint inspections about health services for children and young people

We carry out inspections of Area Special Educational Needs and Disabilities (SEND) and Joint Targeted Area Inspections (JTAI), in partnership with Ofsted and other inspectorates. During these inspections, we were consistently concerned that children are waiting too long for key health services. In several local areas, children were waiting over 2 years for a neurodevelopmental assessment. In one area, inspectors found that maximum waits extended to several years, meaning that some children were approaching adulthood before their needs were formally understood.

We found that these delays have a direct impact on children's safety, wellbeing and ability to engage with their family life, education and social life. Where a child's developmental level, communication needs or mental health needs are not fully understood, professionals may misinterpret behaviour or fail to recognise escalating distress. This increases the risk of school breakdown, exclusion, crisis presentations to mental health services and vulnerability to exploitation.

However, we are seeing a drive across local areas to change the culture around neurodevelopmental diagnosis by offering needs-led services and support while waiting for an assessment – for example through autism hubs in neighbourhoods. One local authority has developed an integrated autism and ADHD pathway for children over 6 years, which reduces duplication and supports a 'tell it once' approach, resulting in some children being assessed more quickly and accessing a broad range of support while they wait. Vulnerable children and young people are prioritised according to risk and need, helping ensure that children who are looked after, or where there is a risk of school breakdown, are seen first.

As well as long waits for neurodevelopmental pathways within community paediatrics, we are increasingly concerned through our joint inspections about pressures on speech and language therapy, occupational therapy, and wheelchair services.

In last year's report, we shone a spotlight on district nursing services, which 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. We reported on a picture of a nationally depleting pool of staff, with the number of qualified district nurses per 10,000 people aged 65 and over dropping by 50% in the last 14 years, contributing to a shift away from providing holistic care to delivering services in a task-based way. This trend appears to be continuing with a 5% fall in the average monthly full-time equivalent of qualified NHS district nurses from 2024/25 to 2025/26, compared with a 2% rise in the total number of registered nurses in community health.

Healthcare inequalities

Primary and community care has a key role in preventative health care, which includes lifestyle support and advice, immunisations, early detection of diseases through screening programmes and routine checks and reviews, and managing long-term conditions to prevent them from worsening.

Through this prevention role, primary and community care plays a vital role in 4 out of the 5 clinical areas highlighted in NHS England's national approach to reducing health inequalities for adults, [Core20PLUS5](#). One of these clinical areas is early cancer diagnosis, which is discussed in the Hospitals section of this report. The other 3 areas are:

- severe mental illness
- chronic obstructive pulmonary disease (COPD)
- hypertension.

The fifth clinical area, maternity, is also discussed in the Hospitals section of this report.

[Core20PLUS5](#) for children and young people is explored in the section on 'Primary and community care services for children and young people' later in this report.

The Core20PLUS5 approach is being used to focus resources and activities to reduce inequalities in these priority clinical areas, as well as the population groups most affected by them and other health inequalities. We note that the new [Quality strategy for NHS-funded care in England](#) explicitly states that NHS organisations must continue to systematically implement the approach, focusing action where gaps in access to services, experience and outcomes from care are widest, including for disabled people and inclusion health groups.

As part of our commissioned research, the [Nuffield Trust](#) surveyed leaders of integrated care boards (ICBs) about their priorities for addressing health inequalities. From the 21 responses across 13 ICBs (of 36 ICBs nationally), 16 leaders answered the health inequalities section of the survey. Cardiovascular disease (including hypertension) was identified as a clear area of priority, with 15 of the 16 respondents indicating it as a high priority (and no respondents indicating that it was low priority). Severe mental illness was the next highest area of priority (with 6 respondents considering it a high priority and 9 as medium priority).

However, fewer respondents said their ICB was prioritising inequalities work for non-clinical population groups. This included work concentrating on differing geographical groups, such as urban or rural communities (with 6 considering this a low priority, 8 considering it a medium priority, and 2 considering it a high-priority area), and socially excluded groups, such as people experiencing homelessness (with 5 considering this a low priority, 7 considering it a medium priority, and 2 considering this a high-priority area).

To help to identify priority populations, several interviewees in the Nuffield research referenced the use of local population data or population health management tools to help them build local needs profiles. Others cited the work they had undertaken with directors of public health at borough or neighbourhood level to assess opportunities to maximise the impact and co-design local health equity strategies that set out community priorities. However, respondents also described difficulties identifying baselines and challenges in measuring improvement. This was affected by recent re-organisations, mergers and boundary changes of ICB areas. Interviewees emphasised difficulties in understanding the impact of different interventions on local health inequalities without a robust evidence base that would give directors confidence in the work they are doing.

Severe mental illness

NHS England's Core20PLUS5 approach to reducing health inequalities for adults includes severe mental illness as 1 of its 5 clinical areas of focus. The [10 Year Health Plan for England](#) also announced plans for a dedicated Modern Service Framework for severe mental illness as a national mechanism for improving outcomes associated with these conditions and across priority groups.

Severe mental illness refers to mental illnesses, such as schizophrenia and bipolar disorder, that are often so debilitating that people's ability to engage in everyday activities is severely impaired. Many people with a severe mental illness also have one or more chronic physical health condition at the same time as their mental illness.

For adults living with a severe mental illness, the risk of dying prematurely is almost 5 times that of those who do not have a severe mental illness, and premature deaths of people living with severe mental illness are increasing. This is a health inequality and this disparity in health outcomes is largely due to preventable physical illnesses, with high smoking rates making the largest contribution to the life expectancy gap.

The 6 elements of the 'core' annual severe mental illness physical health check are:

- alcohol consumption status
- blood glucose test
- blood pressure
- body mass index
- cholesterol test
- smoking status.

A range of health professionals can deliver the severe mental illness annual physical health checks and support for follow-up interventions. Roles include GPs, nurses, pharmacists, occupational therapists, healthcare assistants, health coaches, and voluntary, community and social enterprise (VCSE) staff.

After a large increase in the rate of people with a severe mental illness receiving all 6 health checks between 2019/20 and 2023/24, in 2025/26 the rate stood at 65%. This is a small decrease of 1.3 percentage points since 2024/25, after a change in the way the data was submitted.

When looking at health checks at ICB level there is huge variation – only 53% of people on a severe mental illness register had a full health check in the lowest performing ICB area compared with 81% in the highest. There are no discernible links to the top and bottom performing ICBs in terms of geography or level of deprivation.

Chronic obstructive pulmonary disease (COPD)

COPD is the umbrella term for serious lung conditions that include chronic bronchitis and emphysema. Smoking is the biggest preventable risk factor.

Early diagnosis and effective ongoing management of chronic obstructive pulmonary disease in a primary care setting allows people to start treatments to manage symptoms and improve their quality of life, as well as keeping people healthier for longer and reducing emergency admissions to hospital.

Nationally, 77% of patients with COPD (including people with personalised care adjustments) had a review in the 12 months preceding March 2026.

Regionally, this varied between 74% and 81%, with only slightly higher variation at ICB area level, ranging from 71% to 85%.

Supporting healthier lives and improving outcomes – an outstanding GP practice

We visited a GP practice that had a proactive approach to identifying and managing patients with long-term conditions, by working with system partners to improve outcomes.

Practice staff had lead roles in areas such as diabetes, asthma, chronic obstructive pulmonary disease and cardiovascular disease. Activities under these roles included working to build connections with patients and their carers to ensure a positive response to invitations for regular health checks, undertaking clinical searches and additional health checks to identify patients with previously undiagnosed conditions, and seeking support from secondary care specialists.

For example, the practice's 'Diabetes Champion' attended a monthly diabetes online meeting that facilitated access to a diabetes consultant, a dietician with a special interest in diabetes, and a diabetes specialist nurse. Staff told us the meeting was an opportunity to discuss patients whose care was complex and who would benefit from specialist input without the need to make a referral.

(From a CQC inspection report)

Hypertension (high blood pressure)

Uncontrolled hypertension, or high blood pressure, increases the risk of heart attacks, stroke, and heart failure, as well as a number of other diseases related to cardiovascular health. Following a diagnosis of hypertension, regular monitoring and reducing blood pressure to specific treatment thresholds is recommended to reduce these risks.

Hypertension prevalence has been increasing nationally, with 15% of patients on a GP patient list in 2024/25 recorded as having established hypertension. Data from [CVDPREVENT](#) shows that in 2024/25, 70% of people on the hypertension register had their blood pressure managed to NICE-recommended treatment thresholds, with a 9 percentage point difference between the highest and lowest performing ICB areas.

We see variation between different groups of people on whether hypertension is treated to the appropriate threshold, with the largest gap seen between younger and older adults. While younger adults are far less likely to have hypertension than older adults, only half (51%) of people aged 18-39 on the hypertension register were treated to the appropriate threshold in 2024/25, compared with more than 4 out of 5 (82%) people aged 80 and over.

We also see variation by ethnicity, with White or Asian people being more likely to have their hypertension treated to the appropriate threshold (both 71%) than people with Mixed or Black ethnicity (both 63%).

GP practice leading neighbourhood working and using data to understand the local population

At community level, an outstanding GP practice played a leading role in developing integrated neighbourhood teams, with a particular focus on frailty. One example was its collaboration with the local 'hospital at home' service, which allowed people to receive acute medical care within their own homes. Staff told us this prevented unnecessary hospital admissions, maintained continuity of care, and kept people in familiar surroundings when they were unwell. People told us they valued the reassurance and convenience of being supported at home, and data shared with inspectors confirmed a reduction in admissions for this group of people.

The service understood the diverse health and care needs of its local community and used data to target resources where they were most needed. For example, staff used information, combined with their local knowledge, to identify groups at risk of poorer health outcomes, including people with cardiovascular disease from ethnic minority backgrounds, people experiencing poverty, and military veterans. These people were then offered tailored outreach and support, which led to greater engagement with the service. For example, service records showed an increase in attendance at health checks and follow-up appointments among these groups, with 84.6% of eligible patients

receiving a health check and 81.1% having a health action plan in place – both figures above the county averages of 76.3% and 74.2%, demonstrating consistently high performance.

(From a CQC inspection report)

Smoking, prevention and health inequalities

Moving from sickness to prevention is 1 of the 3 core strategic shifts of the 10 Year Health Plan for England, published in July 2025.

This includes the ambition to create a smoke-free generation through “bringing smoking prevalence to essentially zero during the expected lifetime of a child born today”. Achieving this will not only improve the health and wellbeing of individual people and their families, but it also has the potential to dramatically reduce health inequalities.

Neighbourhood health approaches, including integrated neighbourhood teams, are an important tool for achieving a smoke-free country by bringing easily accessible health services and advice direct to the communities who are most in need.

Through our work with the Nuffield Trust, we heard how one London borough used a neighbourhood health approach to improve child respiratory health in areas facing multiple deprivation. Using local health data, the pilot found that children living in the most deprived postcodes were more likely to live with a smoker, and young children from ethnic minority groups had disproportionately higher percentages of undiagnosed asthma.

As part of the pilot, family link workers joined a multidisciplinary team at a newly established community respiratory clinic. They also carried out home visits to support families to identify and reduce household pollution risks, including from tobacco smoke, and advised parents where they could find smoking cessation services where appropriate. Parents said they felt listened to and valued the time given by the workers.

Annual health checks for people with a learning disability

In our State of Care report last year, we discussed the barriers and inequalities faced by autistic people and people with a learning disability when accessing and using GP services. This year’s GP Patient Survey shows that they continue to have less positive experiences than others, with only 67% of autistic people and 70% of people with a learning disability reporting a good overall experience of their GP practice compared with 77% across all respondents.

People aged 14 and over who are recorded on their GP’s learning disability register should be offered an annual health check to help in preventing and treating new and unmet health conditions. We highlighted how, as at March 2024, there were around 1.3 million

people with a learning disability in England, yet only around a quarter were recorded on their GP's learning disability register.⁶

Encouragingly, the number of people aged 14 and over on the learning disability register has been increasing – up 4.1% between March 2024 and March 2026, from 328,995 to 342,580 people. In March 2026, around 80% of people aged 14 and over on the learning disability register had received a health check in the previous 12 months (273,430 people with completed checks compared with 342,580 people on the register).

However, these figures vary by ICB area. The highest proportion of health checks carried out was 86% compared with the lowest at 70%. From a regional perspective, as at March 2026, London had the highest percentage of health checks at 84% and the South West had the lowest proportion at 76%.

GP practices supporting good quality services and experiences for autistic people and people with a learning disability

It is important that practices consider the best ways to meet people's needs, including autistic people and people with a learning disability.

One GP practice used a system that ensured all the patients with a learning disability were offered an annual health check, including appointments with a variety of reasonable adjustments available – for example, at different locations, different times of the day and in rooms with low lighting. In the first 4 months of the year, more than half of the people with a learning disability (56%) had received an annual health check, with the other patients either already booked in or staff were making further attempts to schedule one.

Another practice had established an autism working group to understand how they could meet their needs as a population group in the best way. The service received feedback to a survey from 68 people with lived experience of autism and learning disability. We saw evidence of actions from the survey, such as the use of a 'health passport', to document reasonable adjustments, including preference for a named clinician for continuity of care. A 'sensory box' had been developed in partnership with people with lived experience, which contained cards to help people identify their communication preferences, ear defenders, and fidget accessories. People who used the sensory box gave feedback that these tools helped them cope with unfamiliar and stressful environments.



Adult social care



State of Care

Adult social care

Key points

- 7 out of 10 of the 3,783 care homes we have assessed are rated as either good (67%) or outstanding (3%), while the remaining care homes required improvement (27%) or were providing an inadequate service (3%).
- Leadership is a key area for improvement in care homes, particularly in relation to governance, systems of accountability and clarity of roles and responsibilities, as around a third of care homes were rated as either requires improvement (31%) or inadequate (3%) for the well-led key question.
- 8 in 10 of the 2,121 homecare services we have assessed are rated as either good (76%) or outstanding (4%), while 18% were rated as requires improvement and 2% as inadequate.
- Despite recent increases in funding and provision, the long-term sustainability of local authority-funded social care is uncertain. More than three-quarters of council budgets go towards social care for adults and children, and across England they are over-spending on their annual adult social care budgets by £715 million.
- Around 223,000 fewer adults were receiving long-term council-funded social care support at the end of 2024/25 compared with 20 years earlier, and no further action beyond providing information, was recorded for 70% of new requests for council-funded social care support. As the financial means test to receive state-funded care has been capped at £23,250 for the last 15 years, fewer and fewer people are eligible to receive fully state-funded care and so need to either fund care themselves, rely on care and support from unpaid friends and family, or go without.
- The social care market is changing shape – it is moving towards a more diverse and fragmented community-based sector, and the care home market is consolidating, with more of the available care home beds now located in large care homes. There is also an increase in institutional investors acquiring homes. This can lead to better experiences and outcomes for those able to access community-based services, as they can be supported to live with greater independence in their own homes and communities. However, risks such as more complex commissioning processes can present challenges for providers.
- Potentially driven by financial pressures, social care services are increasingly looking towards the growing numbers of people who will be self-funding their care, particularly in care homes. While the majority of social care delivered remains state-funded, our data shows the proportion of self-funded care is increasing and varies across the country.

- While staff vacancy and turnover figures continue to reduce in the sector, they remain high. In services rated as inadequate for the safe key question, we identified issues around recruitment processes and ensuring a safe and sufficient level of staffing, which resulted in breaches of regulations, and had an impact on the delivery of safe, high-quality care and staff wellbeing. International recruitment has played a vital role in reducing staff vacancy and turnover pressures in adult social care. However, as the numbers of staff recruited internationally continues to reduce, the stability of the workforce is a key concern. As a result, more work is needed to strengthen recruitment and retention strategies.
- Staff training and qualifications are also an area of concern. We found that services rated as inadequate for the safe key question did not always ensure staff had the necessary skills, knowledge or competence to safely meet people's needs. Data from Skills for Care suggests that only 38% of staff directly providing care to people had completed training in dementia care, for example. While most (83%) social care employers highlight the importance of qualifications for career progression into management positions for care workers, the cost and time to train staff were identified as the most common barriers to investing in developing the skills of staff.
- Local authorities are broadly performing well in the face of significant challenges, with 3% rated as outstanding, 59% rated as good, 37% rated as requires improvement, and 2% rated as inadequate for their provision of adult social care and support.
- The quality of partnerships in an area is important, and results in positive benefits where the voice of adult social care is respected and understood. But, in too many instances, people were waiting too long for their care to be negotiated, and for assessments, reviews, services and equipment to be arranged. Nationally, 1 in 8 delays in discharging people who had been in hospital for 14 days or longer in 2025/26 were a result of delays in completing transfers between hospitals and social care services.

Adult social care ratings

The following analysis relates to 6,294 adult social care services (care homes, homecare and supported living) assessed under our current assessment framework. We have been using this framework since the beginning of 2024. During this time assessments have been largely risk based, so the services assessed may not be representative of all services across the sector.

Our ratings of care homes as at August 2026 show that more than 7 out of 10 of the 3,783 care homes assessed under our current framework are providing good (67%) or outstanding care (3%), while the remaining care homes required improvement (27%) or are providing an inadequate care service (3%) (figure 8).

Figure 8: 7 out of 10 care homes are providing good or outstanding care

Proportion of care homes rated using our current assessment framework with an overall rating of outstanding, good, requires improvement or inadequate, August 2026



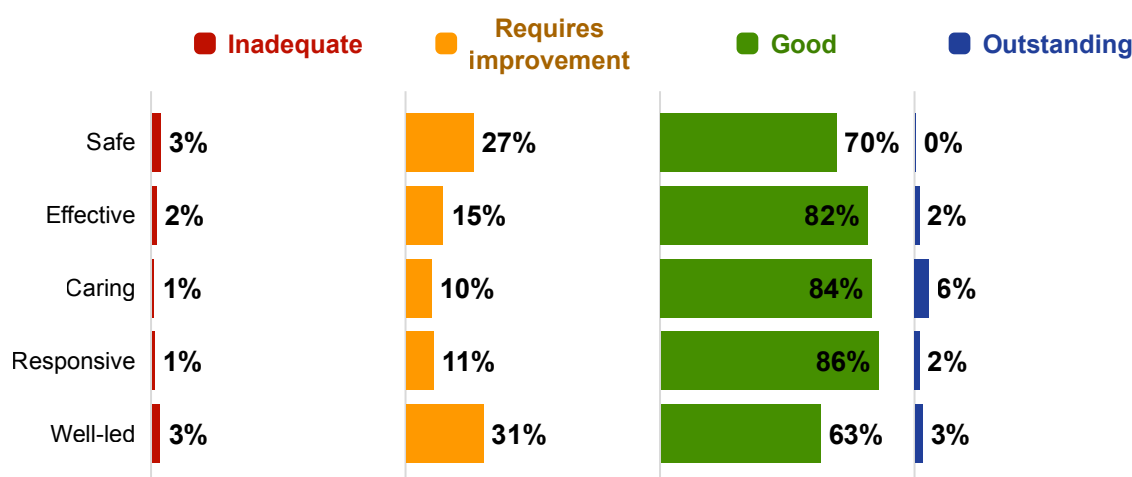
Source: CQC, ratings data

Around 9 in 10 care homes are rated as good or outstanding for providing caring (89%) and responsive (88%) support. However, we found the most common problems are related to their leadership, as around a third of care homes were rated as requires improvement (31%) or inadequate (3%) for the well-led key question (figure 9).

An analysis of our assessment data looking specifically at the quality statements under the well-led key question identified concerns in governance, management and sustainability in particular, with shortfalls in standards identified for more than half (55%) of the care home assessments that looked at this quality statement. This quality statement relates to the requirement for services to have clear responsibilities, roles, systems of accountability and good governance. In a focus group to inform this year's State of Care report, CQC inspectors and specialists fed back that the key concerns included leaders not having the time and support they need to provide good oversight and drive improvements, and not listening to staff or acting on their feedback.

Figure 9: Leadership issues identified in a third of care homes

Key question ratings for care homes, rated using our current framework, August 2026



Source: CQC, ratings data

A personal story – a care home giving caring, flexible support

Abbie's parents, Andrew and Mary, were in their early 80s and had long-term health conditions. When Andrew had to go to hospital, Mary had to stay with Abbie to be cared for. Abbie told us this separation was taking a toll on her parents, both physically and mentally, as they had been happily married for over 60 years.

Abbie took on the task of finding a care home that would be able to provide high levels of care for them both so they could be together. She described the search as being like a "minefield", as many care homes in their area did not cater for their needs or cater for couples wanting to be together.

However, after many visits to care homes, she found a home that was "incredibly understanding and supportive" and was flexible to accommodate the couple together. Abbie explained how the home was very attentive to Andrew's needs and placed him at the centre of his care, "They really wanted to know him holistically and not just his physical needs". The care home manager also supported Abbie, who said, "A friendly pat on the arm and a cup of tea and an acknowledgement of what a daunting time it is was so refreshing and needed at such a traumatic time in my life."

Mary sadly passed away in the home. Abbie said that the care home staff had enabled her to pass "very peacefully in the way that we would have all wanted for her". The support the home gave to Abbie and her Dad following Mary's passing was described as immeasurable. For example, the care home staff supported Andrew by "bringing him flowers, encouraging him to take part in activities, just listening to him talk, making sure he eats, and getting the chef to cook his favourite meals and snacks."

Abbie is a frequent visitor at the home to see Andrew and has observed that "the management of the care home socialise with the residents; they are not locked away in their offices, they are genuinely interested in the care of their residents and families." Abbie is incredibly grateful for the kind and compassionate care they have and are receiving from the home as a family.

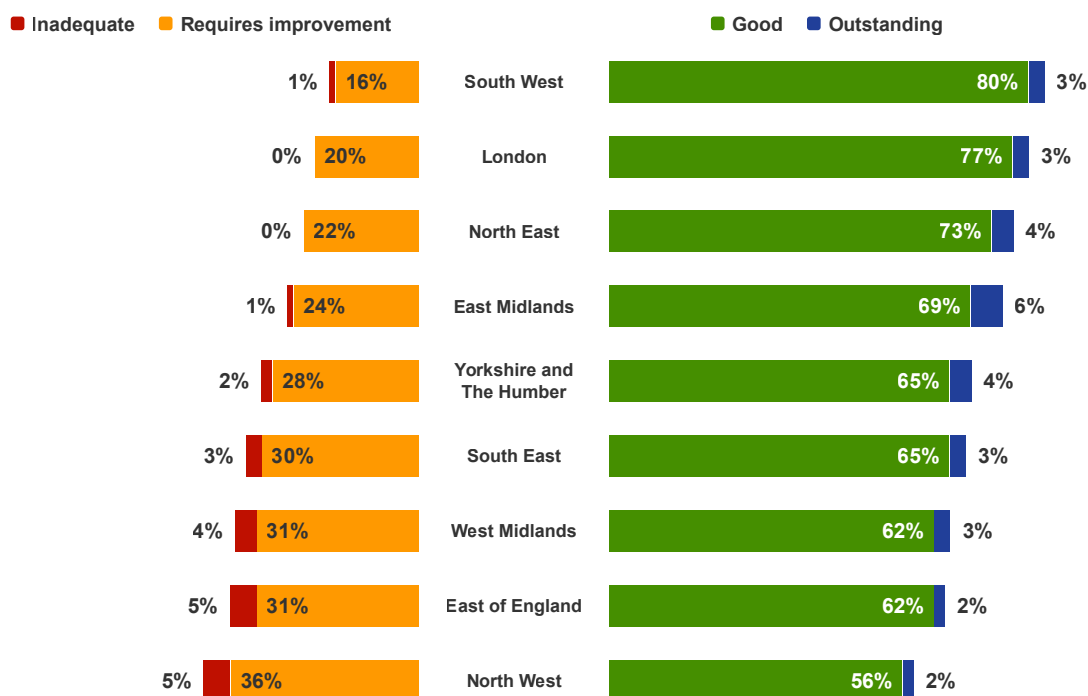
(Taken from an online submission through Give feedback on care)

Regionally, for care homes assessed under our current assessment framework, those in the South West and London areas have the best ratings for the quality of care, with 82% and 80% rated overall as good or outstanding respectively.

The North West has the poorest overall ratings for care homes, with only 59% of all assessed services rated as either good (56%) or outstanding (2%) (figure 10).

Figure 10: **The quality of care homes varies across the country**

Overall ratings for care homes rated using our current assessment framework by region, August 2026



Source: CQC, ratings data

In the homecare sector, as at August 2026 we have assessed 2,121 services under our current assessment framework since January 2024. Of these, 80% have been rated as either good (76%) or outstanding (4%), while 18% were rated as requires improvement and 2% as inadequate (figure 11).

Figure 11: **8 in 10 homecare services are providing good or outstanding care**

Overall ratings for homecare services using our current assessment framework, August 2026



Source: CQC, ratings data.

We have assessed 390 supported living services since January 2024, of which, 78% were rated as either good (74%) or outstanding (4%), while 19% were rated as requires improvement, and 2% as inadequate.

An outstanding supported living service for autistic people and people with a learning disability

We assessed a supported living service providing support to autistic adults or adults with a learning disability, and rated it as outstanding for 4 key questions and outstanding overall.

Some people using the service were not able to tell us about their needs and feedback verbally, but staff and managers showed exceptional commitment to developing a deep understanding of their wishes, needs and preferences by using bespoke techniques to enable them to communicate these. Other people were able to tell us with pride about their achievements since moving to the service and spoke with excitement about plans for the future.

People's relatives and professionals told us how much more independent and healthy people were. They told us people had been supported to visit family homes, in some cases for the first time in many years.

(From a CQC inspection report)

Requests for adult social care and capacity in the sector

We have noted in [previous years](#) that local authorities have been facing an increasing number of requests for adult social care and support. We are unable to comment on how this trend has changed due to changes in data collection and statistical methodology. However, the latest official statistics published by the [Department of Health and Social Care](#) show that there were just over 2 million new requests for local authority-funded adult social care support in 2024/25. Around two-thirds of these requests related to adults aged 65 and over, while a third related to working-age adults (18 to 64 years old). As a single person can account for multiple requests, the data shows these 2 million requests related to 1.4 million people.

Regionally, new requests for local authority-funded social care in 2024/25 were highest in the North West and lowest in the South West. However, it should be noted that there may be some regional variation due to differences in recording data.

In 2024/25, no further action was taken, beyond providing information, in 7 out of 10 new requests for local authority-funded support (71%). Taking no further action was more likely in relation to requests from working-age adults (86%) than from older adults aged 65 and over (66%).

As these figures imply, older adults were much more likely to receive care than working-age adults in 2024/25:

- nearly a quarter (23%) of new requests from older adults received a short-term package of care, compared with 8% of requests from working-age adults

- 8% of new requests from older adults received long-term care, compared with 4% from working-age adults.

Support for people with a learning disability is the most common reason working-age adults are receiving long-term care (accounting for 44% of working-age adults receiving long-term care); for older adults the most common reason is for personal care (62% of older adults receiving long-term care).

The majority of local authority-funded long-term support is provided in community settings (mostly in people's own homes) – 86% for working age adults and 61% for older adults.⁷

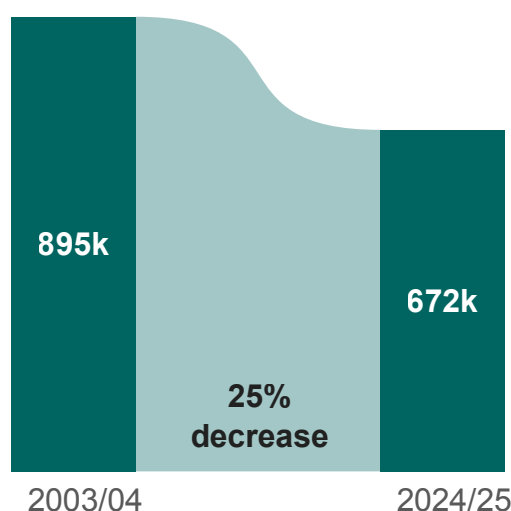
There is regional variation in the rates of provision of long-term social care funded by a local authority:

- **for older people:** rates are highest in London and the North East, and lowest in the South East and South West
- **for working-age adults:** rates are highest in the North West and North East, and lowest in the South East and West Midlands.

The number of adults receiving local authority-funded long-term social care at the end of 2024/25 was 25% lower than it was 20 years earlier, falling from nearly 895,000 at the end of 2003/04 to just over 672,000 at the end of 2024/25 (figure 12). However, local authorities have increased their provision of long-term support by 10% over the last few years since their lowest level of provision at the end of 2021/22.

Figure 12: **Local authority-funded long-term social care has fallen by 25% in the last 20 years**

Number of adults receiving local authority-funded long-term social care at the end of the financial year, England, 2003/04 to 2024/25



Source: Department of Health and Social Care, Adult social care activity report, England. The data collection methodology changed twice across the course of this time series.

Consolidation of the care home market

All providers that deliver a regulated activity in England must be registered with CQC. Using data from our register of locations, we have looked at trends in the number and sizes of care homes across England. These findings represent a considerable shift in the structure of the care home market.

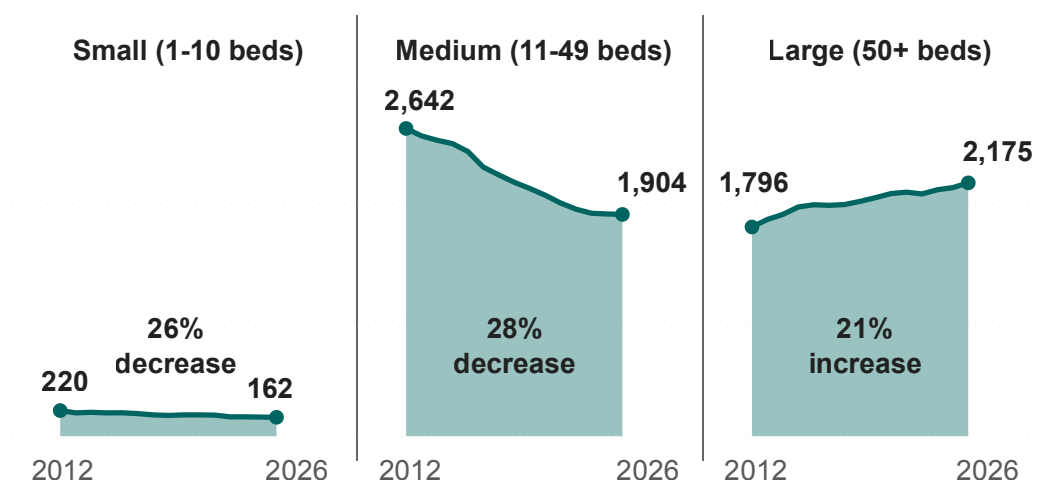
Data on active locations that are registered with CQC shows that the total number of beds in care homes in England has remained broadly stable in recent years (fluctuating by 1% or less since April 2019), despite the total number of care homes falling by 8%.

However, the number of beds in care homes is being outpaced by an ageing population, which means the relative capacity in care homes is falling. For example, there were nearly 450 fewer care home beds per 100,000 adults aged 65 and over in April 2026 than there were in April 2019.

The data reflects the changing shape of the care home market, consolidating capacity in fewer but larger care homes. Between April 2012 and April 2026, the proportion of care homes that were large (with 50 or more beds) grew by three-quarters, from 13% to 23%, while their share of available care home beds grew from 59% to 70%.

These changes are most marked in care homes providing nursing support. Between April 2012 and April 2026, the proportion of nursing care homes that were large (50 or more beds) grew from 39% to 51%, while small-sized services (1 to 10 beds) became rarer (from 5% to 4%). In February 2021, for the first time, the number of large nursing homes exceeded the number of medium-sized (11 to 49 beds) nursing homes (figure 13).

Figure 13: **Care homes providing nursing support are becoming larger**
Number of care homes providing nursing support by size, April 2012 to April 2026



Source: CQC, HSCA register

The data for 2026 shows that the proportion of small, medium and large nursing homes varies greatly between regions. Southern regions like London, the East of England and the South East have greater proportions of large nursing homes. In contrast, medium sized homes were slightly more common than large ones in the North West and Yorkshire and the Humber, and much more common in the East Midlands (by 17 percentage points)

Trends for care homes that do not provide nursing support show that medium and small-sized services remain more common than large ones. Although, there has been growth in the number of large-sized services here too, with the number of large sized care homes nearly doubling since 2012.

Within this context of growth in larger care homes, it is interesting to note that analysis of ratings for services assessed using our current assessment framework suggests that performance is better in large homes than medium-sized homes. In every region except London, a higher proportion of large-sized care homes that had been assessed received ratings of good or outstanding than medium-sized homes.

Reflecting on these findings, a focus group of CQC inspectors and specialists commented that medium-sized care homes may not have the financial stability and resilience of larger ones, or be able to invest to keep their buildings, systems and resources up to date. Some inspectors are seeing that medium-sized care homes have a high turnover of management staff, whereas larger homes may have a bigger leadership structure to improve governance. These issues can have an impact on the quality of care people receive.

“It isn’t a vast, showy place that brazenly shouts its glory across the rooftops: it is a comfortable, welcoming place that exudes a friendly, caring, nurturing atmosphere. It is clear that all staff care.”

(Online submission through Give feedback on care, about a care home)

However, small care homes rated under our current assessment framework received the best ratings, with our inspectors and specialists commenting that small-sized homes may be able to operate more flexibly, and ‘think outside the box’ to make use of local community resources. It is notable then that the number of small-sized care homes reduced by more than 1,500 between April 2012 and April 2026, with the proportion of care homes that were small in size falling from 32% to 29% of the market over this period.

Small homes are often designed for specific care, such as to support autistic people and people with a learning disability. Analysis of nearly 700 small-sized care homes (10 or fewer beds) registered to care for autistic people or people with a learning disability that have been assessed since January 2024 shows that 80% are providing good (75%) or outstanding (5%) care. This is 9 percentage points better than the overall ratings for all care homes that have been assessed through the current framework.

An outstanding care home for autistic people and people with a learning disability

We rated a small residential care home providing support to autistic adults or adults with a learning disability as outstanding in all key questions in our assessment.

Staff consistently used kind, reassuring approaches and demonstrated a genuine understanding of each person, including their preferences. The provider also prioritised education, personal development and upskilling, ensuring people were supported to learn both practical and life skills. All relatives we spoke with said they were extremely happy with the provider. They described notable positive changes in their loved ones since living at the home, including improvements in confidence, emotional stability, independence, engagement and quality of life.

(From a CQC inspection report)

The reduction in the total number of care homes, combined with the growth in larger homes, comes in the context of recent increases in consolidation in property ownership by institutional investors. Between September 2024 and September 2026, the number of homes owned by the top 5 largest providers of care homes for older people increased by 26%, driven primarily by transactions between one US-based real estate investment trust (REIT) with 3 of the largest providers. Our data shows that this REIT is now the dual-registered operator and owner of care homes which, in total, represent 9% of all CQC-registered care home beds in England.⁸

Given the scale of these recent acquisitions, the Competition and Markets Authority (CMA) launched an investigation in January 2026 because of concerns that the acquisitions could potentially lead to higher prices or a reduction in the quality of care for residents. We note the findings of the [CMA investigation](#) and the acceptance of proposed remedies in relation to a small number of care homes.⁹

The level of consolidation of property ownership by institutional investors and the possibility that this trend will be ongoing means we will continue to monitor quality carefully so that this does not come at the cost of flexible, personalised care.

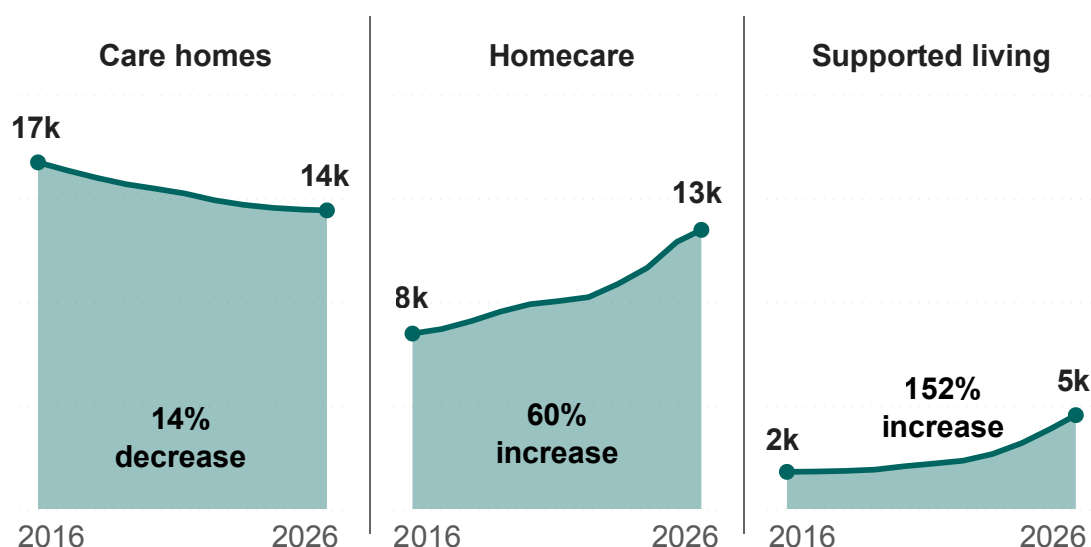
Fragmentation in community adult social care

CQC's register of active locations shows that the number of homecare services has continued to increase, reaching just over 13,500 in April 2026, an increase of 42% on April 2019, with an extra 700 homecare services registered in the last year nationally (figure 14). The growth in the homecare sector is reflected in data from our statutory Market Oversight scheme. This scheme assesses 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. Data from homecare providers in the scheme shows that over the 2 years from March 2024 to March 2026, there has been a 5.8% increase in the number of hours of homecare delivered.

Figure 14: The homecare and supported living sectors have increased hugely over the last 10 years, while the number of care homes has reduced

Number of care home, homecare and supported living services, April 2016 to April 2026



Source: CQC, HSCA register. Analysis uses a 3-month rolling average. Dormancy flag introduced in May 2021, dormant services are excluded from subsequent counts.

Enabling people to live more independent and supported lives in their own homes reflects the policy shift in local authorities that aims to commission more community services to support more people to stay in their own homes for longer, so the increases in care delivered in this model of care are encouraging.

“Carers arrive morning and evening, giving personal care in a respectful, unhurried and loving way. My husband still has his dignity, and really looks forward to seeing them.”

(Online submission through Give feedback on care, about a homecare service)

However, the homecare market is also increasingly fragmented, with the sector comprising a growing number of very small services. Analysis of the data we gather to determine our annual fees for providers suggests homecare services providing care to 4 or fewer people account for 30% of services in the market in April 2026, up 2 percentage points on last year.

Increased fragmentation is also reflected in commissioning practices, and this can present challenges for providers.

In last year's State of Care, we reported that providers of homecare had been saying that commissioning of their services was an increasingly slow process and that commissioners were spreading care packages across a broader range of services. This had resulted in under-used capacity and was seen as one reason behind the small reduction in the number of hours of care delivered in data for the subset of providers in our CQC Market Oversight scheme where a direct comparison over time could be made.

Concerns around commissioning and under-used capacity are supported by evidence published by the Homecare Association in November 2025, which found the majority of local authorities across England purchased an average of 500 or fewer hours of care during a sample week. This is well below the 1,500 hours that their Minimum Price for Homecare model assumes is needed for a service to remain financially sustainable and delivering predominantly state-funded care. Commissioning delays and under-used capacity add to the financial drain for services, increasing sustainability pressures and driving the sector towards more self-funding clients.

However, there is some indication of improvement in this area. Our most recent CQC Market Oversight scheme data for the quarter ending March 2026 suggests this issue stabilised for providers in the scheme over 2025/26, with the final quarter of the year showing a small increase of 1.6% in hours of care delivered compared with 2 years earlier for the subset of providers where a direct comparison over time could be made.

We are keen to understand how changes in the homecare sector and increased complexity in commissioning affect people's experiences. Issues with commissioning are also highlighted in the following section on 'Local authority baseline assessments'.

An increasing proportion of newly registered homecare services also provide supported living services, accounting for 27% of the homecare market (an increase of 6 percentage points in the last 2 years). Indeed, the Supported Living market continues to grow at pace. In last year's State of Care report, we noted that the number of supported living services had increased by nearly 50% between 2022/23 and 2024/25. In 2025/26, the market has grown a further 20%, bringing the total number of registered supported living services to over 4,500 as at April 2026.

These findings about the fragmentation and diversification of the homecare market are also supported by research from LaingBuisson, which talks about "an increasingly diverse provider landscape, marked by the growth of supported living, the persistence of small-scale micro-providers, and ongoing shifts in how care is delivered between settings".

A personal story – experiences of 2 homecare services

Joanne noticed a steady change in her father Raymond's behaviour: he no longer looked after his diet or personal hygiene like he once did, and the food in his house had become mouldy. She also worried that he was becoming lonely. After he started having problems remembering to take his medication properly, he was assessed and diagnosed with Alzheimer's disease.

After many difficult conversations with Raymond about his declining ability to live independently, Joanne found him some care at home, which he paid for privately. The service worked with Raymond for 18 months, during which time Joanne observed care delivered inconsistently, an unpredictable stream of carers, and seemingly untrained staff. She told us, "You never knew who was coming... there was no continuity".

The carers were consistently late and didn't stay with Raymond for the whole of their allocated shifts, as set out in his care package, and they regularly missed his medication doses. The service didn't build a rapport with Raymond or Joanne, and Joanne felt that Raymond's care "wasn't person-centred... and wasn't meeting his needs". Joanne also noted a high turnover rate of care staff, and, despite her concerns, was advised to retain Raymond's care with the service due to a high demand for other services.

Joanne tried contacting other local services and soon learned that it was very difficult. However, she eventually found a different homecare service that had capacity. Given their poor experience with the previous service, Joanne had to convince Raymond to make the transition, but the quality of care at the new service proved to be much higher.

For example, in contrast with the previous service, a core group of 6 carers at the new service consistently visit Raymond punctually, and for their whole shift. There seems to be "no real turnover of staff" and Joanne no longer feels the need to check Raymond's medicines because the carers administer them to him consistently.

The carers have built a strong rapport with Raymond, "They... know him inside out" and seem to have received thorough training on interacting with people with his conditions and on meeting their needs with the use of specialist equipment. The service logs medication updates on a mobile app to assure Joanne of the actions that staff have taken while caring for Raymond.

Raymond's care plan is reviewed regularly, and staff work with agility to update it when appropriate. Joanne says that in comparison with the previous service, this one is proactive, not reactive, "He's happier, he's more content; I'm more reassured, I feel that he's safe". Both Raymond and Joanne are keen for Raymond's care to continue in the community to retain a sense of personal independence and financial security.

(Interview with a member of the public)

Pressures on the adult social care market

As we have discussed, the adult social care system is changing, with the care home market consolidating around fewer, larger homes owned by large businesses, and community services fragmenting into smaller, more diverse services. This divergence can be difficult for local authorities to navigate and complicates their commissioning arrangements. As we highlighted in our report, *Local authority assessments 2023 to 2026*, commissioning services is one of the most powerful levers in adult social care systems to drive improvement in the quality, equity and sustainability of care and support for people. However, our assessments highlighted significant variation in both the quality and practice of commissioning across England, with the better performing local authorities demonstrating:

- alignment between commissioning, prevention to support people to maintain their health, and workforce planning
- meaningful engagement with providers
- explicit consideration of both local authority-funded and self-funded markets.

In some others we identified weaknesses in market shaping and engagement with providers, and a lack of alignment between commissioning and outcomes from safeguarding and equity activity. These issues had increased the risk of pushing pressure elsewhere in the system and having a negative impact on people's lived experience. After the quality statement in the local authority assessment framework on assessing needs, the care provision quality statement, which includes assessment of commissioning, was one of the 2 quality statements most likely to receive a lower score of either 1 or 2.

Within this context of a changing market, some local authorities are struggling to meet people's needs and adult social care providers are increasingly seeking people who can self-fund their care in order to remain financially viable.

Local authority finances

On average, local authorities spend over three-quarters (78%) of their funds on social care for both adults and children, rising to 86% in county councils, and this expenditure is increasing.¹⁰

In the last few years, increased spending power has enabled local authorities to spend more on social care, increase the fees they pay providers to deliver home care, and increase the number of adults receiving long-term social care to the highest number in 2024/25 than at any point in the previous decade. Prior to the last few years, although local authorities were spending more on social care, this nearly all went towards increasing the fees paid to social care providers, who faced increasing operational and staffing costs.¹¹

Gross current expenditure on local authority-funded adult social care increased by 9% between 2023/24 and 2024/25 and was at just under

£30 billion. Of this expenditure, 80% was on long-term care, which saw a 10% increase in spending between 2023/24 and 2024/25. The average cost of a week's care in a care home and the average cost of an hour of homecare support both increased by 7% between 2023/24 and 2024/25.¹²

However, despite increased spending power, local authorities are still struggling to meet the needs of their communities, and their financial position is deteriorating. The ADASS Spring Survey 2026 reports that they overspent on their 2025/26 adult social care budgets by £715 million – the second year running that the overspend has been near to three-quarters of a billion pounds.

The ongoing struggling financial situation in local authorities has far-reaching impacts for the sustainability of state-funded social care and beyond. There are repercussions not only around increased complexity of the social care market and inequitable access to care and quality discussed above, but also the potential for:

- increased reliance on friends and family to provide unpaid care (and the knock-on impact on their lives, as reflected in the Carer's UK State of Caring 2025 report and the section in this report on 'Unpaid carers')
- increased financial costs for people during a period of sustained cost of living pressures (this includes more people fully self-funding their care as well as more people having to contribute financially to their local authority-funded care).
- an impact on local authorities' provision of other statutory services¹³
- increased pressures on healthcare services, especially hospitals, as a lack of access to social care not only leads to a deterioration in health but is also a leading cause of delayed hospital discharges (see 'Causes of delayed discharges from hospital'), contributing to blockages through the hospital system and longer waits for hospital admission, discussed in the Hospitals section of this report.

The King's Fund notes that:

"...although local authorities are spending more on social care, their overall financial situation is worsening. In 2024/25, external debt at English councils rose by 10% and useable reserves fell by 4%. Some councils relied on 'exceptional financial support' from government, which permits them to use receipts from asset sales to fund day-to-day expenditure."

We welcome the launch of the national conversation about adult social care, as part of the Independent Commission chaired by Baroness Casey of Blackstock. We will continue to contribute to this conversation and the wider work of the Commission to reform the adult social care system.

Self-funding in adult social care

Despite local authorities increasing the fees they pay to care providers, the financial pressures they are under means these fees are still below the rising costs that social care providers face in delivering care.¹⁴ Consequently, social care services are increasingly looking to people who will be self-funding their care, to whom they can charge higher prices.

Since 2010/11, if a person has more than £23,250 in savings and investments, they must pay the full cost of their care. This means the threshold hasn't changed for over 15 years, which has failed to keep pace with inflation and resulted in more people having to fund part or all of their social care.

Our provider information return (PIR) defines a 'self-funder' as someone who pays for their own care privately. For instance, this might be either:

- a person whose savings or income are over the threshold to receive state-funded care and, as such, they privately fund their care in full
- a person who might receive care provided by a charity or nursing care funded by the NHS, while privately funding the remainder of the cost of their care.

The PIR defines any person whose social care is funded either in part or in full by their local authority or by the NHS as 'state-funded'.

In 2025/26, estimates from our PIR show that more than a third (37%) of people in England residing in a care home were self-funders. This is a slight increase on the previous 2 years, where the proportion of people self-funding their residential care was 36%.

Broadly speaking, rates of self-funding in care homes are higher in the south of England and lower in the north.

For instance, the regions with the highest rates of self-funding are:

- the South East (47%)
- the East of England (42%)
- the South West (41%).

Whereas the regions with the lowest rates of self-funding are:

- the North East (24%)
- the North West (30%).

Given this, a person in a care home in the South East is twice as likely to be a self-funder compared with someone in the North East of England.

Rates of self-funding are lower for people accessing homecare services. In 2025/26, almost 1 in 4 people (24%) receiving homecare in England were self-funding their care (a 1 percentage point increase from 2 years before).

Proportionally, less social care is being funded by the state and yet it still accounts for over three-quarters of local authority spending.

The increased income from people who fund their own care has helped some social care providers, particularly in the care home market, to mitigate rising operating and staff costs. CQC's Market Oversight analysis for the quarter ending March 2026 showed that, at 27%, profitability levels in care homes for older people have been broadly stable over the last 2 years, and the proportion of income from self-funders in these services has risen from 48% in March 2024 to 52% in March 2026.

Adult social care workforce

Recruitment and retention

Data from CQC's provider information returns for care homes shows that across 2025/26, average staff vacancy rates in care homes were at 4.6%, a very small reduction on 4.8% in the previous financial year. In real terms, this means almost 1 in 20 care home roles remained vacant in 2025/26.

Staff turnover in care homes also continues to reduce. Across 2025/26 average staff turnover was at just over 23%, down nearly 2 percentage points from the previous year.

There is more regional variation in levels of turnover for care home staff than in vacancy levels. Regionally, the North East and Yorkshire region has the highest staff turnover in care homes at 27% for 2025/26, which is 4 percentage points higher than the national average. Meanwhile, London continues to have much lower staff turnover rates in care homes compared with the rest of the country – averaging 16% over 2025/26, which is 7 percentage points lower than the national average and 11 percentage points below the North East and Yorkshire region.

Our provider information returns for homecare services show a small reduction in staff vacancy rates in homecare services: reducing from 11% to 9% between 2023/24 and 2024/25, and then remaining static at 9% over 2025/26. In real terms, this means almost 1 in 10 homecare roles remained vacant in 2025/26.

The data also show a small but continuous reduction in the staff turnover rate for homecare services in England, from 21% to 19% between 2023/24 and 2025/26.

Although the reductions in staff turnover seen in care homes and homecare services are encouraging, it still means that almost 1 in 4 care home staff and 1 in 5 homecare staff left their job in 2025/26. This can have a negative impact on the continuity of care and the ability to build trusted relationships with people.

In the [State of the adult social care sector and workforce report 2024/25](#), Skills for Care identified a range of factors from its workforce data collection that were most associated with higher levels of staff turnover. These included longer distances to travel to work, lower pay, being aged under 25, and lower levels of experience, training and qualifications.

Although the data show reductions in vacancy and turnover rates, this can mask the challenges that providers and people using services experience. Analysis of our inspection reports that resulted in a rating of inadequate for the safe key question in 2025/26 found that these services did not always operate safe recruitment practices or maintain effective oversight to ensure they identified and managed risks. Recruitment processes were not always followed in line with regulatory requirements or providers' own policies, and governance systems did not provide sufficient assurance that staff were suitable to work with people.

We saw examples where application forms from staff did not include a written record of any employment history. This meant managers were unable to assure themselves that staff had the appropriate skills, experience, or competencies to deliver safe care.

In addition, essential pre-employment checks, such as a Disclosure and Barring Service check (DBS), were not consistently completed or were sometimes delayed for months while staff were supporting people, exposing them to potential abuse and avoidable harm.

By contrast, services we rated as outstanding for the safe key question in 2025/26 were found to be actively promoting a career in adult social care, and creating a culture where staff feel valued, supported, and cared for within their roles, as the following example shows:

"Where they wished to, staff were supported to follow the career pathway within the organisation, and the registered manager told us how staff had been supported to develop and [were] promoted in-house... The manager shared examples of how staff were supported in their roles, including providing emotional support during difficult times such as bereavement, and holding open and supportive discussions about working hours. Staff told us how they were proud working for the service. A staff member told us, 'The [homecare service] is like a big family, which I'm honoured to be a part of'."

(From a CQC inspection report)

International recruitment

While a continued national reduction in vacancy and staff turnover levels in social care is positive, concerns around the long-term sustainability of the social care workforce remain.

International recruitment has played a vital role in supporting the capacity of the social care workforce and reducing vacancy rates from a peak of over 10% in the aftermath of the pandemic. The valuable contribution of workers from overseas to the delivery of social care in recent years cannot be over-emphasised.

However, international recruitment into the social care workforce has continued to decline following changes to the Health and Care Worker visa policy in March 2024.

International recruitment into the workforce more than halved between 2023/24 and 2024/25 falling from 105,000 to 50,000. Over 2025/26, quarterly estimates published by Skills for Care show that international recruitment into the sector has fallen by a further 40% to just over 30,000 over the year.

The cessation of the Health and Care worker visas followed by increases in Home Office revocations of visa licences (see below) is driving worries that the pressures on staffing levels could spike again.

Although social care workers are no longer able to apply for Health and Care Worker visas to come to the UK, international recruitment into the sector is still continuing, albeit at much lower volumes, through other routes such as people on student visas.

Data from Skills for Care shows the social care sector has become increasingly dependent on non-British care staff and staff recruited internationally in recent years. With staff vacancy rates remaining around 3 times higher than the wider UK economy, the continued decline in overseas recruitment could worsen staffing pressures, affecting continuity of care, workforce stability, and the sector's ability to meet growing needs.

When asked to select from a list the most important barriers to recruitment and retention that needed to be addressed, 24% of respondents to the April 2025 Adult Social Care Workforce Survey identified "immigration rule changes which have reduced the volume of applications", while 15% identified "immigration rule changes which have impacted retention".

More work is needed to strengthen recruitment and retention strategies, including through negotiations around Fair Pay agreements and implementing effective interim measures to support recruitment and retention while waiting for Fair Pay agreements to come into effect in 2028.

Care providers that have recruited staff internationally require a licence to sponsor care worker's visas. Where abuse of the immigration system with regards to these visa sponsorship licences is identified, the Home Office will act to suspend or revoke the provider's licence. The Home Office notifies CQC of their suspension and revocation activity so that we can consider this during our day-to-day regulatory work, such as the risk to people using the service.

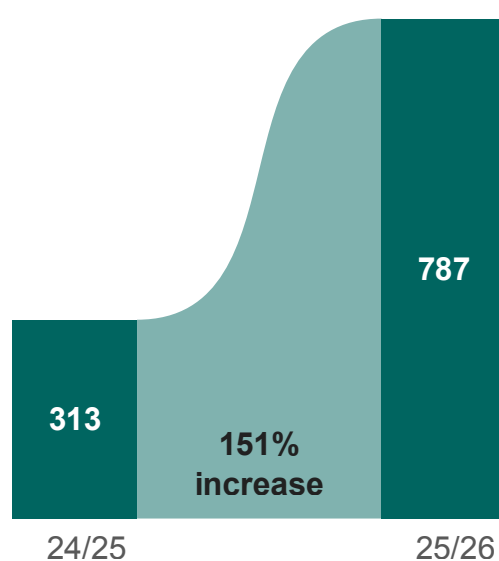
Home Office UK Visas and Immigration (UKVI) data at the end of May 2026 shows that we were notified of the visa sponsor license being revoked, and not subsequently reinstated, for 787 services (the majority of which were adult social care) over the course of 2025/26 (figure 15). This is 2 and-a-half times as many as in the previous financial year. These revocations of sponsor licences were for a range of reasons,

with large volumes related to incorrect salary payments, while smaller numbers related to exploitative practices, such as debt bondage and concerns that vacancies being filled were not genuine.

Given the tenuous stability of the social care workforce and reliance on internationally recruited staff in some areas, there are concerns that large scale abuses of immigration rules by care providers and subsequent revocations of visa licences could impact the stability of the social care workforce within local areas.

Figure 15: Notifications of visa licence revocations have more than doubled in a year

Number of notifications to CQC of visa sponsor licence revocations, 2024/25 to 2025/26



Source: Home Office, UKVI data (supplied in May 2026)

Staffing levels

Through analysis of our inspection reports we have seen stark differences in people’s experiences of using adult social care services where they relate to the workforce. Where staffing was well managed, people were much more likely to experience safe, consistent and person-centred care, with good continuity and meaningful relationships with staff. This supported positive outcomes, increased satisfaction, and improved people’s quality of life.

In these services, providers made sure there were always enough qualified, skilled and experienced staff, with well-planned rotas and sufficient travel time between visits for staff working for homecare services. Staff told us that, “*we have enough staff... we have time to sit down and talk to people*”, and people confirmed this, saying “*there are always staff around to talk to*” and “*they always turn up on time*”. Good practice included consistent staff teams, effective matching of staff to people, and tools for monitoring staffing levels and responding when people’s needs changed, as the following shows:

[Care home] staffing was deployed with exceptional flexibility, shaped entirely around people's individual needs and preferences. This meant staff were readily available at the times people wanted support, enabling them to choose what they wished to do and when they wished to do it... One person told us, "The staff are very kind, they have lots of patience"... One relative said, "The care is very consistent, [family member] has the same carers and they know us. They know what [family member] likes, they have made the decision for care easier for the family."

People and relatives described the care delivered from a small team of [homecare] staff who kept a close eye on everything. There was consistency, care staff were proactive and seemed to work well together and had good communication skills. The provider ensured new staff were introduced to people. A person said, "There is a small team of care staff allocated to me, so it does change, but I have never had a stranger walk into my house."

(Extracts from CQC inspection reports)

When providers did not ensure there were enough staff working who were suitably qualified, skilled and experienced to safely meet people's needs, their staffing levels could fall below those needed for people who have a specified staffing ratio to meet their needs.

Rotas could also fall below the provider's own safe staffing levels, and in some cases did not accurately reflect the staff on duty. In one example, inspectors saw that there were fewer staff working on each shift than the provider had told both CQC and the local authority.

The impact of staffing levels on the quality of care were commonly highlighted in our analysis of breaches of regulations in services rated as inadequate for the safe key question, where those that had breached regulations had failed to ensure sufficient numbers of suitably skilled and competent staff or had allocated staff poorly. This meant that people experienced delays, inconsistent care, and increased risk of harm, particularly where their needs required timely or specialist support.

Staff told our inspectors about their experiences of these pressures, stating there were not enough staff to support people's needs, and that they didn't get time to sit and chat with the people they were providing care for. Our inspectors also observed this, including call bells ringing for a long time and visitors having to step in where there were no staff around:

"We observed a visiting relative intervening when a physical situation between two people began to escalate and there were no staff in the vicinity. This placed the relative and people at risk of harm."

"There had been a number of falls in the service, and we were concerned that if someone rang their call bell or activated a sensor mat to alert staff that they were attempting to walk, the limited number of staff on shift may not be able to react quickly enough to protect them from further harm."

(From CQC inspection reports)

Staff also described working long days and nights without taking appropriate breaks. In one example, they described working over 95 hours in one week or in another where rotas showed that one member of staff routinely worked 48 hours at a time (2 consecutive 24-hour shifts, including sleep-ins) without a scheduled break. In one week, they worked 3 sleep-in shifts (72 hours) without a break. In some inspections staff reported being pressured to cover excessive workloads:

"Shift shortages are frequent and often ignored, with employees pressured to cover excessive workloads without adequate breaks or assistance. The result is not only burnout, but avoidable harm to those under our care."

(From a CQC inspection report)

Qualifications and training

In their 2024/25 State of the adult social care sector and workforce report, Skills for Care reported that only 56% of all social care staff had either partly or fully completed the Care Certificate. Care Certificate standards are a recommended tool to support minimum training, supervision and assessment that staff new to care (health and adult social care) should receive as part of induction. Furthermore, over half (54%) of staff providing care directly to people did not hold a relevant social care qualification in 2024/25.

Workforce development and access to qualifications are a key factor associated with improved staff retention. Skills for Care's analysis shows that care workers with a relevant social care qualification were less likely to leave their roles, with 21% leaving within a 12-month period compared with 27% of those without a qualification.

Qualifications are also key to career progression within the sector. In September 2025, the Department of Health and Social Care published the Adult social care workforce skills survey of CQC-registered residential or homecare providers. This found that nearly 83% of respondents said qualifications were important when it comes to promoting care workers into management positions. Where survey respondents said there are barriers to investing in skill development for the current workforce, they most commonly highlighted the cost of training (82%) and time for training (56%) as barriers stopping this investment.

Releasing staff to receive training may be challenging because of shortages and the need to maintain service continuity. For example, inspectors in our focus groups highlighted how some people working in care homes are not paid to complete training, and have to complete it in their own time.

These pressures may present a wider systemic challenge within the sector. Where organisations are unable to invest in workforce development due to financial or operational pressures, this may affect workforce capability, staff retention, as well as the quality and safety of care being delivered. Our inspectors also commented on the implications of adult social care providers not being supported by local healthcare partners to undertake training to enable them to safely carry out healthcare activities. This can lead to people's needs not being met and a reliance on emergency healthcare services, which could be avoided or reduced if collaboration was facilitated.

Meanwhile, unweighted Skills for Care data shows that only 38% of staff providing care directly to people had completed training in dementia care. This is notable given the large number of people who are living with dementia within adult social care settings. Recent findings from Alzheimer's Society highlight gaps in dementia training, with fewer than half of care staff receiving dementia training as part of their induction and many reporting limited confidence in delivering care. The report highlights concerns that training provision may be insufficient, with some care workers receiving minimal dementia-specific training. This reinforces the importance of ensuring staff are equipped with the skills needed to support people living with dementia effectively.

In March 2026, we published research on what good practice looks like in caring for people with dementia. This research highlighted the importance of having staff who know about dementia and how to provide proactive support. We will use the findings from this research, alongside our 2025 report on Health and social care support for people with dementia, to co-produce statutory guidance on delivering care for people living with dementia, which means that all CQC-registered providers across health and social care must follow it.

“Music clearly plays a huge role in the lives of the residents, and it was incredible to see the carers and nurses not just providing care but creating a joyful, engaging atmosphere. Seeing them singing, encouraging residents to sing along, and even dancing – whether standing or just moving along in their chairs – was heartwarming. It’s this kind of engagement, this sense of warmth and happiness, that makes such a difference in the lives of those living with dementia. It was a beautiful reminder that care is not just about meeting physical needs but about enriching lives.”

(Online submission through Give feedback on care, commenting on a care home)

Our inspection reports demonstrate the importance of training. Services rated outstanding for the safe key question ensured they adhered to training requirements with full oversight of any gaps. These providers regularly monitored competency through audits, observations of practice or supervision, and staff described feeling confident and well-supported. Members of staff told us that “the training gives me the confidence to do my job”. People and relatives also reflected this, with feedback such as “all [staff are] trained extremely well” and “the knowledge and expertise of staff here is amazing.”

In a few services rated as outstanding for the safe key question, training had a direct positive impact on people’s outcomes from their care. For example, staff were able to recognise early signs of deterioration or distress and respond appropriately, reducing the need for restrictive interventions and improving quality of life, as the following shows.

The provider had recruited an ‘in-house’ accredited trainer... to offer responsive, year-round education, adapting quickly to emerging needs. A relative told us, “The meticulous daily reporting, the regular contact with me, the training programme which requires all new carers to shadow for a time before going ‘solo’: all of this in combination gives me every confidence.”

A member of staff told us, “They offer extra training for Parkinson’s disease and dementia. The training gives me the confidence to do my job. The training has taught me that I do know what I am doing. For example, when a lady I cared for had a stroke. I knew something wasn’t right and I didn’t hesitate in ringing. The training gave me the skills to be able to identify the stroke.”

A second member of staff told us, “People with lived experience delivered training. The training taught me to not stand in front of the person; you give them the chance to have the first interaction with someone who they might meet, which I always remember.”

(From a CQC inspection report)

We also found that providers had tailored their training to the individual needs of people using services in areas such as learning disability and dementia. In these services, the culture enabled staff to feel able to request training. This resulted in staff showing high levels of competence, for example on implementing the practice of ‘redirection’ in dementia care:

In instances where people became anxious or distressed, staff fully understood the needs of the person, enabling them to offer personalised care. A member of staff told us, “I’ve had dementia training with the company, where I learned about redirection when someone is confused. They gave us lots of examples, and I use redirection daily. For example, a person I support says “see my mum, see my mum”, I change what they’re doing, talk about something else, or switch the TV over. It’s all about engaging. They love Songs of Praise, and we sing the hymns together, clapping and singing along.”

(From a CQC inspection report)

In contrast, many services we rated as inadequate for the safe key question did not always ensure staff had the necessary skills, knowledge or competence to safely meet people’s needs. Training was often incomplete, not aligned to people’s needs, or not translated into safe practice. This meant people were at risk of unsafe care and avoidable harm, as staff did not always have the knowledge or skills required. Evidence of this includes outcomes such as wounds going unnoticed, incorrect medicines being administered, and people being supported by staff who could not explain basic safety concepts, such as diabetes risks.

Across the inspection reports for services rated as inadequate for the safe key question, there were gaps in core and specialist training. For example, in one service, 19 staff had not completed training in preventing pressure ulcers, including 5 of the 6 staff caring for a person whose wound had gone unnoticed, placing them at risk of avoidable harm. In another service, none of the agency staff had received dementia training, despite the majority of people at the service living with dementia. Similarly, training gaps were identified in key areas such as epilepsy, diabetes, dysphagia and positive behaviour support, with one example where “only 6 out of 21 staff had completed epilepsy training despite multiple residents having epilepsy.”

In some cases, staff were undertaking care tasks without the required training or competence, placing people at risk of unsafe care, for example supporting people with their feeding tube, and a newly recruited care worker administering medicine before any recorded competency assessment was conducted. One member of staff at another service told us, “I have not received any training... but I have to show the new staff what to do.”

In contrast, a homecare service we rated as outstanding for the safe key question ensured that staff had suitable levels of training by using a “digital safeguard” on their rostering system, which ensured that before staff were allocated to people using the service, they had relevant training to the person’s specific, specialist needs.

The [Oliver McGowan Code of Practice](#) provides guidance to providers about how to organise training in learning disability and autism, including putting learning into practice. Many providers we speak with have accessed and achieved the e-learning element of training in learning disability and autism. We have seen some innovative and positive examples of providers working hard to ensure staff are able to meet the specific needs of autistic people and people with a learning disability who use their service.

However, there is still more to do. Not all providers are actively seeking appropriate training for their staff despite this being a requirement under Regulation 18 of the Health and Social Care Act 2008. This endangers the outcomes and wellbeing of autistic people and people with a learning disability who receive care from those services.

We will continue to use our inspections to assess the quality of training and competence of staff to deliver safe care in all settings.

Adult social care and the wider system

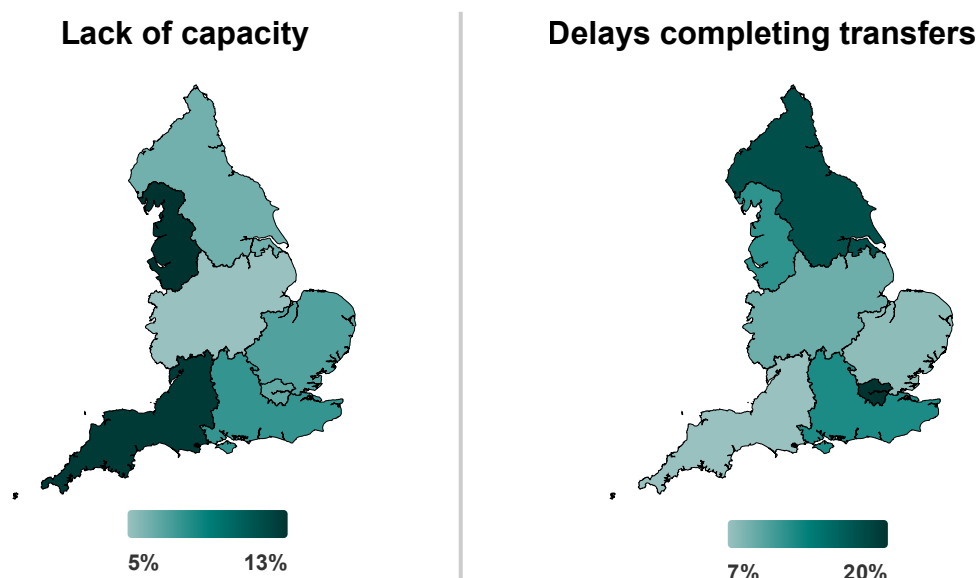
Causes of delayed discharges from hospital

In our previous State of Care reports, we have highlighted the pressures in adult social care that lead to further pressures in the wider health and care system. Data from [NHS England](#) on delayed discharges from acute hospitals show that in 2025/26, around 1 in 8 (12%) people who had been in hospital for 14 days or longer and were ready to be discharged were delayed due to a lack of capacity in social care services – amounting to nearly 1,000 people on average each day (see section on Ongoing issues with discharge from hospital).

Most of these delays were due to a lack of suitable places in care homes, accounting for 8% of delayed discharges nationally. The North West and South West areas of England had the most hospital discharge delays due to a lack of available care home beds (both at 13%) (figure 16). Notably, the South West has the second lowest (after London) number of care home beds per 100,000 people aged 65 and over, and the number of beds per older population has fallen there by 13% over the last 7 years.

Figure 16: Care home capacity is a bigger barrier to hospital discharge in the North West and South West, while delays completing transfers to social care are more common in London

Proportion of delayed hospital discharges of people who had been in hospital for 14 days or longer (2025/26) by cause



Source: NHS England, [Acute discharge situation report](#)

Another 12% of delayed discharges in 2025/26, for people who had been in hospital for 14 days or longer, were because transfer arrangements between hospitals and social care services were still being negotiated. This is equivalent to delays for an average of nearly 1,100 people each day. The inefficient system working between hospitals and social care services was most prevalent in London, where 1 in 5 delayed hospital discharges (20%) in the year were because of delays in completing transfers between hospitals and social care services, the majority of which (13%) related to the interface between hospitals and care homes (figure 16).

In our [Learning from Independent Care \(Education\) and Treatment Reviews in 2024 and 2025](#) report, we identified that poor discharge planning and a lack of joined-up system working were also exacerbating delays in discharging autistic people and people with a learning disability from mental health hospitals into community-based care.

Understanding and working to break down the barriers to hospital discharge for these groups of people is a key area of focus for us as we continue to lead on the programme of IC(E)TRs over the next 2 years. We discuss the programme and impact on people in the [Focus on restrictive practices](#) section of this report.

System partnership and collaboration

Despite the impact of poor transfer arrangements between hospitals and adult social care, we have seen examples of good partnership working between adult social care and the wider health and care system.

We undertook an analysis of our assessment data for adult social care services assessed under our current assessment framework since January 2024, looking specifically at the quality statements under the well-led key question. We found that services were performing well in 84% of assessments that looked at the partnerships and communities quality statement. This quality statement checks whether services understand their duty to collaborate and work in partnership, and that they share information and learning to promote improvement and joined-up care.

Example of partnership and collaboration in an outstanding care home

The provider clearly understood and fulfilled its duty to collaborate effectively, working in partnership with others to ensure services operated seamlessly for people. Information and learning were consistently shared with partners to drive improvement, and collaboration was embedded across all areas of practice to enhance outcomes for people.

Partnership working with health and social care professionals was a clear strength. External professionals consistently described collaborative, outcome-focused relationships, with the service working routinely alongside GPs, district nurses, therapists and specialist teams. Professionals reported that leaders were receptive to feedback, responsive during quality visits and proactive in acting on recommendations, ensuring people received safe, well-coordinated and joined-up care. People were supported to remain connected to their community through strong links to local schools, faith groups, community organisations and events that promoted inclusion and reduced social isolation.

These partnerships ensured people experienced continuity of care, strong community belonging and opportunities to live full, connected lives, underpinned by a rights-based, partnership driven approach that consistently enhanced their wellbeing and quality of life.

The provider also maintained strong commissioning and system-level relationships. Local authority commissioners described a positive and proactive partnership, highlighting the service's willingness to innovate, engage constructively and sustain high standards in a challenging care market.

(From a CQC inspection report)

The emerging themes and findings from our assessments of local authorities in England with adult social care responsibilities showed how local authorities are playing an active leadership role across systems. Our report (see below) highlighted the importance of the quality of partnerships in an area, and how some people will be experiencing the positive benefits of living in a place where the voice of adult social care is respected and understood. Through these assessments, we found that the partnerships and communities quality statement had the highest combined percentage of local authorities that were scored at a good (74%) and exceptional standard (7%).

Local authority baseline assessments – 2024 to 2026

In July this year, we published our report, Local authority assessments 2023 to 2026: Emerging themes and findings, which drew together findings from the first-ever national programme of assessments of the performance of local authorities in England with adult social care responsibilities.¹⁵ The programme, which began in December 2023, assessed how local authorities are delivering their adult social care duties under Part 1 of the Care Act (2014). The report provides the most comprehensive picture of how local authorities are managing the needs of people who use adult social care services across England.

Since publishing the report in July 2026, we have updated the figures. As at the end of August 2026, based on the 152 assessment reports published, we found that local authorities are broadly performing well in the face of significant challenges, with:

- 59% rated as good
- 37% rated as requires improvement
- 3% rated as outstanding
- 2% rated as inadequate.

Although the majority of local authorities were rated as good, there were still areas that needed to improve, which caused most ratings to be at the lower end of the scoring threshold for good, suggesting they are still relatively far away from being outstanding.

Over three-quarters of local authorities achieved the lower scores of 1 or 2 for how they assess people's needs, mainly because of the delays experienced by people, including unpaid carers, in receiving an initial assessment and a timely review of their needs.

We also found there is no statistically significant relationship between the average Index of Multiple Deprivation scores for local authorities and their overall ratings. This means there is no clear link between the performance of a local authority in delivering its Care Act responsibilities and the level of deprivation.

We used our analysis and the experiences of inspectors throughout the baseline assessment activity to highlight a number of key themes throughout this report.

Prevention

Local authorities broadly understood the value of an effective and consistent preventative approach. Partnership working, particularly with voluntary, community, faith and social enterprise organisations, was key to this.

However, they were not always able to show how they were implementing this approach and the impact on people:

- There was limited evidence of how local authorities were using outcome tracking or population-level evaluation to monitor the impact of preventative activity.
- Gaps in the provision of enablement and reablement services have a significant impact on people's outcomes, and mean that people are not always supported to regain or maintain their independence.
- Prevention of mental ill-health is far less developed than prevention for physical health.
- Poorly-designed prevention pathways risk widening inequality, particularly where they disproportionately exclude people who are least able to navigate services.
- Prevention is often framed in the context of hospital discharge within local authorities, rather than through proactive, community-based early intervention.

Safeguarding

Where there were effective partnership arrangements for safeguarding, local authorities were able to carry out enquiries promptly that were sensitive to individual needs, wishes and best interests.

Where we considered low waiting times to be credible and indicative of positive outcomes for people, the enabling factors included skilled decision making at the 'front door' (first point of contact), effective multidisciplinary working and clear escalation routes.

However, low waiting times did not automatically indicate quality. Where meeting the 28-day threshold for safeguarding enquiries was prioritised over thoroughness, the quality of investigations could be poor. This could lead to poorer outcomes for people.

We found systemic weaknesses in governance, oversight and assurance of safeguarding:

- While some people felt listened to and involved in the safeguarding process, this was not the case for everyone.
- There was variation in local authorities' understanding of safeguarding concerns and whether a concern met the threshold for a section 42 enquiry.
- The effectiveness of multi-agency working varied, with issues around sharing information with partners on the outcomes of safeguarding referrals.
- Safeguarding Adult Reviews were not used enough as system assurance tools. Without greater consistency and external scrutiny, their ability to prevent recurrence remained limited.

Both the safeguarding and the assessing needs quality statements received the most number of lowest scores, with 8 local authorities (5%) scoring 1. Improvements are needed in how local authorities discharge their responsibilities for safeguarding under the Care Act (2014).

Transitions from children's to adult services

Transitions from children's to adult services were consistently identified as one of the most challenging areas and a persistent area of risk. This meant people's experience and the quality of care varied across, and even within, local authorities.

The National Institute for Health and Care Excellence quality standard (QS140) states that planning for transition should start by school year 9 (age 13 to 14). While some local authorities achieved this goal, in others planning did not start at the recommended age.

Poor transition planning has a negative impact on young people and their families. It can also be a safeguarding risk, with the lack of early contact and unclear accountability contributing to crisis-driven referrals and poorer outcomes for young adults and their families.

Clear communication and ensuring that young people and their families and carers knew what to expect when moving out of child services was essential to a successful transition. This involved supporting families through the process of moving from a focus on the ability of a young person's family to provide care, to supporting a young adult to be independent. However, communications about transitions varied, with young people and families raising concerns about the quality of communication.

The transition process ran more smoothly when local authority teams worked well together – both within the local authority and with their partners. However, many inspectors described children's services and adult services working in isolation, with unclear lines of responsibility and limited shared ownership.

Unpaid carers

Unpaid carers are less satisfied with the services and support they receive than the wider cohort of people using services.

Our report highlighted identification of carers as the biggest challenge, as well as inconsistent access to support, with language seen as a significant barrier. Terms such as "hidden carer", "respite", and "eligible needs" were described as masking risk, normalising burnout and implicitly placing responsibility on individuals rather than on systems. Many carers do not recognise themselves within the language used by the system, because they are not paid or they may feel that it is their 'duty' to care for their family member. Partnerships with the voluntary and community sector are a vital way of identifying carers.

Access to assessments for carers varied, and carers often described long delays, with some not being offered an assessment at all, and feeling "forgotten about".

Some unpaid carers valued when their local authority tailored its approach to support their needs. However, some local authorities failed to assess and monitor carers' individual needs, and there was an enduring cultural tendency to view carers "as extensions of the person receiving care and support", rather than individuals who have needs of their own.

A personal story – experiences of family carers

As Sylvia's Alzheimer's disease progressed, her sister Alison and her family were left to carry an increasing amount of responsibility because support was delayed, inconsistent, or unavailable. After a long wait, the family secured support from a homecare company, but concerns about the quality of care and communication led them to "lose faith" in the service.

Sylvia needed 24-hour care. Although a residential place was found, it proved unable to manage her complex needs and so her family chose to take on her care, keeping her in her own home – somewhere familiar to her. Most of her care was provided by her daughter, Catherine, who left her job to take care of her mum. She was supported by her siblings and Alison, all of them taking time away from work, family life and their free leisure time, to help. The family did their best to navigate the physical and emotional toll on them all of caring for Sylvia day and night, but stresses started to creep in. Catherine bore the brunt of this as she was more isolated as the primary carer, navigating increasingly unpredictable routines and sleepless nights as Sylvia woke many times each night. Although Sylvia eventually received a comprehensive package of care, the family continue to provide most of Sylvia's care.

In addition to caring, Alison took on the role of managing Sylvia's care package and budget. Each month she reviews and submits care workers' timesheets, processes invoices from care companies, liaises with social workers and care companies, and challenges poor practice to ensure that Sylvia receives the best possible care. This also includes co-ordinating the family's time to ensure that Sylvia is always cared for, balanced with legislative requirements for time off and holidays. Alison interviewed each personal assistant herself in a small, personally developed induction, introduced them to Sylvia and the wider family, explained Sylvia's likes and dislikes, and shared techniques for helping her when she became anxious.

Alison and Catherine have had to learn to use the electronic record system that the care workers use to update district nurses on any relevant work that the service has carried out and vice versa.

Alison described managing Sylvia's care as "like having a little company". Alongside travelling considerable distances to support her sister several times a week, she acts as the main source of knowledge and co-ordination for the family and professionals involved in Sylvia's care.

(Interview with a member of the public)

Equity in experience and outcomes

We found strong intent around equality, diversity and inclusion within local authorities, but weaker evidence of strategic action or measurable impact. Local authorities that were managing equalities well understood their communities and had well-resourced co-produced strategies and action plans on how they could tackle inequality. However:

- Data was not consistently used in an evidence-based way to tackle risks and inequalities or improve performance and outcomes for people.
- There was often a failure to use the knowledge of people whose voices are seldom heard and people with intersecting needs to drive effective commissioning to reduce inequalities.
- Local authority staff involved in carrying out Care Act duties had varied levels of understanding about people's needs.

There was not always equality of provision and access to care and support. We saw disparities in waiting times and access to support for people with a learning disability, autistic people, people with complex mental health needs and people with sensory needs. These were often accepted as operational realities rather than recognised as equity issues.

Co-production

Coproduction was most effective:

- where it is embedded and aligned with decision-making, leading to clear and measurable improvements
- where leadership, commissioning and funding decisions in local authorities were driven by input from people with lived experience.

Partnerships with voluntary, community, faith and social enterprise organisations supported more effective co-production, particularly in reaching groups whose voices are seldom heard.

Commissioning

We found significant variation in commissioning practice across England.

- Inconsistent fee-setting, failure to account for workforce pressures and weak provider engagement directly constrains quality and sustainability, particularly in carers' and preventative services.
- We found wide variation in the criteria to determine whether people were able to access services, shaped by financial or political considerations rather than people's assessed need.
- Provision of specialist sensory services was often not commissioned locally or was fragmented across providers, resulting in people travelling significant distances for basic support, which resulted in inequalities.

After the quality statement on assessing needs, performance against the care provision quality statement, which assesses commissioning, was one of the 2 quality statements most likely to be scored the lower scores of 1 or 2.



Mental health care

Mental health care

Key points

- Pressure on mental health services across the care pathway has continued to rise in 2025/26. The number of people in contact with community mental health services has increased by 34% over the past 3 years. This pressure is being compounded by more people with severe mental illness accessing care.
- As demand for care increases, we continue to see that people who live in the most deprived areas and people in ethnic minority groups have greater levels of need and contact with mental health services. But not everyone is able to access the care they need when they need it. Long waiting times remain a concern and we are particularly concerned about children and young people.
- The way community mental health services are commissioned and delivered is changing. Positively, providers have told us about working more closely with the voluntary, community, faith and social enterprise sector to deliver care in the community, but a lack of national standards and guidance is leading to a patchwork of different service models.
- People in crisis still struggle to access appropriate care and support when they need it, with only 25% of very urgent referrals receiving care within 4 hours. Those seeking help from urgent and emergency care services also face long waits for assessment by psychiatric liaison services, though this has improved over the last 2 years.
- For people admitted to hospital, we remain concerned about the risks created by the physical environment of mental health wards, and impact of challenges with staffing levels and capacity. However, we have seen examples of providers listening and responding to feedback to improve environments.
- A lack of community placements, incomplete information sharing, or poor representation from social care at planning meetings are creating challenges with discharging patients from secondary mental health services into the community. When systems don't work together to support people to access community care, they remain an inpatient for longer, increasing the risk of relapse or readmission.
- After being discharged, we are concerned that people with complex needs who present with high risks are being lost in the system and not receiving appropriate support, including specific groups who are more likely to disengage with services or those whose voices are seldom heard.
- We continue to be concerned about the use of restrictive practice, particularly for autistic people and people with a learning disability. Our Independent Care (Education) and Treatment Reviews highlight the importance of person-centred, trauma-informed care, and how skills and knowledge of staff can have a direct impact on the quality of care.

Access to mental health care

Rising demand for community mental health services

The pressure on mental health services has continued to rise in 2025/26, with increasing numbers of people needing support from services across the mental health pathway. Between 2024/25 and 2025/26, the average monthly number of referrals to secondary mental health services increased by 7% from 453,930 to 483,797, which is more than the increase of 6% we saw in the previous year (2023/24 to 2024/25).

In community mental health, the number of people with open referrals to services has also risen by 34% over the last 3 years, from 1.6 million on average each month in 2022/23 to 2.2 million each month in 2025/26. A 'contact' is defined as a care contact resulting from a referral, such as a face-to-face appointment, phone call, or home visit. The number of these contacts during the same period has also increased by 26%, from 2.3 million on average each month in 2022/23 to 2.9 million a month in 2025/26.

Since 2023, there has also been a steady rise in the numbers of people with severe mental illness who are accessing community mental health services. Severe mental illness refers to a group of conditions, including schizophrenia and bipolar disorder, whereby people's ability to engage in functional and occupational activities is severely impaired. People with severe mental illness experience some of the widest health inequalities in England – guidance from NHS England highlights that their life expectancy is 15 to 20 years shorter than that of the general population, and that the gap is widening.¹⁶

Between 2024/25 and 2025/26, the average number of people each month with severe mental illness who were accessing community mental health services for adults, and who had at least 2 care contacts in the previous year, rose by 6% from 640,619 to 681,149. This places additional pressure on community mental health services, given the complexity of care that is required to support people with severe mental illness.

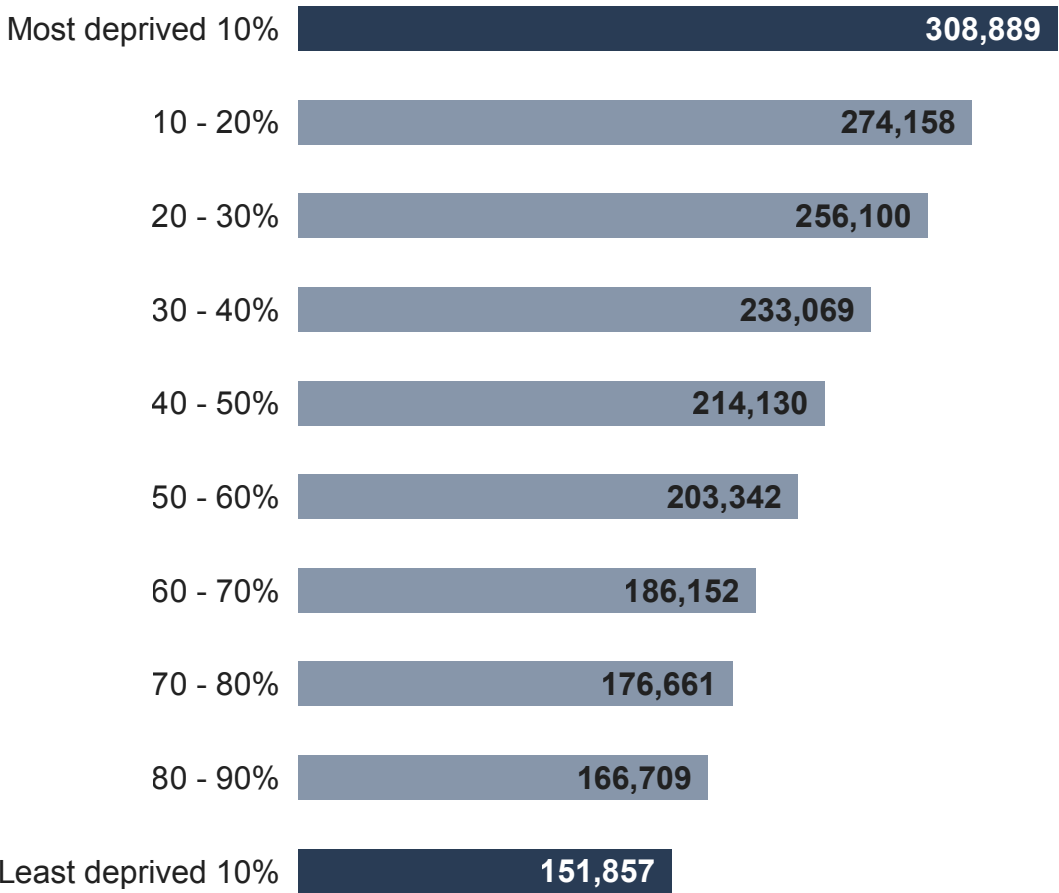
Although there is an increase in both the numbers of people and contacts in community mental health services, it is not rising at the same rate. The average number of contacts for each person has decreased from 1.4 per person in 2022/23 to 1.3 in 2025/26. The reasons for this could include more people presenting with less severe needs, or people being referred inappropriately to community services. However, it could also reflect that staff are having to support more people and/or people are potentially not getting the care they need.

As demand for services increases, we continue to see that people who live in the areas with most deprivation have greater levels of need and more contact with mental health services. In 2025/26, each month an average of 308,889 people in the most deprived population decile had open referrals to community mental health services. This is double

the amount of people in the least deprived decile, where on average 151,857 people had open referrals with services per month (figure 17).

Figure 17: **The most deprived areas have twice the rate of community mental health service open referrals than least deprived**

People with open referrals to community mental health service by deprivation decile, 2025/26



Source: NHS England, [Mental Health Services Data Set](#)

Data from 2024/25 shows that people with severe mental illness in the most deprived decile were over twice as likely to have accessed community mental health services at least twice in the previous year compared with those in the least deprived decile.

Similarly, we see inequality in care for people from ethnic minority groups, with highest rates for people with open referrals to services from the groups ‘any other mixed background’, ‘any other ethnic group’ and ‘any other Black background’.

Increasing need for mental health care can add to the pressure on services and could lead to ineffective care, or even to care not being given at all to those who need it. As well as creating a safety concern, not having the capacity to meet this increasing need risks widening inequalities.

Long waits for community mental health care

As reported in last year's State of Care, alongside increasing demand for services, people are still waiting too long to receive the care they need from community mental health teams. Results from the [2025 Community mental health survey](#) show that 39% of respondents felt the waiting time was too long between their assessment and first appointment for treatment. Where referrals remain open for extended periods without contact, there is an increased risk that changes in people's needs may not be identified or appropriately supported quickly enough. This could potentially result in unmet needs and increased safeguarding risks.

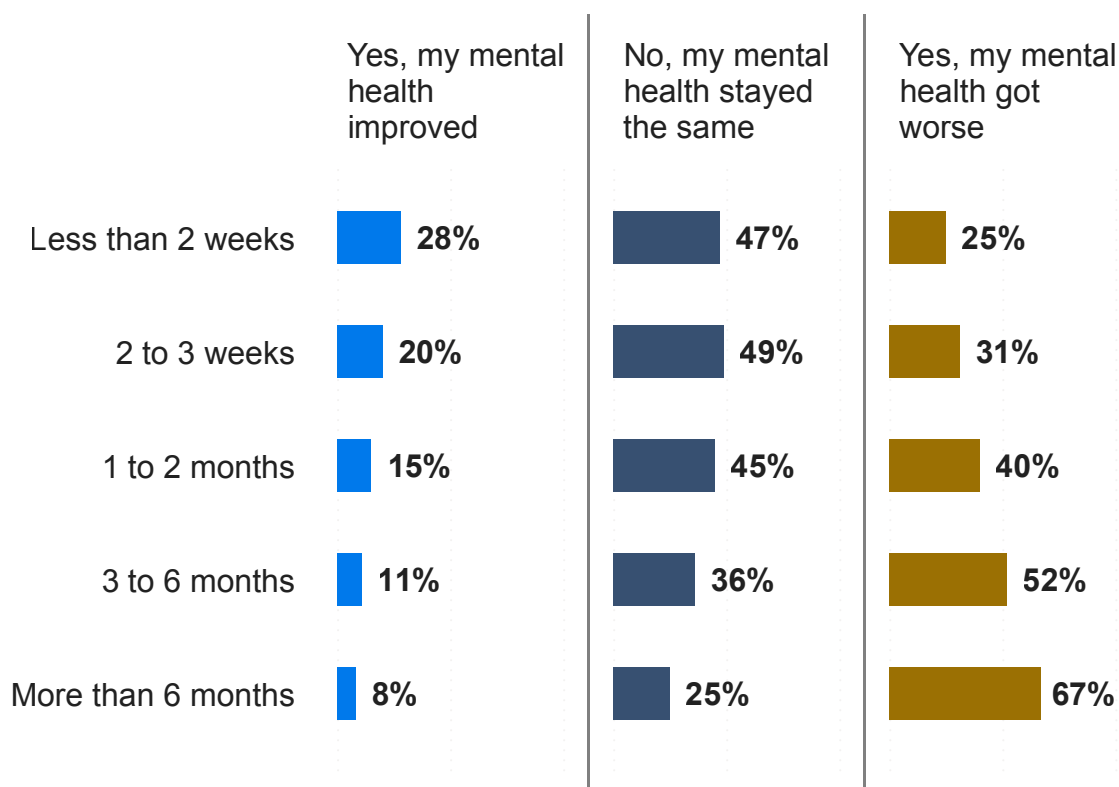
Longer waiting times also increase the likelihood of people's mental health getting worse, potentially leading to them reaching crisis point or needing more intensive interventions later on. Results from the 2025 Community mental health survey found 67% of respondents who had waited more than 6 months said their mental health got worse while they waited, compared with a quarter (25%) of people who waited less than 2 weeks (figure 18). This was worse for respondents who had a disability, with nearly half (46%) reporting that their mental health deteriorated while waiting compared with those who did not have a disability (26%). One respondent described the impact of their long wait in the free text comments:

"Once I was under the care of CAMHS I felt I had the right team around me but it took 6 months to get this ... I got increasingly more ill until I was in a catatonic state before I finally was admitted under hospital care... Too many hoops to jump through whilst I was getting progressively more unwell."

(Respondent to the 2025 Community mental health survey)

Figure 18: Longer waits are associated with worse mental health outcomes

Self-reported mental health outcomes by waiting time for community mental health services in 2025



Source: CQC, [Community mental health survey](#)

Changing models for delivering care in the community

We continue to hear mixed feedback about changes to the way community mental health services are being commissioned and delivered, and the impact this is having on people. This is against the backdrop of more people with mental health needs and people finding it harder to access the services they need when they need them.

As part of our comprehensive programme of inspections of community mental health services for working-age adults, and crisis care we held engagement events with providers in late 2024. At the events, providers told us they were concerned about a lack of national guidance and standards for adult community mental health services. There were particular concerns about a lack of guidance around safe staffing levels, medicines management, caseload management, and a lack of focus on a proactive and longer-term approach to preventative care and recovery.

At our events in 2025, attendees again described the challenges facing community mental health services, and highlighted how there is no single model for delivering community mental health services in England. Providers described how they often felt that they were left to interpret national guidance alone, resulting in them “going off

in different directions”. We heard this was leading to a patchwork of different service models, which varied widely depending on geography, demographics, commissioning arrangements, and workforce capacity. While some local variation allows providers to respond to different needs, there is a risk that variation driven by lack of national agreement on the most effective service models may contribute to inequalities in people’s access to care, experiences and outcomes.

However, to ensure they are meeting the needs of their local populations, providers told us that they are developing models of care that are responsive to these needs, including neighbourhood and place-based models of care. The aim of these models is to bring care closer to where their local population lives, often with walk-in access, extended hours, and co-located partners, such as the voluntary, community, faith and social enterprise (VCFSE) sector. For example, one attendee described how many of their VCFSE partners worked in the same building in a small rural town, which made it easier for people to access services at the hub. As well as being able to access VCFSE services, there were also a small number of beds at the hub to help people avoid hospital admission.

Other providers highlighted how working with the VCFSE sector was helping them to identify and meet the needs of people from different ethnic groups. For example, one attendee described how they had contracted the VCFSE sector to provide walk-in services on high streets, with the stipulation that the diversity of the local population must be reflected in the diversity of VCFSE staff. The attendee said that this decision had been successful and has changed the profile of people using the walk-in centres, including Black men. Following this, the provider was looking to ask the VCFSE organisation to introduce a Black family carers group.

This is supported by evidence from our inspections of adult community mental health services. For example, at one service, staff told us how they were working with their local community to remove barriers and improve access to services:

“... the trust worked with a local charity to address mental health inequalities faced by the South Asian community... The project sought to address mental health inequality and inequity, by ensuring the South Asian population ... were equipped with the knowledge, resources, and community support to address their mental health issues, and have equitable access to mental health services where needed.”

(From an inspection report for community-based mental health service for adults of working age)

However, a couple of providers told us that it was difficult to ‘scale up’ successful pilots. They described how many models of care are resource-intensive and cannot be replicated across all localities without significant investment. This is supported by figures from NHS Providers’ State of the

Provider Sector Survey, which shows that 19% of mental health providers have de-prioritised spending on transformation initiatives, and a further 32% are considering doing so because of financial pressures.¹⁷ One provider at our engagement event also highlighted the risk that VCFSE-led hubs may attract people with lower-level needs, while those with severe mental illness remain disengaged or unreachable.

In May 2026, the government announced a call for evidence for the development of a new mental health strategy to support people with mental health conditions to live a full life and stay active in education, work, family life and their communities. The strategy is the next stage in the NHS 10-year plan and aims to transform care in England, driving the move towards prevention, and treating people earlier and faster in their local communities.

24/7 neighbourhood mental health centres

In July 2025, as part of its Quality Transformation Programme, 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 severe mental illness, such as schizophrenia or bipolar disorder, 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.

Attendees at our 2025 provider engagement events spoke about the transformation of crisis and urgent care, describing how changes have meant that people are able to self-present without going to the emergency department. The use of short-stay beds was also said to have helped reduce inpatient admissions at one NHS trust.

During our inspections of emergency departments and medical wards over the winter of 2025/26, we interviewed leaders in mental health trusts to discuss the adult acute pathway. We spoke with one trust that is a pilot trust for a 24/7 neighbourhood service. The trust described how it works closely with local partners including primary care and mental health partners in the VCFSE sector. No referral is needed, and people are not discharged from the service. Leaders at the service told us they hope the service makes it easier for people to get help by reducing the barriers to care. The trust reported seeing a reduction in its home treatment team caseloads, and described how access to 4 short stay beds is leading to positive outcomes as it gives staff more time to assess people.

In another trust, a provider told us how the integrated 24/7 urgent care walk in service it runs had supported people to get access to the service they needed quickly and reduced pressures on the emergency department. Leaders felt that co-locating health and social care works well and enables people to get quicker access to support.

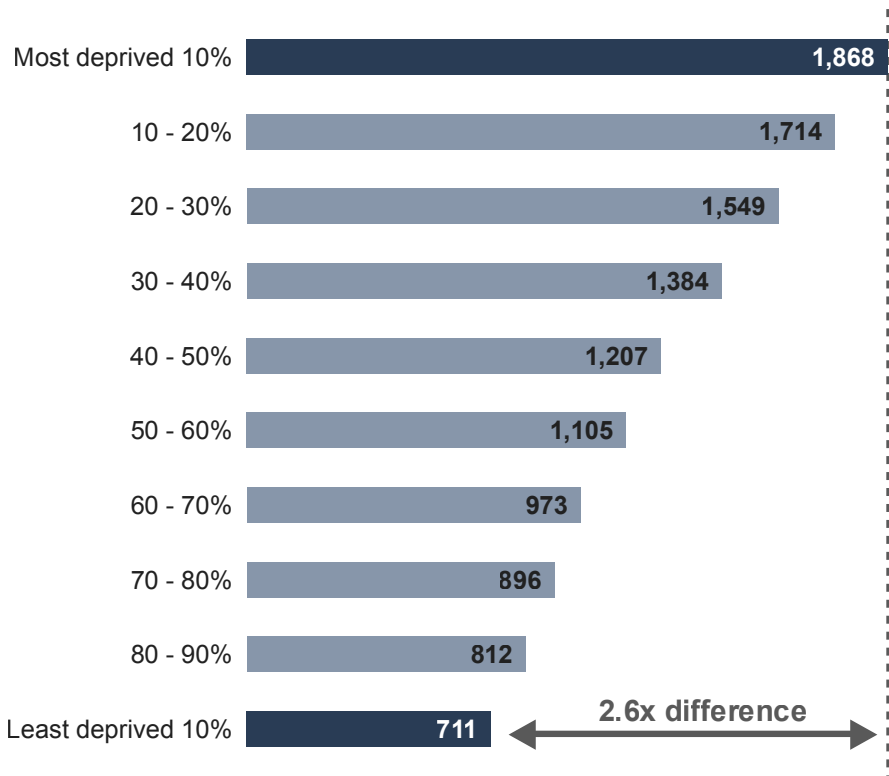
Tackling variation in access to care and health inequalities

Providers at our engagement event told us about their work to tackle variation in people’s access to care and health inequalities in their areas.

One specific area of concern for providers is meeting the needs of people living in more deprived areas. As noted above, people in this group have more needs than those in more affluent areas and their needs are also more likely to be more complex. In 2024/25, people living in the most deprived areas were 2.6 times more likely than people in the least deprived areas to have a severe mental illness and be accessing community mental health services. These people had at least 2 contacts with services in the previous year (rate of 1,868 per 100,000) compared with those in the least deprived area (rate of 711 per 100,000) (figure 19). This increases pressure on services, particularly where capacity and targeted support are insufficient, contributing to the widening of inequalities and poorer outcomes for people receiving services.

Figure 19: **People in the most deprived areas were 2.6 times more likely to access community mental health services at least twice a year**

Rates of people with a severe mental illness per 100,000 people accessing community mental health services at least twice in the previous year, by deprivation level, 2024/25.



Source: NHS England, [Mental Health Bulletin](#)

Some attendees described the challenges they faced operating in a region with areas of both affluence and deprivation, and the steps they were taking to make sure services were accessible to all. One provider described the differences within deprived areas, such as high rates of suicide in one area and people aged in their 40s who were living with frailty in another area. These providers have divided their trusts into separate areas, implementing their models of care differently in each area to better meet the needs of the population in those deprived areas.

Providers also highlighted Black men as a group who are disproportionately affected, because they are not accessing services, and are ultimately being subject to more restrictive practices. As we reported in last year's *State of Care*, stigma can be a barrier for Black men in seeking help, disclosing symptoms and engaging with medicine – in terms of both the way communities often viewed mental illness as a sign of weakness or shame, and people's past experiences that have led to distrust in services. Differing cultural beliefs and practices related to mental health and wellbeing can also lead to misunderstandings and misdiagnoses.

One attendee at our provider engagement events described the challenges of engaging Black people who use services in its region, which lacks a major urban centre. Describing its Black community as dispersed, the attendee said they were working with church groups and relevant community organisations to improve the accessibility of their mental health services.

Providers also shared their progress in implementing the Patient and Carer Race Equality Framework (PCREF). For example, one attendee described how their team is conducting in-reach work in Afro-Caribbean hairdressers as part of its PCREF and quality improvement work. Many attendees discussed how they used data and insight to identify inequalities and deliver services more effectively, using tools to generate insights about demographic groups as well as capture protected characteristics and identify any gaps in services.

However, some providers expressed a need to improve analysis and reporting processes, to enable a better understanding of their data.

This feedback is supported by early findings from our inspections of adult community mental health services, which have found variability in the progress around PCREF. Some of the trusts we inspected had published their self-assessment against PCREF and subsequent action plans, which included evidence of involving people with lived experience, communities and staff with their work, or they had embedded PCREF within their governance frameworks. We will continue to encourage services to embed PCREF through our regulatory and monitoring activity, and will be checking how services use the framework as evidence to inform our assessments.

Examples of progress we have seen through our adult community mental health inspections include one provider that had worked with Black Heritage Community organisations to support it to implement

PCREF. Staff at another provider had improved their data collection on protected characteristics for patient experience and outcomes, including complaints, waiting times and admissions to services. Another trust worked with a neighbouring trust on implementing PCREF across its area and had participated in community engagement events to reduce racial inequalities. This trust had received praise from NHS England for its progress, particularly in the development of a local dashboard to help monitor inequalities.

As an organisation, we are committed to improving quality for everyone using health and care services. To better understand how providers are addressing inequalities, we will be continuing to improve how we understand equity, human rights and inequalities within local contexts. In mental health services, this includes aligning with principles in the Patient and Carer Race Equality Framework (PCREF).

Secondary mental health care

Access to crisis care

When patients deteriorate into crisis, they should enter the emergency mental health pathway whether or not they are already known to community mental health services. Through our interviews with leaders of mental health trusts during inspections of emergency departments and medical wards over winter, we found that people are not always able to access crisis support when they need it. For example, one trust noted that it was not sufficiently funded to provide a home treatment crisis response in the evenings.

The crisis care standards from the Royal College of Psychiatrists state that the most urgent patient referrals should be seen face-to-face within 4 hours of referral and urgent referrals should be seen within 24 hours. Referral times have improved over the last year:

- 25% of very urgent referrals received care within 4 hours, compared with 20% in 2024/25
- 18% of urgent referrals were seen in 24 hours compared with 17% in 2024/25.

However, they are still well below the required standards. The Royal College of Psychiatrists has been clear that not meeting these standards creates a significant threat to patients' safety, rights or dignity.

This is supported by the findings from the 2025 Community mental health survey. This found that of the respondents who said they knew who to contact out of office hours and had attempted to make contact, a fifth (20%) said they waited too long to get through to someone, and 5% said they were unable to get through at all. Of the people who said they had attempted to make contact, 32% did not receive the help they needed and of those who would have liked their family or carer to receive support, 45% said that the NHS mental health team did not provide them with support or information.

To help people in crisis get help quicker, NHS 111 introduced a new dedicated service for people experiencing a mental health crisis in April 2024. In the first year, the service received 1.9 million mental health calls. Over the last year, this increased by 7.6%, to 2.1 million calls. However, more than 1 in 4 calls (26.4%, over 521,000) were abandoned before they were answered, and on average people had to wait 3 minutes 43 seconds for their call to be answered. These figures are significantly below the abandoned call standard of 3% or less, and well below the standard of 20 seconds or less for the average time to answer calls. They are also substantially worse than the overall NHS 111 calls average, with 3.2% of calls abandoned and an average call answer time of 54 seconds (see also section on urgent and emergency care).

As we consistently report in State of Care, when people cannot get the care they need when they need it in the community, they may end up in urgent and emergency care. In March 2026, there were 1.5 million reported attendances to type 1 and 2 emergency departments in England (see section on urgent and emergency care). Over 43,000 of those attendances were identified as mental health-related attendances.

In its January 2026 Quality Watch report, the Nuffield Trust reported that between April 2024 and March 2025, people presenting with mental health needs at urgent and emergency care departments have increasingly complex needs, with 50% of these presentations involving self-injurious and/or suicidal intent and 34% involving complex behaviour and hallucinations.¹⁸

To help people get help earlier and closer to home when they are struggling with their mental health, the government announced the opening of 159 new NHS mental health facilities across England in August 2026. Backed by £343 million, the rollout includes 59 dedicated mental health emergency departments to help people in crisis access specialist care in a place designed for them. It also includes 100 new community mental health centres offering walk-in support without a referral.¹⁹

Psychiatric liaison services in emergency departments

Once in hospital, people often face long waits for assessment by psychiatric liaison services (including assessment under the Mental Health Act 1983), treatment and discharge. Data from NHS England shows that in March 2026, 8% of mental health attendances at emergency departments lasted longer than 24 hours. That equates to 3,323 people.

A psychiatric liaison team should respond to referrals for anyone who arrives at an emergency department with a mental health need within 1 hour. Over the last 3 years, data from NHS England shows a year-on-year improvement in the number of adults (aged 18 and over) seen within waiting time standards following referral to psychiatric liaison services, rising from 48% seen in 1 hour in 2023/24 to 56% in 2025/26. The picture is similar for children (aged under 18), which has improved

from 37% referred to psychiatric liaison services and seen in 1 hour in 2023/24 to 45% in 2025/26. However, this still means that nearly half of adults, and over half of children, who need this care are not getting it quickly enough.

As part of our inspections of emergency departments and medical wards carried out over winter 2025/26, we found that most trusts could not always complete initial assessment and arrange admission or packages of care within 12 hours of arrival for people with mental health needs.

During these inspections, our interviews with mental health trusts revealed that some psychiatric liaison teams did not have enough funding to respond to all requests promptly. Some of the leaders we spoke with noted that psychiatric liaison models did not meet people's current needs, and one trust was considering increasing the amount of psychiatry provision.

We found similar concerns relating to psychiatry provision in our analysis of data from Learning from Patient Safety Events (LfPSE), as some incident reports raised concerns around staffing shortages in psychiatric liaison services and a lack of cover. For example, one provider had noted that assessments were either not happening or that they were unable to complete them because of shortages of liaison psychiatry staff. The LfPSE analysis also highlighted some concerns around the responsiveness or willingness of liaison psychiatry to review some patients. For example, one service reported a delay of more than 6 hours for a patient for their first contact with liaison psychiatry. In a few other instances, liaison psychiatry had declined a referral or failed to respond to an urgent referral.

During our engagement events with providers, we heard about the work with psychiatric liaison services to improve transitions between urgent and emergency care and community or crisis services. For example, one attendee described how the psychiatric liaison service was auditing who attends urgent and emergency care. They use this work to better understand where people move to after they have visited urgent and emergency care and how community mental health teams can work better with urgent and emergency care. One attendee highlighted how their work had reduced some of the delays for people sitting in urgent and emergency care.

Impact of pressures on mental health inpatient beds

Our analysis of inspection reports in urgent and emergency care found that long waits in urgent and emergency care were often linked to difficulties securing appropriate mental health inpatient beds. While some mental health trusts were working with partner organisations to improve people's access to suitable mental health placements, all trusts we spoke with in our interviews described having daily relentless pressure on their beds, with most reporting on bed occupancies that were at, or near to, 100% capacity.

This finding is backed up by data from NHS England, which shows that between 2022/23 and 2025/26, the average number of available overnight mental health beds fell by 1.5% (from 18,139 in 2022/23 to 17,870 in 2025/26). During this time, occupancy has remained above the 85% standard recommended by the Royal College of Psychiatrists in each year, standing at 89% in 2025/26 (down from a peak of 90% in 2022/23). At the quarterly level, when looking at data from 2023/24, occupancy has never gone below 89%, indicating sustained pressure on inpatient bed capacity. The lack of beds can lead to people facing delays in getting access to mental health beds and having to stay longer in urgent and emergency care.

The length of time people wait in urgent and emergency care varies across the country. In our inspections over the winter of 2025/26, inspectors in London and the South-East found that some people with mental health needs were waiting several days in emergency departments. At one location, a patient had waited 6 days.

Such long waits can lead people's condition to deteriorate, as we found in our analysis of Learning from Patient Safety Events (LfPSE) data. For example, a patient in one service had been in the emergency department for 39 hours because they were waiting for a Mental Health Act assessment. The LfPSE report warned of potential further episodes of distress for this patient, which would require them to be sedated. At another service, a patient with a history of violence and aggression threatened to cause harm either to themselves or others if they had to continue waiting.

The following free text comment from the 2025 Community mental health survey shows the impact of long waits on people:

"My time in A&E was awful. I waited and slept on armchairs for 2 nights before I was given a bed, when I was experiencing psychosis due to stress and lack of sleep."

(Respondent to 2025 Community mental health survey)

Lengthy waits for care can also increase the risk of people leaving before receiving the care they need. In its investigation report Mental health crisis care: legislative challenges in emergency departments, the Health Services Safety Investigations Body (HSSIB) highlights a lack of clear legal powers to lawfully prevent vulnerable people from leaving the emergency department while waiting for an assessment or admission to hospital. The report states that this exposes patients to increased risk and puts staff in a position of uncertainty when attempting to manage safety. It can also be exacerbated by prolonged delays in Mental Health Act assessments and unavailability of mental health inpatient beds.²⁰

Many LfPSE incidents showed people leaving or absconding without being seen or assessed, or before being allocated a mental health bed. This was supported by evidence from our inspections over the winter of 2025/26, where staff in emergency departments and medical wards told us they had seen an increase in people leaving departments before assessments had been completed. At one location, more than 30 people with mental health needs had left the department in the last 6 months.

Our inspections have found that children and young people often had long waits before being assessed by child and adolescent mental health services. Assessment support was usually provided by child and adolescent mental health community services, which could cover large geographical areas and more than one emergency department. This meant that staff often took a longer time to attend. Out-of-hours adult psychiatric liaison teams often provided cover, but this meant children and young people often waited until the morning to be assessed.

This reflects concerns highlighted by the Royal College of Nursing, which reported on the increase in the number of children presenting at urgent and emergency care in crisis, and concerns about the number of children waiting over 12 hours in urgent and emergency care before being admitted to a mental health unit.

Providers at our engagement events for the adult community mental health programme told us how these young people, as well as adults, were sometimes at risk of being discharged without being followed up and then re-presenting in crisis. They suggested that strengthening pathways for early intervention and post-discharge support was essential to reduce readmissions.

Out-of-area placements

The pressures on availability of beds continue to result in people being placed in a service outside of their local area. We highlighted this issue in our 2024/25 Monitoring the Mental Health Act (MHA) annual report, and have raised this concern previously. Being placed out of area can be isolating and makes it harder for people to have regular contact with friends and family, which can have a significant impact on their care and recovery.

In 2016, the government set out its ambition to eliminate inappropriate out of area placements in mental health services for adults in acute inpatient care by 2020/21. Again, this is not a new issue and our ongoing concern is that, despite this ambition, the numbers of inappropriate out-of-area placements have continued to increase. In last year's MHA annual report, we noted that data from the Mental Health Services Data Set (MHSDS) for 2024/25 showed more people were placed out of area inappropriately, with more new inappropriate out of area placements.

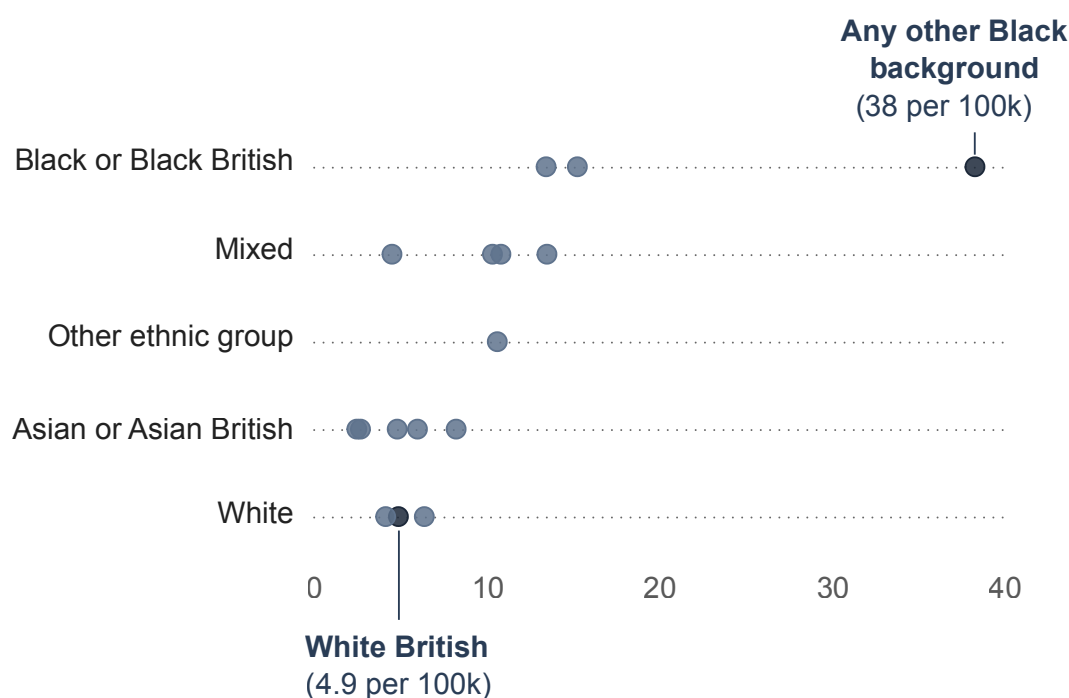
Encouragingly, the number of inappropriate out-of-area placements has fallen by nearly 30% over the last year, with 3,982 started in 2025/26, down from 5,649 in 2024/25. This fall in out of area placements

suggests some improvement in the quality and co-ordination of care, and reflects ongoing efforts to minimise placements that are potentially disruptive to people’s care, safety and recovery.

However, the number of new out-of-area placements varies for different groups of people. There is variation by ethnicity, for example people from Black and Black British groups are more likely to have out-of-area placements than people from White groups. In particular, people from ‘any other Black background’ are 8 times more likely to be placed out of area than people who are White British (38 per 100,000 people compared with 4.9 per 100,000) (figure 20). While there may be some potential reporting issues that could affect this figure, this variation indicates potential structural inequalities in access to appropriate, culturally responsive local services, which may affect both people’s experiences and outcomes from care.

Figure 20: **Out-of-area placement rates vary substantially by ethnic group**

Inappropriate out-of-area placements started per 100,000 people by ethnic group, 2025/26



Source: NHS England, [Mental Health Services Dataset Monthly Statistics](#)

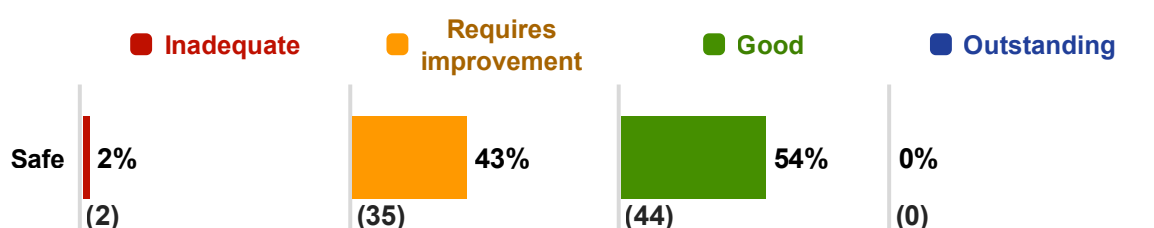
Keeping people safe in hospital

When people experience a mental health crisis and need to stay in hospital, there is an expectation that they are kept safe, and treated with dignity and respect.²¹ However, as we have consistently reported through our [Monitoring the Mental Health Act](#) annual reports, issues including the pressures on services, low staffing levels and poor quality ward environments can lead to people feeling unsafe and increase the risk of restrictive practices being used.

Evidence from our data on breaches of regulations shows that some trusts and mental health care providers are struggling to keep people safe. Of the 81 acute wards for adults of working age and psychiatric intensive care units that have been assessed and rated under our current assessment framework, just under half have been rated as either requires improvement (43%) or inadequate (2%) for the safe key question (figure 21).

Figure 21: Almost half of acute adult wards are rated inadequate or requires improvement for safety

Ratings for the safe key question in acute wards for adults of working age and psychiatric intensive care units assessed under our current framework, August 2026



Source: CQC, ratings data. Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%. Numbers in brackets denote number of rated services.

Examples of breaches relating to risk management include:

- not updating patient risk assessments after incidents of risk, and not including all safeguarding incidents
- a lack of risk assessments and care plans for people with physical health conditions including diabetes, falls, and epilepsy
- staff not completing risk management and safety plans.

Other issues identified include gaps in record keeping, inconsistent communication from providers with people's families and not always embedding learning from incidents.

Recent national inquiries such as the ongoing [Lampard Inquiry](#), which is investigating the deaths of mental health inpatients in Essex between 2000 and 2023, highlight the impact on people and their families when things go wrong.

However, our inspections of mental health services have also found examples of good practice in some trusts. We have seen some providers taking steps to keep people safe in hospital, including:

- routine risk and environmental assessments
- making changes to the environment such as anti-ligature fittings and alarms
- supporting learning from incidents with timely incident-reporting and debriefs.

In these services we found positive safety cultures, where leaders held regular safety huddles, governance meetings, and patient safety forums, with staff sharing learning from incidents and providing clearer guidance about how to escalate concerns. We also found positive examples of people and their families being involved in care planning and managing risk. In these services, people were encouraged to access advocacy services, attend community meetings, contribute to ‘you said, we did’ boards, and actively participate in care planning, where possible.

Many trusts and providers had governance measures in place to manage and assess risk. Most commonly, they had policies and procedures in place, and active risk registers that were monitored and updated accordingly.

Safety of urgent and emergency departments

Our inspections of emergency departments and medical wards over winter 2025/26 found that the departments we visited were not offering a therapeutic and safe environment for people with mental health needs. Furthermore, our analysis of data from Learning from Patient Safety Events (LfPSE) found that when people experience long waits in unsuitable urgent and emergency care environments, there’s a risk that this delay will cause distress, worsen their condition, or they may leave without getting the care they need.

Our inspections found that while most emergency departments had adult assessment rooms that met the Royal College of Psychiatrists’ PLAN guidelines, they were often occupied, which meant people had to wait in other areas that presented risks. Most of these assessment rooms were clinical in nature and some had been poorly maintained with ripped furniture. These rooms were often used as bays for people to sleep in, which meant there were sometimes trolleys in them.

We also found that staff in emergency departments did not always demonstrate a good understanding of ligature risks and how to manage them. At the hospitals we visited, staff could not always describe where the ligature cutters were kept in the department.

However, some trusts had identified the need to improve understanding of ligature risks among staff and had introduced training to support this.

Although departments managed risks by using one-to-one observations, not everyone who was waiting to be assessed were always observed. This finding is supported by data from the Royal College of Emergency Medicine, which found that around half of higher-risk mental health patients in emergency departments were not properly observed during their stay last year.

However, in our analysis of urgent and emergency care inspection reports, we found examples of the steps some trusts were taking to address this challenge, as the following example shows:

“... patients experiencing mental health conditions who required continuous one-to-one observation could not always receive this because the template failed to account for additional staff. In response, the service had developed their own in-house mental health support team which included Registered Mental Health Nurses (RMNs) and Enhanced Care Workers. If a patient had been identified as high risk (self-harm or absconding), they were recommended for one-to-one care and supported by department staff. During our inspection, we identified 3 patients receiving one to one care from RMNs.”

(From inspection report for an NHS urgent & emergency care service)

Safety of ward environments

As with emergency departments, we found similar ongoing concerns about the poor quality of many ward environments and the resulting impact on the safety, privacy and dignity of patients and staff. We analysed a sample of mental health inspection reports, which found variation in the safety of the environments, which in several areas, was not conducive to safe and therapeutic care. Although many trusts had systems in place, such as daily environmental checks, ligature risk folders and audits, and had planned work to improve estates, these were not always sufficient to mitigate the risks created by the physical environment.

Ward layouts varied considerably across sites. We found ward designs that were compartmentalised, with separate clinic rooms, therapy rooms, communal lounges as well as female-only lounges, and bedrooms. This layout could affect the quality, reliability and safety of patient observation across the wards. Inspectors also identified blind spots in garden areas, corridors, bathrooms, and lounges, meaning areas could not be seen from observation points. We heard how limited visibility could make it difficult for staff to detect early signs of distress, escalating behaviour or potential self-harm, which could leave them feeling unsafe when supervising patients outside. In some instances, these concerns amounted to breaches of the Health and Social Care Act 2008 regulations. This means that a provider has failed to meet a legal requirement set out in the legislation that CQC inspects against.

While some wards were clean and functional, many physical spaces displayed signs of deterioration (for example, crumbling walls, peeling plaster, ripped furniture, graffiti, and mould), where inadequate maintenance and environmental hazards directly affected the safety of both patients and staff.

Noise also continues to be a recurrent environmental issue across wards and often had a negative impact on patients' experience, the ability of staff to observe and de-escalate, and the therapeutic quality of care. Where noise levels were high, staff and patients reported increased distress, reduced sleep, and difficulties in communication that undermined safety and recovery.

However, an inspector identified a trust that was acting on feedback from patients and staff relating to the noisy environment. We saw how silent alarms and noise reducing sound panels were implemented to support patients with sensory needs, and those who also struggled with noise on the wards. We also found some evidence of good practice from our additional analysis of inspection reports relating to the environment:

“The service demonstrated innovation in response to identified need. This included...work to improve sensory and neurodivergent-friendly environments. The bespoke sensory room was under development and was clear evidence of innovative practice in response to feedback regarding the environment.”

(From an inspection report for a Children and young people's service in an NHS trust)

Another inspection report highlighted work to improve the ward:

Staff used the Essen Climate Evaluation Schema questionnaire to measure the ward's atmosphere in 3 domains including patient cohesion, therapeutic hold and experienced safety. Staff and patients shared their views anonymously. Staff used the information collected to assess the atmosphere of the ward, how safe the staff and patients were feeling and used this to determine whether new admissions were accepted on to the wards or not.

(From an inspection report for an acute and PICU ward in an NHS trust)

Our inspections of mental health wards enabled us to see other examples of safe, therapeutic environments, which have contributed to both staff and patients feeling safe. For example, at one service, we found:

“The wards were purpose-built, consisting of large en-suite bedrooms that also had lounge areas within the ensuite bedrooms. Staff explained that this allowed carers to stay with the patient if appropriate to do so, as the lounge sofas pulled into beds. Staff gave us examples of family members who had stayed overnight where their relative had been unwell or comforted by their loved one's presence. There were specific sensory bathrooms with specialist equipment to provide a therapeutic

experience during personal care interventions. The décor of the units encompassed local landmarks, familiar wall art and was well received by both patients and carers”. [...]

(From inspection report for a ward for older people with mental health problems)

The impact of staffing pressures on patient safety

We still have concerns about issues with low staffing levels, including challenges around recruitment and retention, and the impact of this on keeping people safe. This is another area where we have consistently raised concerns through both our State of Care and MHA annual reports.

Vacancy statistics for mental health staff in 2025/26 show a slight reduction compared with the previous year, as the total workforce vacancy rate for mental health has reduced from an average of 9.8% in 2024/25 to 9.0% in 2025/26. However, this is still 1.3 times that of the national total workforce figure of 6.8% in 2025/26.

This mirrors the findings from our inspections. Analysis of our mental health inspection reports found that on many wards, staffing levels were sufficient and enabled trusts and providers to safely care for people. Where there were enough staff on duty, they were able to observe and supervise patients on escorted leave, as well as enable access to outdoor areas, lounges, and gyms, while also providing appropriate levels of support when patients were distressed, which needed staff to intervene.

However, in other services inspectors identified challenges with staffing levels and capacity, which meant that routine therapeutic activities, escorted leave and supervision were sometimes cancelled or delayed. Inspectors noted that this affected patients’ access to therapeutic time, reduced one-to-one contact with staff, and was associated with increased distress for them. It can also increase pressure on staff.

The results of the 2025 NHS staff survey showed that many people are still working unpaid hours, which suggests continuing workforce pressures. More than half (54%) of the people working in mental health & learning disability trusts, and in mental health, learning disability & community trusts reported working unpaid hours beyond their contracted hours each week.

These persistent workforce pressures pose risks to staff wellbeing and the quality of care. The 2025 NHS staff survey also showed that more than a quarter (27%) of staff in these trusts also reported often or always feeling burnt out by work. In addition, around 2 in 5 (41%) have felt unwell as the result of work-related stress, while more than half (55%) have attended work in the last 3 months despite not feeling well enough to perform their duties.

The King’s Fund has highlighted how staff burnout, stress and overload are associated not just with a poorer quality of care, but also higher

levels of staff turnover, more errors that harm patients, and worse financial performance in trusts.

To mitigate high levels of vacancies and turnover, some trusts and providers had increased the use of bank and agency staff. However, in some cases, bank and agency staff were not always fully inducted, which added to the risk of incidents occurring on the wards, and could also affect the continuity of care for patients. To improve continuity for patients, and the knowledge of staff on the ward, some trusts and providers had block booked bank and agency staff for longer periods.

Discharge from hospital

In its 2024 report Discharge from mental health care: making it safe and patient-centred, the Parliamentary and Health Service Ombudsman describes the importance of patient safety during discharge, and how people's experiences should not be overlooked when moving from inpatient to community care. It highlights that unsafe discharge potentially leads to poorer outcomes for patients and the risk of repeated cycles of readmission.²²

We found some good examples of improving discharge from hospital in our analysis of mental health inspection reports. Discharge and onward pathways were strengthened where there was good, multidisciplinary team working. This included, for example, embedding care co-ordinators in ward rounds, ensuring multidisciplinary representation at planning meetings, and making accessible care plans available at every transition. Another inspection report stated:

“Staff employed by the trust described staff employed by partner organisations as full members of the multidisciplinary team. Several members of staff told us that being in the same buildings as partners enhanced their communication and aided collaboration. This meant people who used services were able to get access to the right service provision quickly, without being ‘bounced’ between services.”

(From inspection report of a ward for working-age adults)

These approaches helped to keep people safe by preserving therapeutic relationships, enabling timely referrals, and ensuring that the right setting and supports were in place when patients moved between services, as the following experience shows:

“When I was discharged from section 3 Mental Health Act I was seen only once in 3 months by my community psychiatric nurse, not at all by a psychiatrist and my 117 aftercare was not started. The psychiatrist in hospital told me things would be put in place for my discharge, 4 months have now gone by and they are still not in place... It feels like I have been passed from one team to another with each claiming it is the other’s responsibility and no-one helping me. The individuals in the service largely seem caring and want to help but resources are stretched so far that nothing is done until beyond the point of emergency.”

(Respondent to the 2025 Community mental health survey)

Inspectors identified instances where discharge from hospital was delayed due to lack of community placements, sharing incomplete information, or poor representation from social care at planning meetings. When systems do not work together to support people to access community care, this results in more delayed discharges, which will increase pressures on inpatient services. This means people remain in inpatient services for longer and can increase the risk of relapse or readmission.

Ongoing care and support

Step-down and shared care in the community

As part of our adult community mental health inspection programme in 2025, we held engagement events for providers. These enabled us to learn that it could sometimes be challenging for them when stepping patients down from secondary mental health services into primary care. Attendees told us about their working relationships and mixed experiences of working with GPs. We heard how GPs’ willingness to accept discharged patients, particularly those stable on depot injections, varied widely.

Wim’s Protocol: for the safe prescribing and monitoring of clozapine is the latest guidance from the Royal College of Psychiatrists. Although this recognises that responsibility for prescribing, monitoring and ensuring engagement with monitoring lies with the initiating clinician or clinical service, the guidance highlights the need for appropriate training, funding, formal shared care agreements for GPs, and clarity around responsibilities and liability, including around managing disengagement from clozapine monitoring.²³

Shared care agreements are important in enabling safe step-down of care, and we heard that where these worked well, it reduced secondary care caseloads and improved patient flow.

One provider described how it had made positive progress around shared care agreements, which resulted in GPs taking over the care for patients on antipsychotics and people with dementia. At another trust where there were strong shared care agreements in place for people receiving oral medications, we heard that GPs were assured that the person would have regular review points from a specialist perspective, and that a relapse plan was in place.

But some attendees at our engagement events told us how prescribing and monitoring were central friction points between primary care services and secondary mental health services. As we reported in last year's State of Care, attendees described how shared care agreements were frequently contested, inconsistently implemented and under-resourced, with unclear finance and responsibility arrangements, and lack of national standardisation.

Every year we also proactively engage with chief pharmacists in NHS trusts, to enable us to learn about their arrangements. Some pharmacists told us about the processes they had implemented to mitigate some of the risks with shared care agreements. However, others described how challenges with shared care agreements continued to present one of the biggest areas of risk for people using their services, including delays to treatments, as well as a lack of a single care record.

This echoes the feedback from adult community mental health providers, who told us at our engagement events that the challenges and delays with stepping down care could lead to patients experiencing care that is fragmented rather than continuous, and being at increased risk of deterioration or crisis.

Wim's Protocol highlights the importance of effective communication between healthcare providers, and of clear roles and responsibilities across the patient's care pathway, including between primary and secondary care services. It also emphasises the importance of physical health monitoring and early recognition of serious adverse effects of medicines.

GPs also have a key role in providing annual physical health checks and support for people with severe mental illness. Many people with severe mental illness have one or more chronic physical health conditions at the same time as their mental illness, and adults living with severe mental illness are almost 5 times more likely to die prematurely compared with those who do not have a severe mental illness. The 'core' annual severe mental illness physical health check has 6 elements including:

- alcohol consumption status
- blood glucose or HbA1c test (as clinically appropriate)
- blood pressure
- body mass index
- lipid profile
- smoking status.

In 2025/26, 65% of people with a severe mental illness received all 6 health checks, a fall of 1.3% since 2024/25 and 3.2% less than in 2023/24.

At our provider engagement events, we heard examples of how co-locating mental health staff in GP surgeries, introducing outreach practitioners who rotate between practices, and having medicines-optimisation leads has helped to improve handover and monitoring of patients.

Supporting people at high risk

In March 2024 we published our [Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust](#). This identified concerns around people with complex needs who presented with a high risk of harming themselves and others being lost in the system and not receiving appropriate support. [The Nottingham Inquiry](#), launched in May 2025, is continuing to build on the findings of our review and others that were published in relation to the Nottingham attacks. It aims to provide a clear understanding and holistic view of the events, acts and omissions that led up to the attacks, and give clear recommendations to prevent this happening again.²⁴

We discussed the challenges of supporting people who are at high risk of harming themselves or others at our engagement event for providers. One attendee described people who were identified as high risk as having a complex mental health diagnosis, often also needing support for substance misuse, and described it being very difficult to engage them.

Others spoke about people who are 'quietly very unwell' and described how these were not necessarily people who would have been receiving treatment from the assertive outreach team.

To address this challenge, providers told us they use a range of methods to monitor high-risk individuals, including data-driven case-finding and tools such as electronic patient records and regular review of risk

levels. They also told us about multidisciplinary working, including community outreach and information sharing across agencies. These approaches aimed to:

- predict if a person may relapse
- manage transitions between services (for example, release from prison or step-down from high-intensity care)
- reduce out-of-area placements and crises
- identify people who were disengaging with services.

Attendees told us about specific groups of people who were more likely to disengage or whose voices were seldom heard. This was sometimes due to factors such as not wanting to attract attention, cultural or social stigma, and/or feeling unsupported (for example, from a lack of commissioned outreach in the area).

Attendees also described the different approaches they are taking to identifying and supporting people who disengage from mental health services. A key recommendation from our special review of Nottinghamshire Healthcare NHS Foundation Trust was that when people had not attended their appointment, flagged as ‘did not attend’ (DNA), this should not be a reason to discharge that person. One provider had recommended to their trust board that nobody could be discharged purely based on DNAs.

A few attendees stressed the importance of engaging people’s families and carers. They told us that family and carer involvement has been strengthened through [Triangle of Care approaches](#) and emerging training programmes for carers. One attendee told us that they planned to provide training for all their families and carers in suicide prevention, something that is not typically done, to empower the families and carers to understand what fleeting suicidal thoughts are, and how they can help the person. While a couple of attendees discussed their providers’ initiatives around co-production with patients, families and carers, they described them as being “a work in progress” and that there was “more to do”.

Focus on restrictive practices

Restrictive practices, also known as restrictive interventions, are practices that are making someone do something they do not want to do or stopping them from doing something they do want to do, by restricting or restraining them, or depriving them of their liberty.

Most people know and accept that restraint, seclusion, and segregation are more extreme forms of restrictive practice. But there are more subtle forms of restrictive practice, such as making someone use a wheelchair when they’re willing and able to walk or making someone wear a bib when eating, which can easily become day-to-day normal responses to a perceived risk or lack of time.

The use of restrictive practices can have a devastating impact on people, causing trauma and leading to breaches of their human rights. Everyone working in health and care has a role to play in actively reducing the use of restrictive practices.

As highlighted in our [2024/25 Monitoring the Mental Health Act \(MHA\) report](#), we expect that, in all services, the provider should promote positive cultures that support recovery, engender trust between patients and staff, and protect the safety and wellbeing of all patients and people who use services. This includes respecting the rights of all patients, providing skilled, trauma-informed therapy that follows the principle of least restriction, and promotes recovery. However, in the MHA report we highlighted our concerns that the use of restrictive practices is increasing. We will report more on restrictive practices in our 2025/26 Monitoring the Mental Health Act report.

As we discuss in our section on the [Deprivation of Liberty Safeguards](#), the use of restrictive practice is not just specific to mental health services.

Tackling the use of restrictive practices for autistic people and people with a learning disability: Independent Care (Education) Treatment Reviews

In 2020, we called for immediate action to end the abuses in human rights in [Out of sight](#), our review of restraint, seclusion and segregation for autistic people and people with a learning disability and/or mental health condition. We remain particularly concerned about the use of this type of restrictive practice.

The introduction of Independent Care (Education) and Treatment Reviews (IC(E)TRs) was a direct response to this call for action.

The first 2 phases of IC(E)TRs were led by the Department of Health and Social Care in partnership with NHS England and CQC. In 2023, the DHSC asked us to lead on the IC(E)TRs for 2 years, and we took ownership of the programme in January 2024, with reviews starting in May 2024. Between May 2024 and March 2026, we carried out 88 IC(E)TRs. DHSC has asked us to continue to run these reviews for a further 2 years, which we started in April this year.

In July this year, we published the [findings from these IC\(E\)TRs](#), exploring the practices that supported autistic people and people with a learning disability to leave long-term segregation, as well as the barriers that prevent this from happening. Here, we take a look at some of the key themes discussed in the report.

Assessing people's requirements

Understanding people's experiences and requirements, including their previous treatment and support in the community or in previous hospital placements, is key to providing the responsive, trauma-informed care that they need while in long-term segregation.

To support this, providers need to carry out a full assessment of people's requirements with input from families and supporters. Up-to-date, effective care plans are then essential for maintaining a person-centred approach, bringing together information from assessments and other information about a person and their requirements to put them at the heart of decisions. The importance of assessing people's requirements and involving them in their care plans is recognised in the Mental Health Act 1983 (amended 2025), which has introduced statutory care and treatment plans for detained patients.

However, our reviews indicated that for some providers, knowledge about a person was based solely on how they present when in long-term segregation, rather than an understanding of their history and a wider view of how they respond in different settings, which can lead to missed opportunities to support that person.

Staffing

The skills and knowledge of staff can have a direct impact on the quality of care people receive. Where staff do not have the skills or knowledge to meet people's requirements, it can lead to people being more restricted and not getting the support they need to move out of long-term segregation.

Where we saw good practice, staff had training in the skills they need to support autistic people and people with a learning disability, and were given the opportunity to improve their understanding through reflective practice. Getting to know people well and building relational security was essential to understanding what people want and need. This enabled staff to be responsive and adjust how they supported and interacted with them. This included, for example, knowing what support people might need to perform a task or participate in an activity, and providing practical help and support to carry out everyday activities.

However, staff did not always have the right skills, training or attitude to support autistic people and people with a learning disability. Issues included staff:

- lacking knowledge about how to communicate with people
- feeling disempowered when services do not share information about people's assessments
- not seeing it as their responsibility to engage with and form meaningful relationships with people
- taking inflexible approaches to supporting people.

Lived experience: Why relational security matters

While I was in long-term segregation, I learned to associate the door opening with being restrained, injected, and hurt. An unfamiliar staff member began doing something different. He would open the door and then close it again when I ran at him. He kept returning consistently. Over time, he stood in the doorway without escalating. Later, he sat down briefly at first, then for longer. He did not demand interaction.

He did not punish anger. He showed up predictably.

Eventually, he rolled a tennis ball towards me. At first, I threw it at him. But he kept returning, patiently, without retaliating or withdrawing. After weeks, we played catch. Then we played catch in the garden, which was the first time I had been outside in months... [this meant] that trust was built through consistency, containment, and respect.

Looking back, he also connected with my identity – I had been a PE teacher, and the tennis ball seemed like a deliberate link to my past. That matters. People must be met as whole human beings, connected to who they are beyond their distress.

(Taken from the Report of the Independent Care (Education) and Treatment Reviews (IC(E)TR) Oversight Group)

Environment

As reported in our [2024/25 Monitoring the Mental Health Act annual report](#), ward environments often do not support the sensory needs of autistic people and people with a learning disability.

Our IC(E)TR reviews demonstrated that to meet people's requirements effectively, providers must have a clear and holistic understanding of the person, their experiences of staying in a restrictive and segregated environment and how they respond to different settings.

To protect people's rights and dignity, providers need to be adjusting and personalising care to people's individual requirements. For example, making reasonable adjustments to people's sensory requirements such as providing different types of sensory items, like a weighted blanket and/or access to sensory resources.

Long-term segregation rooms may cause people distress, particularly when specific requirements related to their learning disability or autism are not met. If people's distress is caused by the environment they are living in, but their distress is used to justify being detained there, there is a risk of people getting stuck in long-term segregation.

Discharge planning

Discharge planning is a necessary part of the process of supporting people to leave long-term segregation. The recommendations made through our reviews called for a range of staff, professionals and services to work together to support people to leave long-term segregation through delivering joined-up care. Commissioners were highlighted as being able to play a key role in bringing the right stakeholders together.

Involving people and their families in conversations about leaving long-term segregation was key to enable them to share views in meetings and conversations with staff, be kept informed, and have their wishes acted on. Advocates also had an important role in understanding people's requirements and speaking up for them, for example at meetings with external stakeholders, multidisciplinary team meetings and ward rounds.

However, our reviews often noted that not everyone was involved in conversations about a person leaving long-term segregation, including the person themselves, who was not listened to. If services fail to listen and respond to the concerns of the family and carers of a person in long-term segregation, there can be significant consequences, for example leading to a deterioration in their emotional wellbeing and causing substantial and preventable distress.

We also found a lack of clear objectives or goals to achieve to enable a person to move to less restrictive conditions and no discharge plans. This, together with a lack of leadership in clinical teams, 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.

Not enough services with the required skills, as well as insufficient infrastructure and funding to support the bespoke placements that people need, were seen as barriers to discharge them into the community.

Impact of our IC(E)TR programme and next steps

As at 30 March 2026, two-fifths (35 out of 88) of people who had a review have left long-term segregation. Of these:

- 11 people have been discharged to the community (one person has since returned to hospital but remains out of long-term segregation)
- 5 have moved to more appropriate hospitals
- 19 people remain on wards, with some engaged in active discharge plans.

Over time, from data provided by NHS England, we have seen that fewer autistic people and people with a learning disability are in long-term segregation. The numbers have reduced from:

- 101 people in November 2023, to
- 71 people in June 2026.

The sustained reduction is welcome news and indicates that the IC(E)TR programme is working. The findings from our review also illustrate the improvements in people's lives, as well as for their family and carers, through implementing the recommendations in our IC(E)TRs.

Despite these improvements, 71 people in long-term segregation is still too many. In December 2025, DHSC asked us to continue to lead on the programme for a further 2 years, running from April 2026 until March 2028. Over the next 2 years, we will continue to build on the progress made in 2024 and 2025 by continuing to deliver IC(E)TRs, strengthening our oversight, and using our regulatory levers to make sure providers are implementing our recommendations.



Secondary care



State of Care

Secondary care

Key points

- Urgent and emergency care services are under sustained pressure. In 2025/26, there were just under 27.9 million calls to NHS 111 or online completions, nearly 14 million 999 ambulance calls, and 28 million attendances to urgent and emergency care services – over 608,000 more attendances than in 2024/25.
- In line with the ambitions of the NHS 10-year plan, more people are using community-based initiatives such as Pharmacy First, hear and treat, as well as see and treat ambulance services. While there are some signs of improvement, urgent and emergency care services are continuing to struggle to meet national response standards in the face of high demand.
- In 2025/26, there was slight improvement in the number of people waiting 4 hours to be either admitted, transferred or discharged from type 1 emergency services, with 60.9% of attendances (10.4 million) seen in under 4 hours. There was also a marginal reduction in the number of people waiting more than 12 hours from arrival to being either admitted, transferred or discharged across type 1 and type 2 emergency services.
- But more people who need to be admitted to hospital are facing long waits. In 2025/26, 571,000 – more than 1,500 people a day on average – waited more than 12 hours from the decision to admit them to being admitted. Findings in our urgent and emergency care inspections indicate how this is creating significant operational challenges for emergency departments, with some patients having to wait in departments or corridor escalation areas for prolonged periods.
- The average number of general and acute hospital beds available has remained broadly level in 2025/26, but has not kept pace with the size of the population. In 2025/26, the number of beds per 100,000 people decreased by 0.9% from 174 per 100,000 in 2024/25 to 172 per 100,000. This, together with challenges in the wider system and hospital processes, can affect patient flow through the hospital.
- There are still ongoing challenges and delays in discharging patients. In 2025/26, on average 13,000 people who were ready to be discharged on any given day remained in hospital, up from 12,700 in 2024/25. Data from NHS England shows how system pressures, including a lack of capacity or delays in onward care and treatment, are the most common reasons for delays for longer stay patients.
- People are waiting a shorter time for elective care treatment. Over the last year, the average number of incomplete pathways for planned care has fallen from 7.5 million in 2024/25 to 7.3 million

in 2025/26. Performance against the interim standard has also improved, with 61.7% of waits for care of 18 weeks or less on average in 2025/26 compared with 58.9% in 2024/25.

- More people are also receiving a diagnosis or having cancer ruled out within 28 days. However, we continue to be concerned that people are having to wait too long with a diagnosis of cancer before starting treatment. In 2025/26, 69.4% of people with an urgent referral started treatment within 62 days, below the target of 85%.
- We reiterate the need for a faster pace of improvement nationally in maternity services, particularly around the safety of services and the inequalities for groups of people with protected characteristics. Our analysis of the rates of maternal readmissions this year highlights variation in readmission within 6 weeks of birth, with the highest rates for women from Black ethnic groups.
- Despite signs of ongoing improvement, inequalities in recruitment, career progression and staff experience remain widespread across the NHS. In 2025, the proportion of staff from ethnic minority groups in senior roles remained nearly 17% lower than the overall workforce at 30.7%, with staff from White ethnic groups continuing to report better opportunities for career progression or promotion than staff from ethnic minority groups.

Urgent and emergency care

Changing picture for NHS 111

NHS 111 is a non-emergency 24/7 service enabling people to receive urgent advice, care and treatment in situations that are less urgent than the need to call 999. Initially launched as a telephone service in 2011, NHS 111 online was rolled out in 2017.²⁵ The service is constantly evolving and a new dedicated service for people experiencing a mental health crisis was introduced in April 2024 (see section on [access to mental health care](#) in the community).

In last year's report, we reported that the number of calls to NHS 111 had dropped dramatically. In 2025/26, use of the NHS 111 call service has continued to decrease but at a slower rate, dropping by 85,000 calls to less than 19.9 million. This ongoing decrease could be linked partly to the increase in use of NHS 111 online, the rollout of [online booking for GP appointments](#) in 2025, and the introduction of the national NHS [Pharmacy First](#) service in January 2024.

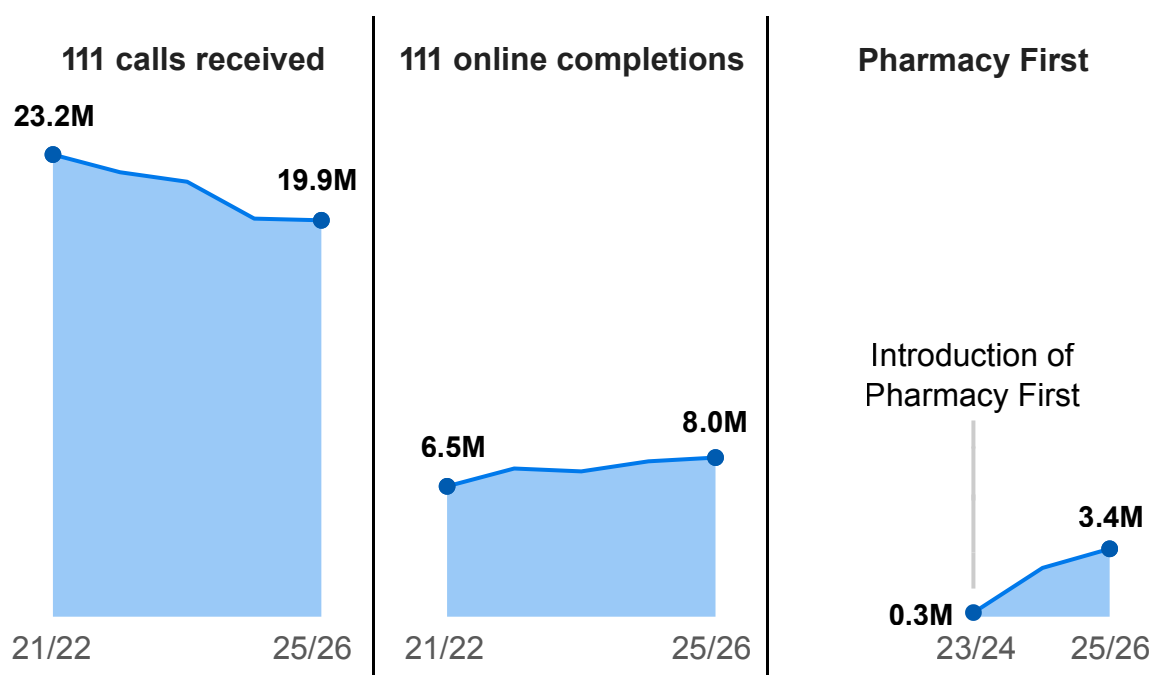
While the number of calls to NHS 111 has been falling year-on-year since 2021/22, more people are now seeking help through the NHS 111 online service, with almost a third (29%) of people seeking advice from the online service as opposed to calling in 2025/26.

Similarly, since its launch, the number of consultations provided by the NHS Pharmacy First service has continued to increase, with over

3.4 million consultations in 2025/26. In addition, a recent Healthwatch poll of 7,029 adults showed that of the 3,104 people who responded, almost 9 in 10 (86%) reported a positive experience of visiting their pharmacy to get support with one of the 7 common conditions covered by the scheme.²⁶

Figure 22: **Changing picture for NHS 111**

Number of NHS 111 calls received, online completions, and Pharmacy First consultations 2021/22 to 2025/26



Source: NHS England, [111 calls and online completions](#) and NHS Business Services Authority (NHSBSA), [Pharmacy First](#)

For people calling the NHS 111 service, we continue to see an improvement in how quickly they are able to get help. In 2025/26, people waited on average 54 seconds for their call to be answered, 6 seconds faster than in 2024/25 where the national average speed to answer calls was 1 minute. However, this is still above the standard for the average time to answer calls of 20 seconds or less.

Once people are assessed, either over the phone or online, if their symptoms meet the criteria, they will be offered a callback from a clinician and given a timeframe in which this will happen. The standard is that 90% of people who require a clinical callback should receive this within the agreed timeframe.²⁷

The number of NHS 111 callers or online contacts that needed a callback increased by 146,000 (3.3%) to over 4.6 million in the 2025/26. Only 41% of those who needed a clinical callback received it within the agreed timeframe, compared with 43% in 2024/25. Over the last year, no region or care provider met the 90% standard.

Ambulance services still under pressure

As we have reported in previous State of Care reports, the pressure on ambulance services continues to grow, with nearly 14 million 999 ambulance calls in 2025/26, which is 435,000 (3.3%) more than in 2024/25. Alongside this growth in demand, the average time taken to answer a 999 call for an ambulance has continued to improve, with an average time of 4 seconds in 2025/26, down from 5 seconds in 2024/25.

Similarly to last year, although the performance of ambulance services against response times has improved, they are still not meeting the required standards. For the most serious category 1 calls, ambulances should respond on average within 7 minutes.²⁸ These are life-threatening events that need immediate intervention and/or resuscitation, such as cardiac or respiratory arrest. In 2025/26, the average category 1 response time was 7 minutes 55 seconds – this is 24 seconds faster than in 2024/25 but still 55 seconds above the standard.

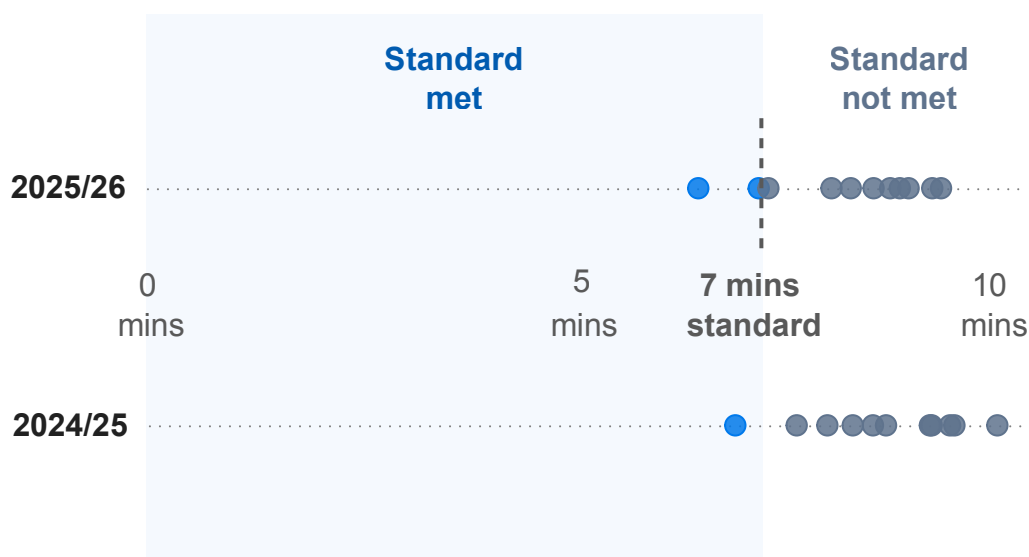
Category 2 calls are serious emergency events that need intervention and/or taking to hospital, including injuries such as burns, epilepsy or strokes. On average, ambulances should respond to category 2 calls within 18 minutes. As part of the plan to recover urgent and emergency care, in January 2023 NHS England raised this to a target of responding in 30 minutes on a temporary basis.²⁹ In 2025/26, ambulance services were over 5 minutes faster in responding to category 2 calls, with an average response time of 30 minutes 4 seconds. This remains slightly above the revised category 2 standard.

However, the demand for ambulances and performance of ambulance services varies across the country. In 2025/26, data from NHS England Ambulance quality indicators shows:

- The average time taken to answer a call ranged from 1 second to 10 seconds, a slight improvement from 2024/25 where average times ranged from 1 to 14 seconds.
- For category 1 calls, only 2 out of 11 ambulance trusts met the 7-minute standard, with average times varying from 6 minutes 17 seconds to 9 minutes 3 seconds (figure 23).
- For category 2 calls, just over half (6 out of 11) of ambulance trusts met the 30-minute temporary standard with response times ranging from 21 minutes 34 seconds to 38 minutes 51 seconds (figure 24).

Figure 23: **Despite improvements most ambulance trusts failed to meet the category 1 standard in 2025/26**

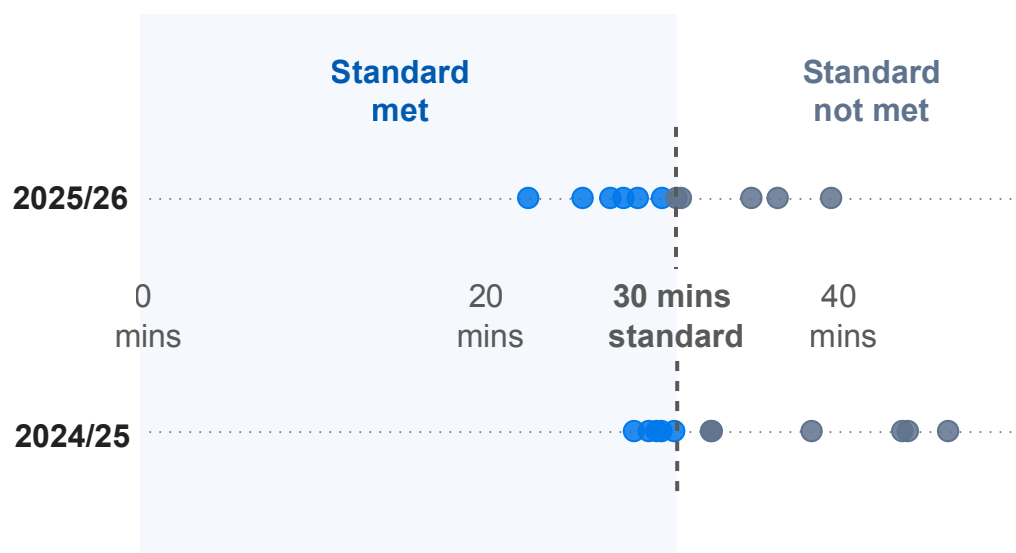
Average ambulance response times by NHS ambulance trusts for category 1, 2024/25 and 2025/26



Source: NHS England, [Ambulance Quality Indicators](#)

Figure 24: **Despite improvements almost half of ambulance trusts failed to meet the temporary category 2 standard in 2025/26**

Average ambulance response times by NHS ambulance trusts for category 2 incidents, 2024/25 and 2025/26



Source: NHS England, [Ambulance Quality Indicators](#)

The impact of this variation in performance is reflected in people's experiences. Analysis of our pathway tracking interviews during our inspections of emergency departments and medical wards in 2025/26 show that some patients had positive experiences, often seeing the service as responsive:

"... the patient contacted NHS 111 due to chest pain, back pain, and wheeziness. NHS 111 arranged an ambulance, which arrived within approximately 5 minutes. The ambulance crew carried out an assessment, including observations and an ECG, and determined that the patient needed to be taken to hospital."

(Pathway tracking patient interview)

As well as conveying patients to type 1 and type 2 emergency departments, ambulance services may take patients to alternative healthcare destinations, such as minor injury units. They also provide the following services:

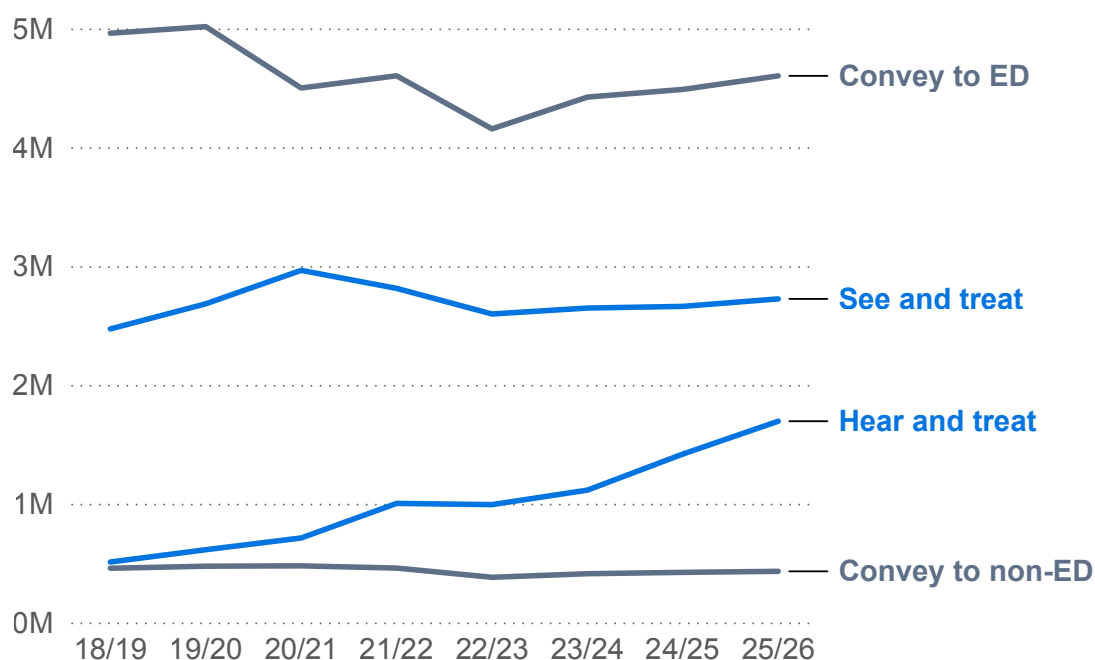
- See and treat – where an ambulance crew responds to a call face-to-face but, following assessment and/or treatment, does not take the patient to hospital.
- Hear and treat – where the ambulance service provides advice over the phone to people who do not have a serious or life-threatening condition.

Last year, we reported that the volume of both see and treat, and hear and treat responses had grown, in line with the government's NHS 10-year health plan to provide patient care and treatment in the appropriate environment and move more care from the hospital into the community. This growth has continued in 2025/26 as the number of see and treat responses increased by 63,000 (2.2%) to 2,723,000 responses. Similarly, compared with 2024/25, there were 276,000 more hear and treat responses (an increase of nearly 20%), increasing to 1,694,000 in 2025/26. This figure has more than tripled since 2018/19 when there were 509,000 responses.

However, despite the increasing use of see and treat and hear and treat, more people are being taken for further care by ambulance due to the growing demand for ambulance services. In 2025/26, the number of people conveyed by ambulance increased by 123,000 (2.5%) to 5,031,000, of which 4,601,000 were taken to an emergency department (figure 25).

Figure 25: **Hear and treat responses continue to grow**

Number of responses by type, 2018/19 to 2025/26



Source: NHS England, [Ambulance Quality Indicators](#)

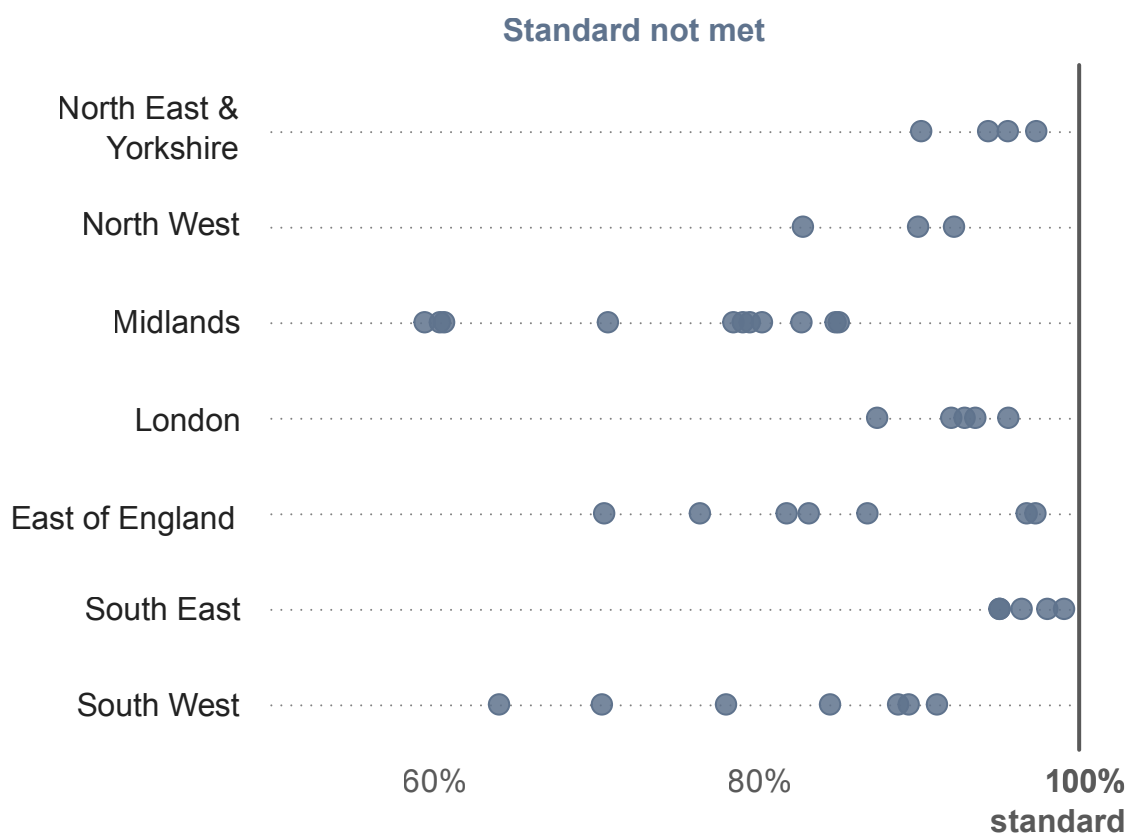
Handovers to hospital

As a result of the increased demand for ambulances, the number of people who are transferred from an ambulance into hospital has risen by 107,000 in 2025/26 to 5,063,000 ambulance handovers, up from 4,956,000 in 2024/25.

It is important that patients are transferred as quickly as possible into the care of the hospital. Average ambulance handover times have improved nationally – reducing from 34 minutes and 57 seconds in 2024/25 to 29 minutes and 52 seconds in 2025/26. However, the standards set out in the [Urgent and Emergency Care Plan 2025/26](#) were still not met, with only 87.6% of patients transferred within 45 minutes. This varied by integrated care board (ICB) area, ranging from 62.5% of people transferred within 45 minutes in the lowest performing area to 98.8% in the best performing area (figure 26).

Figure 26: **A 40-percentage point gap in timely ambulance handovers between ICB areas**

Percentage of patient handovers completed within 45 minutes by integrated care board within each NHS England region, 2025/26



Source: NHS England, [Ambulance: Management Information](#)

We interviewed patients to find out about their pathway through care as part of our inspections of emergency departments and medical wards during the winter of 2025/26. Some people told us that they had experienced a relatively timely and smooth handover from the ambulance to the urgent and emergency care department. However, others reported severe delays in handovers, including having to wait over 2 hours to be transferred. These experiences reflected what we found in our analysis of urgent and emergency care inspection reports which showed that, although not universal, ambulance handover delays were a widespread issue.

People we spoke with in our patient pathway tracking interviews also described how their initial treatment had started and continued in the back of the ambulance, due to system pressures, and a lack of available beds and capacity in the emergency department. In one instance, a person told us that they were moved between ambulances while their treatment continued in the vehicle because of overcrowding in the department. This echoes the findings from the 2024 Adult inpatient survey where respondents reported experiencing long waits:

“The admission to the hospital was extremely long-lasting. I understand that this happened due to the particularly big number of patients delivered to A&E, so I could understand the situation and do not blame anybody, as the staff is really doing their best to help the situation. My awaiting time was 1 hour in the ambulance in front of A&E...”

(Respondent to 2024 Adult inpatient survey)

We have previously warned of the consequences of handover delays. In our [2021/22 State of Care](#), we cautioned that ambulances are not suitable environments in which to treat people and that handover delays are a consistent risk to the quality and safety of patients’ care. It can also prevent ambulances from responding to emergencies in the community, delaying people with urgent health conditions getting the care they need, when they need it, resulting in serious injury and, in some cases, deaths.

Our analysis of urgent and emergency care inspection reports found that leaders in some services recognised the safety risks and slower response times created by ambulance handover delays, and were taking steps to address the problem, as the following shows:

“... ambulance handover performance was strong, with minimal delays over 30 minutes. Senior managers said they prioritised admitting patients from ambulances to avoid delays with patients requiring ambulances in the community. They believed assessing risk inside the department was safer and helped release ambulances to support the wider system.”

(From a CQC inspection report)

Handovers to hospital and medicines reconciliation

When people are admitted to any service, any medicines they are currently taking should be accurately listed, known as medicines reconciliation. This needs to happen in a timely way to make sure that people are able to take existing medicine at the right time and that any information, for example about allergies, is recognised. Identifying medicines that are time-critical early reduces the risk of errors and harm to patients.

NICE guideline [QS120](#) states that medicines reconciliation for people in hospital should happen within 24 hours of admission. Through our annual conversations with trust pharmacy teams, we found variation in how trusts managed this process. Several trusts described using prioritisation tools to help them reach the most vulnerable, critical or at-risk people at admission. Another trust told us it assigned a RAG (red, amber, green) rating to all people on admission. This provided guidance to their staff on which people need to be seen within 24, 48 or 72 hours, helping to direct staff resource to areas of greatest clinical need.

Clinical pharmacy services are ideally placed to support hospital teams to obtain, review and document information about medicines during transfer of care. In 2023, the Royal College of Emergency Medicine (RCEM) released [a joint statement](#) with the UK Clinical Pharmacy Association, which recommended that emergency departments should have dedicated pharmacists and pharmacy services to work as part of the multidisciplinary team supporting people in the emergency department.

Of the 52 reports published from our inspections of urgent and emergency care services between July 2025 and June 2026, 20 reports referred to the pharmacy RCEM guidance, but none of these 20 emergency departments were meeting the recommendations on pharmacy staffing levels. Although some trusts told us that they prioritised pharmacy staff being based “front of house” such as in emergency departments or acute medical wards, funding these posts was an area of concern.

Continuing pressures on urgent and emergency care services

As we highlighted in our [2024/25 State of Care report](#), following the fall in attendances at urgent and emergency care services during the pandemic, the number of people attending has been rising year-on-year.

In England there are 3 types of urgent and emergency care services from which people can seek help:

- 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

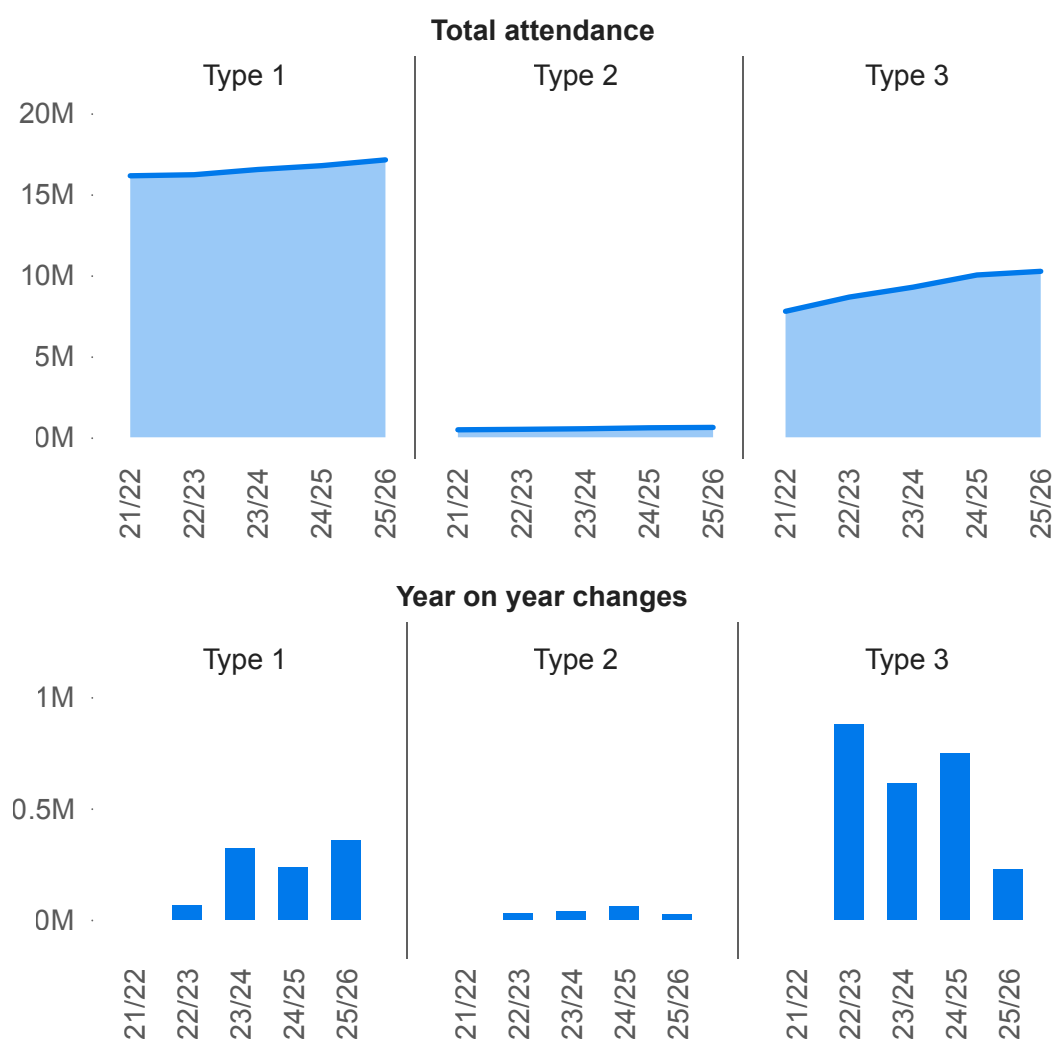
conditions, for example eye conditions or dental problems, and patient accommodation

- type 3 – doctor or nurse-led urgent treatment centres for the treatment of minor injuries and illnesses, which are open at least 12 hours a day and can be accessed without appointment, also offering appointments through the NHS 111 service or a GP referral.

Over the last year, the upward trend in attendances at all types of urgent care services has continued, though at a lower rate. In 2025/26, there were over 608,000 more attendances across type 1, 2 and 3 services, amounting to 28 million attendances compared with 27.4 million 2024/25. We have previously reported how this long-term increase has been largely driven by attendances at type 3 services. However, this year the growth in type 3 attendance appears to have slowed (figure 27).

Figure 27: **Increased pressures on urgent and emergency care services**

Total attendances and year-on-year change in urgent and emergency care services at type 1, 2 and 3 services, 2021/22 to 2025/26



Source: NHS England, A&E Attendances and Emergency Admissions

The increase in England's population may account for some of the

growth in attendance at type 1 emergency departments. We continue to see change in who is attending urgent and emergency care, with the greatest increases in attendance between 2021/22 and 2025/26 for people aged 65 to 79 (up by 27.7%) and people aged 80 to 89 (up by 24.3%). We also continue to see that demand varies across the country, with attendance higher for people living in the most deprived areas.

The NHS 10-year plan sets out how the government aims to ease pressure on hospitals. Working with the [Nuffield Trust](#), we asked [integrated care boards](#) (ICBs) about their confidence in making the ‘three shifts’ outlined in the NHS 10-year plan, including moving more care from hospitals to communities. We received responses from 21 people across 13 ICBs, which means these results are indicative rather than representative of all ICBs.

The survey results showed that respondents’ confidence about the three shifts varied. Results showed:

- Most respondents (19) reported they were at least fairly confident about the ability of their ICB to make better use of technology.
- 17 respondents were at least fairly confident that their ICB would be able to meet the shift to prevention.
- Moving care out of hospitals and into local communities had the lowest number of respondents (16) who were at least fairly confident in their ICB’s ability to deliver. 5 out of 21 said that they were not confident in their ability to make this shift.

We discuss the shift from hospital to community care through a neighbourhood health service further in the section on [Patients’ need and capacity in GP services to meet them](#) in this report.

Long waits in urgent and emergency care services

As demand for urgent and emergency care rises, we have seen some small improvements in the performance of the services that provide it. However, we are continuing to hear of people facing extensive waits for urgent and emergency care. Not only are these [long waits contributing to poorer experiences](#) for people,³⁰ but they can also have a negative impact on people’s outcomes from their care. As highlighted in last year’s [State of Care report](#), data from the Office for National Statistics (ONS) showed the risk of death for people needing non-immediate care increased after 2 hours in emergency departments.

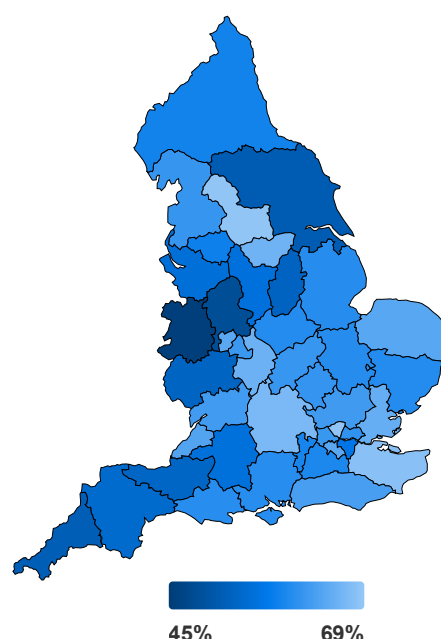
The NHS Constitution pledges that 95% of people should wait no longer than 4 hours in urgent and emergency services from arrival to either admission, transfer, or discharge. The NHS Urgent and Emergency Care Plan 2025/26 set a temporary target for 78% of patients to be seen within 4 hours by March 2026 as part of the recovery of urgent and emergency care services.³¹

Over the last year, the number of people waiting less than 4 hours to be either admitted, transferred or discharged has improved, with 74.9% seen within 4 hours across all types of urgent and emergency care services. Performance reached 77.1% by March 2026.

- At type 1 services, 60.9% of attendances (10.4 million) were seen in under 4 hours, up from 59.3% (9.9 million) in 2024/25. However, this varied across the country from 44.5% to 69.3% (figure 28). The proportion of people seen in 4 hours was better in type 2 services where 95.5% (584,000) attendances waited under 4 hours, and type 3 services where 97.2% (nearly 10 million) attendances waited under 4 hours.
- Initiatives such as Same day emergency care (SDEC) could be having an impact on waiting times. Introduced in 2019, SDEC is a model of care that enables people with relevant conditions to be rapidly assessed, diagnosed and treated without being admitted to a ward and, if clinically safe, allows them to go home the same day their care is provided.
- Analysis of our urgent and emergency care inspection reports found that SDEC services played an important role in improving patient flow, reducing admissions and providing timely assessment for patients who did not need care as an inpatient. SDEC was most effective when integrated with wider urgent and emergency care pathways, including frailty services, virtual wards and specialty teams. However, its effectiveness still depends on capacity in the wider system and that, during sustained periods of pressure, it remains focused on same-day discharges and does not become an extension of urgent and emergency care departments.

Figure 28: Urgent and emergency care performance varies considerably between ICB areas

Percentage of patients seen within 4 hours across type 1 urgent and emergency care services, by ICB areas in 2025/26



Source: NHS England, [A&E Attendances and Emergency Admissions](#)

We have also seen a marginal improvement in reducing long waits of more than 12 hours from arrival to either admission, transfer, or discharge across type 1 and type 2 services. In 2025/26, 51,000 fewer people had to wait more than 12 hours from the time of their arrival – a fall of 2.8% from 2024/25. However, this still means that 1.76 million people (10%) were waiting for more than 12 hours. This equates to nearly 34,000 people a week.

In contrast with previous years, the number of people who were admitted to hospital after attending an urgent and emergency care service has decreased. In 2025/26, 4.82 million people were admitted to hospital from the 3 main types of urgent and emergency care service, which is just over 52,000 fewer than in 2024/25. The number of people waiting over 4 hours from the decision to admit to admission also decreased. In 2025/26, 1,572,000 (32.6%) of people waited over 4 hours from decision to admit to being admitted, which is 75,000 fewer people than in 2024/25.

However, waits of 12 hours or more from decision to admit to admission have continued to increase. In 2025/26, 571,000 people – more than 1,500 people a day on average – waited more than 12 hours from decision to admit to admission, 38,500 more than in 2024/25. This data is supported by our analysis of urgent and emergency care inspection reports where we found that people experienced long waits at type 1 emergency departments. We also identified inequalities in waiting times, as people presenting with mental health needs experienced longer waits for care than patients with physical health conditions in some urgent and emergency departments (see also section on [secondary mental health care](#)).

“Patients described long waits in the department... At the time of our assessment, the longest wait was 40 hours, excluding patients with mental health needs who waited significantly longer. Data showed between May 2024 and January 2025 that the average time non-admitted patients spent in the department was over 4 hours and admitted patients was over 32 hours.”

(From a CQC inspection report)

People in inappropriate spaces while waiting for beds

Our analysis of urgent and emergency care inspection reports also looked at how services cared for people in urgent and emergency care departments while they were waiting for a bed. This remained a significant operational challenge as the difficulties in maintaining high-quality care were closely linked to overcrowding, delayed admissions and wider system flow pressures. In some cases, these led to patients waiting in emergency departments or corridor escalation areas for prolonged periods.

“Patients attending the department often experienced long waits, which increased the risk of deterioration. Between May 2024 and April 2025, 13% of patients waited more than 12 hours. [there are] Longer waits for children and people with mental health conditions.”

(From a CQC inspection report)

These findings were supported by feedback through our patient pathway tracking interviews with people during our urgent and emergency care inspections over winter 2025/26. People told us they were left on trolleys in corridors for extended periods, often many hours, or they were seated in chairs or put into side rooms. People frequently described the environment of emergency departments as overcrowded and chaotic, with pressures affecting nursing capacity and experience for patients.

These interviews also revealed how people often received treatment under these conditions, sometimes in view of other patients. Other people told us how the overcrowded environments left them experiencing discomfort, a loss of dignity and lack of privacy.

This echoes feedback from respondents to the 2024 Adult inpatient survey, with people describing extended waiting periods as stressful and how they were often not attended to with little or no access to food or drink.

“Unfortunately, my time in A&E (waiting for a bed on the ward) was long and uncomfortable. It was very busy, noisy and the nurses were rushed off their feet. I was fortunate to be well enough to advocate for myself but I witness elderly patients being left without food and water for long periods of time.”

(Feedback from 2024 Adult inpatient survey)

In February 2026, NHS England published its guidance The Model Emergency Department: high performing urgent and emergency care pathways. Recognising the longstanding challenges facing emergency departments, and the need for an overall system effort to improve urgent and emergency care, the guidance focuses on elements within the control of emergency departments and sets out opportunities for good practice in internal emergency department pathways.³²

Analysis of our urgent and emergency care inspection reports highlighted the steps some trusts are taking to address the pressure in urgent and emergency care and prevent people receiving care in inappropriate spaces. For example, at one trust staff assessed people quickly and transferred them as soon as possible if they needed more specialist care. They also had procedures in place to quickly escalate and manage growing waits both in ambulances and inside the hospital. Teams worked effectively within the hospital and with external partners to move people quickly and ensure continuity of care. Data from the

trust showed that between February 2025 and January 2026, the service met the national performance standard to admit, transfer or discharge 78% of patients within 4 hours of their arrival in the emergency department. It also had a ‘no corridor care’ approach for people who needed to be admitted to hospital.

“The premises and facilities supported the delivery of safe care. Patients were allocated to different areas of care depending on the severity of their condition: resuscitation unit, majors, ambulatory majors, UTC and the GP centre. Areas were well maintained and monitored to deliver safe care. Patients were not cared for in non-designated areas, such as corridors throughout the period of our inspection.”

(From a CQC inspection report)

In April 2026, the government announced that NHS trusts with the highest levels of corridor care would receive tailored support from the Getting it Right First Time (GIRFT) team. This involves providing bespoke clinical support to leaders to identify how to improve the flow and discharge of patients, helping trusts to understand their own data to improve how they can predict surges in demand, and supporting clinical leaders to improve their decision making.³³

The State of Emergency Medicine in England report by the Royal College of Emergency Medicine, published in June 2026, highlights the impact of long waits, high bed occupancy and a lack of patient flow on patient safety. The report describes how these challenges are continuing to lead to overcrowded emergency departments, and how long waits are closely linked to an increased chance of death within the following 30 days.³⁴ As we describe below, one of the principal reasons why people are kept waiting for so long is because of a lack of available beds.

Challenges in hospital care

Bed occupancy and its impact on people

The NHS 2023/24 priorities and operational planning guidance recommends that no more than 92% of beds should be full at any one time to ensure that people are able to get the care they need and can be admitted to hospital when they need to be. The Royal College of Emergency Medicine (RCEM) thinks this should be lower, recommending that no more than 85% of beds are full at any one time, and that hospitals should justify why they exceed this level. Over the last 3 years, the average occupancy levels of general and acute beds have continued to stay at a high of 93%.

The average number of general and acute beds that are available has steadily increased year-on-year since 2021/22 until 2024/25 and was broadly level in 2025/26. However, the increase in the number of beds has not kept pace with the size of the population, as the number of

beds per 100,000 people decreased by 0.9% from 174 per 100,000 in 2024/25 to 172 per 100,000 in 2025/26. This data is supported by a recent [analysis from the King's Fund](#), which shows that the number of acute and general beds has not grown in line with the number of admissions from emergency departments since 2011/12.

As we highlight in the section on Ongoing issues with discharge, challenges in the wider system and hospital processes can additionally affect patient flow through the hospital.

Pressure on the system and a lack of bed capacity can lead to people being cared for in settings that cannot provide safe and effective care. This is an ongoing concern from last year's report, where we discussed the impact of [providing care in inappropriate spaces](#). We reiterate to trusts that the use of inappropriate, non-clinical spaces is not acceptable. We recognise that the use of risk-assessed, short-term temporary spaces may be necessary to relieve pressure across the urgent and emergency care pathway. However, patients must receive safe and effective care in an environment that allows their privacy and dignity to be protected, and 'corridor care' must never become normalised.

As well as experiencing long waits in emergency departments and receiving care in inappropriate spaces, some respondents to the Adult inpatient survey described instances of being moved from ward to ward without warning multiple times, and often during the night. This caused stress and disturbed people as they were not sure what was going on.

Although moving people might help hospitals to manage the flow of patients in a constrained system, having multiple points of transition can reduce the continuity of specialised care and increases the risk harm, for example people's notes being incomplete or going missing. Through our annual engagement with chief pharmacists in NHS trusts, we heard that having multiple points of transfer was a particular risk for medicines, with documentation on people's medicines not being thorough or well-recorded if medicines reconciliation was not robust at the start of their admission.

Having multiple points of transition can also affect the quality of communication between patients, their families and staff. We heard this sentiment from people we spoke with in our patient pathway tracking interviews, who told us that communication was weaker at points of transition. Some respondents to the 2024 Adult inpatient survey also felt that a lack of continuity was a problem, and they did not appreciate having to repeatedly explain their requirements to new or different members of staff.

Impact of poor ward environments

Once on a ward, people have reported concerns with the environment. For example, respondents to the 2024 Adult inpatient survey reported concerns including that:

- the wards were very busy and overcrowded
- the temperature on wards was not always optimal – either too hot or cold
- they felt wards and/or toilets could be cleaned more frequently as they were often dirty.

The 2025 Adult Inpatient Survey found the proportion of people saying their hospital room or ward was very clean has decreased from 74% in 2021 to 69% in 2025. Results also showed that only 37% of respondents felt they were able to sleep on the ward. Factors that prevented people from sleeping included:

- noise from other patients (36%)
- discomfort from pain (24%)
- noise from medical equipment (18%)
- hospital lighting (17%)
- noise from staff (17%)
- room temperature (10%)
- something else (7%).

This reflects similar findings from the 2024 Adult inpatient survey, where respondents reported that the wards were often noisy at night, as night staff were chatting with each other or on their phones. There was also often noise when staff were moving equipment or furniture around the ward. Other concerns included noise when new patients were admitted, disturbances from equipment, excessive light on the ward and noise from visiting relatives.

“...my only problem was not being able to sleep well at night due to noise, but obviously this could not be prevented due to the necessity of machines and medical alerts during the night”.

(Respondent to the 2024 Adult inpatient survey)

While the 2025 Adult inpatient survey found that the majority of people felt they had enough privacy when being examined or treated, free text responses from the 2024 Adult inpatient survey also described some concerns about privacy on the wards, which could have an impact on people's dignity. For example, some patients reported that they were in full view of other people when being treated or being changed:

“There was a real lack of privacy on the ward as my bed was in a make-shift cubicle. The doctor and my partner had to set up the screens rather than ward staff. I had enough support from nurses and doctors but other people on the ward did not”.

(Respondent to the 2024 Adult inpatient survey)

As we have reiterated to trusts on the use of inappropriate spaces, people should receive safe and effective care in an environment that protects their privacy and dignity. As the feedback above illustrates, creating additional bed spaces to accommodate patients can have an impact on the quality of people's care, as well as compromising their safety.

Ongoing issues with discharge from hospital

As highlighted by [the Health Foundation](#), delayed discharges from hospital are bad for patients, increasing the risk of infection, loss of mobility and worse mental health.³⁵ Delayed discharges refer to people who remain in hospital despite being ready to leave. This means that people are staying in hospital longer than is medically necessary. This can affect patient flow through the hospital as beds remain occupied, limiting capacity for incoming patients and creating knock-on effects throughout the system. As with other areas of hospital care, we continue to see ongoing challenges with delays to discharge.

In 2025/26, a daily average of 13,000 people remained in hospital who were medically fit to be discharged, which is more than 1 in 8 (13.8%) adult general and acute hospital beds. This is up from 2024/25 when an average of 12,700 people were delayed, occupying 13.4% of beds.

NHS England publishes data on the reasons for delayed discharges for longer stay patients (people who have been in hospital for 14 or more days), which provides some insight into why people are staying in hospital longer than necessary. In 2025/26, the most common reasons for delays for longer stay patients were:

- a lack of capacity or delays in completing transfers to rehabilitation, reablement or recovery services (24.6%)
- a lack of capacity or delays in completing transfers to social care services (24.1%)
- hospital process, including waiting for reviews, medicines and other discharge information (18.5%).

This is supported by evidence from our analysis of information gathered from our patient pathway tracking interviews, part of our inspections of emergency departments and medical wards over winter 2025/26. This highlighted issues including delays in arranging packages of care in the home environment, and patients waiting for discharge letters or patient transport services, as the following experience shows:

“Dad’s going home with a package of care. The process was started yesterday morning. We were moved here (to Discharge Assessment Unit) this morning. We’re still waiting. I’ve asked what will happen if it gets to tonight and the carers aren’t ready, and they’ve said he’ll stay here in bed. It’s frustrating, my in-laws were here last year and my husband hates the discharge unit.”

(Patient pathway tracking interview)

In addition, many respondents to the 2024 Adult inpatient survey reported that delays in discharge were because medicines were not available:

“The amount of time it takes for medication once discharged, i.e. sent to pharmacy approximately 10.30am, [but] not ready until approximately 17.30. Total waste of hospital bed could a prescription be given to collect from own pharmacy”.

(Respondent to the 2024 Adult inpatient survey)

People raised the problem of poor communication around discharge in our pathway tracking interviews, as some people and families felt the information they were given was inadequate. Results from the 2025 Adult inpatient survey found that:

- only 49% of respondents said they definitely had enough notice about when they were going to leave hospital
- 77% of respondents were given information about what they should or should not do after leaving the hospital, of these, 70% understood the information very well and 28% fairly well
- only 48% of respondents said their family or carers were given all the information they needed to care for them at home.

Effective communication and planning between hospitals, patients and other agencies is an important factor in allowing a safe and successful discharge from hospital and gives people a better chance of remaining out of hospital.

Challenges with discharge and readmission

To maintain sufficient bed capacity and improve the flow of patients from the emergency departments, wards can be under pressure to discharge patients without delay. However, as highlighted above,

making sure that timely discharge happens safely requires co-ordination with community support services as well as a high level of clinical expertise.

Where there is a lack of appropriate community support or when people are discharged before being medically fit can lead to them being readmitted to hospital. The risk of readmission to hospital is higher for people aged 75 and over, with a rate 17.8%. 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.

Some respondents to the 2024 Adult inpatient survey felt they were discharged before they were ready. Furthermore, only 47% of respondents to the 2025 Adult inpatient survey who said they needed support from health or social care after leaving hospital said they definitely got the help they needed.

This is supported by findings of our analysis of information from our patient pathway tracking interviews, which noted cases of patients being discharged when they did not feel ready to go home.

“Mr X felt there was lack of communication with regards to discharge, and feels he was discharged too early on his last admission, which is why he had become unwell again.”

(Patient pathway tracking interview)

At other locations, patients and their families told us about incidents where they were discharged from hospital, but then had to return or be readmitted within a short period (typically within 30 days).

“... the patient developed a cough and shortness of breath on exertion. The patient’s daughter phoned 999, and the patient was taken to hospital by ambulance but was subsequently discharged home. Following this, community nurses visited to assess the patient and determined that the patient was not fit to remain at home, advising an immediate return to A&E. The patient’s husband then transported the patient back to the emergency department”.

(Patient pathway tracking interview)

At one of these locations, a patient had reportedly been admitted multiple times for the same condition, including being admitted on 3 separate occasions within less than 2 weeks.

“[The patient] has had multiple admission with chest problems last year. Currently on second admission this year. Previously discharged ... with pneumonia and heart failure... However, presented to A&E 5 days later ... to A&E and was discharged... [readmitted 4 days later] ... after wife called the ambulance”.

(Patient pathway tracking interview)

Waits for hospital care

More people waiting for diagnostic tests

We know that prompt diagnosis can save lives, saves time and money, and can prevent conditions from getting worse.³⁶ In last year’s State of Care, we highlighted the ongoing rise in the numbers of diagnostic tests carried out. This trend has continued in 2025/26, with the monthly average of scheduled and unscheduled diagnostic tests and procedures carried out increasing by 78,000 from 2,419,000 to 2,497,000. However, at the same time, the average number of people who are waiting for a diagnostic test has risen by almost 140,000 to nearly 1.8 million people.

This suggests that demand is exceeding capacity.

The NHS Constitution states that people should wait less than 6 weeks from the point at which the referral is made, but performance against this standard has worsened with the increasing demand.

There were, on average, 390,000 people on the waiting list for more than 6 weeks in 2025/26, which is 40,000 more than the previous year.

On average, nationally 77.8% of people had their diagnostic test within 6 weeks in 2025/26. However, performance varies. As at March 2026, 95% of tests were carried out within 6 weeks in the best performing integrated care board areas, while 55% were carried out within 6 weeks in the worst performing areas.

In line with the NHS 10-year health plan to move care away from hospitals into the community, in April 2026 the government announced it was investing £237 million in new community diagnostic centres (CDCs) to boost NHS diagnostic capacity and deliver more care in local communities.

Slight improvements in waits for elective care

Waiting times for routine hospital care are a key measure of NHS performance.³⁷ As well as having a big impact on patients’ experiences, they consistently rank as one of the public’s main concerns with the NHS.³⁸ The 2025 Adult inpatient survey found that 43% of respondents felt their health deteriorated while waiting to be admitted to hospital – the same proportion as the previous survey.

In the NHS, waits for elective care are measured by the number of open or ‘incomplete’ pathways of care. An incomplete pathway represents a patient’s wait for specific treatment. This means a single patient can be on more than one pathway at a time. Data from NHS England shows

that although the numbers of incomplete pathways have fallen, they still remain high. Over the course of 2024/25, the average size of the elective care waiting list had stood at 7.5 million, falling to an average of 7.3 million incomplete pathways of care in 2025/26. Monthly data for 2025/26 shows that the waiting list remained largely stable at 7.4 million through the beginning of the year, before beginning to fall in November 2025 reaching 7.1 million in March 2026.

In January 2025, NHS England set out its plans for reforming elective care. This set the target that by 2029, 92% of waits for care should be 18 weeks or less. As part of its plans, NHS England set an interim target of 65% to be achieved by March 2026.³⁹

The proportion of waits for care of 18 weeks or less has improved, with an average of 61.7% in 2025/26, compared with 58.9% in 2024/25. Monthly figures for 2025/26 show that while performance largely ranged between 61% and 62% in the year, it increased over the last 2 months, reaching 65.3% in March 2026, meeting the 65% interim target. Performance has also improved at integrated care board level, with 21 integrated care board areas meeting the target, and an additional 11 being within 2% of it, in March 2026.

Overall, fewer people are experiencing long waits. The proportion of waits for care over 52 weeks has improved from an average of 3.3% in 2024/25 to 2.2% in 2025/26, with only 1.3% of waits in March 2026 lasting 52 weeks or longer.

However, while this improvement is encouraging, the response from Healthwatch to the March publication of waiting times stated that this still leaves an unacceptably high number of people stuck in limbo, which can take a toll on people's health, work, and family life.⁴⁰ Evidence from our analysis of NHS data shows that some people continue to be at risk of longer waits than others. The Waiting List Minimum Dataset (WLMDs) shows that between June 2025 and March 2026, on average people in the most deprived areas of England had longer waits for treatment than those in the least deprived areas, with 59.7% of people in most deprived areas waiting less than 18 weeks compared with 61.3% in the least deprived areas. WLMDs data also shows that, where ethnicity is recorded, people of Mixed and Asian ethnicities had longer waits for treatment, with an average of 59.3% of people waiting under 18 weeks, compared with people whose ethnicity is White (60.7%).

In its recent analysis of NHS England's Waiting List Minimum Data Set, the Health Foundation highlighted some improvement in inequalities in waiting list times, with the proportion of people waiting for less than 52 weeks narrowing substantially between the most and least deprived areas. However, it notes how progress has been uneven across the country, with a small number of integrated care board areas accounting for a large share of the reduction in inequalities for very long waits.⁴¹

Findings from the 2024 Adult inpatient survey also highlight concerns when appointments for treatment, tests or clinics are cancelled – often

at short notice and on multiple occasions. This included people having their surgery or treatment cancelled or delayed after they had already been admitted to hospital. Those affected told us that there was often little explanation or communication from staff as to why their treatment had been delayed or cancelled.

“I had a lot of appointments cancelled at short notice since my op on 3 times. I was to see my consultant. She was not there so they got a physio to see me”.

(Respondent to the 2024 Adult inpatient survey)

As highlighted in the Healthwatch response, alongside efforts to reduce the length of waits, people must be kept informed about their care, including being given information about the support available to them while they wait, so they feel confident that they have not been forgotten.

Care and treatment for cancer

Cancer will affect 1 in 2 people during their lifetime.⁴² [Macmillan Cancer Support](#) estimates that there are almost 3.5 million people living with cancer in the UK, with more than 420,000 people diagnosed with cancer each year.⁴³

Last year, Cancer Research UK published research showing that since the 1970s, the 10-year survival rate for all cancers combined in England and Wales has doubled, from 24% for cases diagnosed in 1971/72 to 50% for those diagnosed in 2018. However, survival rates vary by the type of cancer, and data from NHS England shows that pancreatic cancer has the lowest 5-year survival rates – less than 10% for both males and females. This data also shows that for most cancers, survival is generally lower in patients diagnosed in areas that are the most deprived and higher in areas that are the least deprived.

Cancer treatment is more likely to be successful when people get an early diagnosis. This means that the cancer is spotted at an early stage, such as [stage 1 or 2](#), when it is usually small and hasn't spread to other parts of the body.⁴⁴ In February 2026, the Department of Health and Social Care published its [National Cancer Plan for England](#), which sets out plans for transforming cancer care and outcomes in England by 2035. This includes improving and modernising the early detection pathway.⁴⁵

On its [cancer advice page](#), NHS England recommends that if people are concerned about symptoms, they should contact their GP. GPs can refer people into secondary care for further investigation, diagnosis and treatment through an urgent suspected cancer (USC) referral.

The [Fingertips dashboard](#) from the Department of Health and Social Care reports the number of USC referrals, and how many of these result in a diagnosis of cancer, for all cancer types.

Nationally, the number of people with a USC referral has increased since 2009/10 but the proportion of people being diagnosed with cancer (known as the conversion rate) has been falling over the same period, and stood at 6.2% between 2020/21 and 2024/25 (the most recent reporting period available). At the same time, the proportion of new cancer cases treated resulting from a USC referral (known as the detection rate) has increased to 55% in the 2020/21 to 2024/25 reporting period. This suggests that more people are being referred for tests and, as a result, more cancers are being detected.

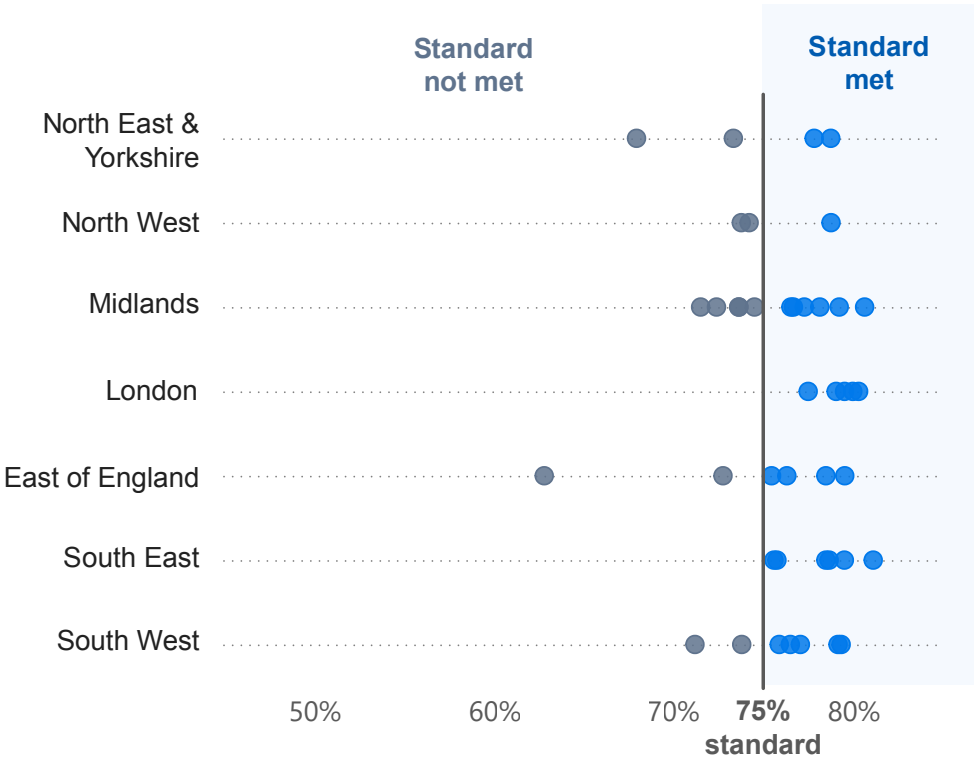
Once referred for a test, the faster diagnosis standard states that 75% of people should receive either a diagnosis of cancer or have cancer ruled out within 28 days. This standard was increased to 80% in March 2026.⁴⁶

Results of NHS England’s National Cancer Patient Experience Survey 2025 showed that 78.1% said they felt the length of time waiting for diagnostic test results was about right (up from 77.5% in 2024).⁴⁷

At a national level, performance against the standard has remained largely unchanged since 2024/25, with 76.3% of people receiving a result within 28 days. Performance in March 2026 was 79.4%, narrowly missing the new 80% standard. At a local level, on average across 2025/26, 29 ICB areas met the target of 75% of people receiving a result in 28 days, of which 10 always met the target in 2025/26 (figure 29).

Figure 29: 29 out of 42 ICBs met the 28-day cancer diagnosis standard on average across 2025/26

Percentage of people receiving a cancer diagnosis or having cancer ruled out within 28 days, by integrated care board within each NHS region, 2025/26



Source: NHS England, 2025-26 Monthly Cancer Waiting Times Statistics

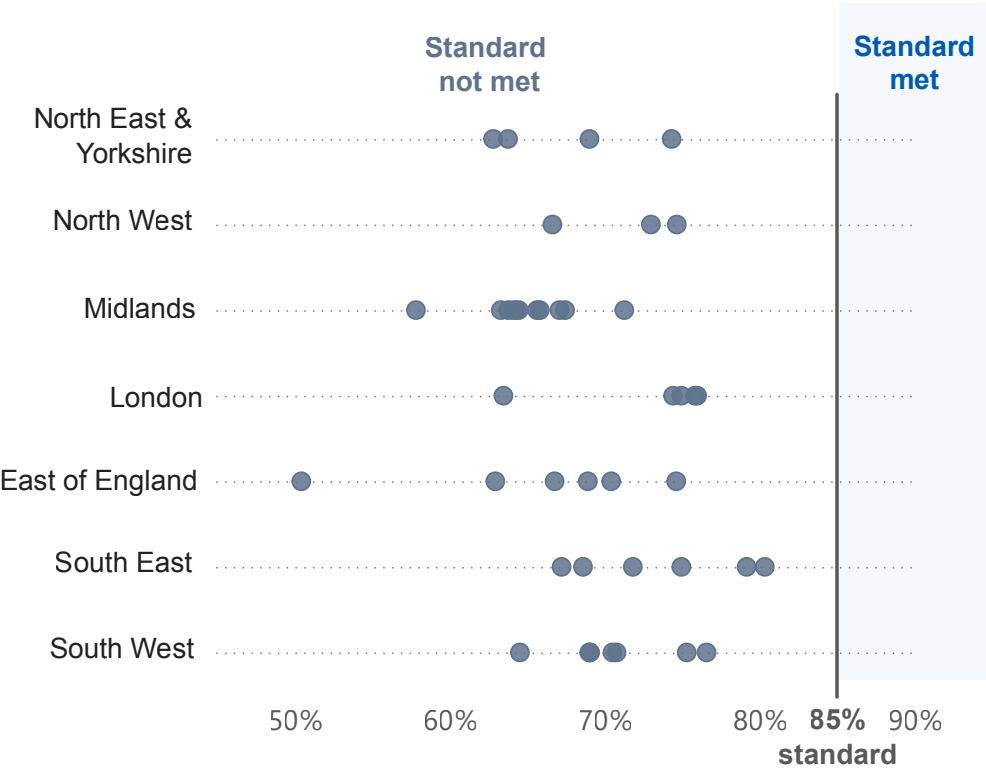
While performance against the standard for diagnosis have remained consistent, we continue to be concerned that people are having to wait too long with a diagnosis of cancer before starting treatment.

NHS guidelines state that 96% of people should have their treatment started within 31 days of a decision being made to treat their cancer. Over the last year we have continued to see some improvement against the standard. The national average was 91.8%, an increase from 91.1% in 2024/25, and only 4 ICB areas met the standard on average across the year. Only 14 out of 42 ICB areas met the standard in at least one month in 2025/26, up from 9 last year.

The current standard is that 85% of people with an urgent referral should start treatment within 62 days. However, performance against this standard remains poorer than the other targets, with an average performance in 2025/26 of 69.4%, and it has not been met once by any integrated care board area in 2025/26. Performance also varies across the country from 80% in the highest performing areas to 50% in the lowest performing area (figure 30). As delays in treatment are associated with worse outcomes for patients, this is a blockage that needs to be addressed.

Figure 30: **No ICB areas met the 85% standard for 62-day treatment on average**

Percentage of people receiving urgent referral treatment within 62 days, by integrated care board within each NHS region, 2025/26



Source: NHS England, 2025-26 Monthly Cancer Waiting Times Statistics

Maternity care

Safe, high-quality maternity care should be everyone's minimum expectation – not just an aspiration. It is what families deserve and what maternity staff want to provide. Yet 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.

In 2026, there have been 3 important reports published into failings in maternity and neonatal care across the country:

- the final report of the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust by Donna Ockenden
- the final report of the Independent Investigation into Maternity and Neonatal Services in England by Baroness Amos
- the Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018 by Lady Justice Thirlwall.

Together, these reports continue to paint a troubling picture of the harm experienced by too many families, adding to the weight of evidence showing the vital need for improvement.

Our National review of maternity services in England 2022 to 2024 gave us a comprehensive view of the quality of maternity services. Of the 131 locations inspected as part of that programme, overall:

- 12% were rated as inadequate
- 36% were rated as requires improvement
- 48% were rated as good
- 4% were rated as outstanding.

As at 4 August 2026, we had rated 51 maternity services under our current assessment framework since its introduction. It is important to note that assessments of services under the current framework have been largely based on risk to people using them, so ratings may not be representative of all services in a particular sector. This means that we have prioritised our assessments where our data indicated there may be greater risk to quality and safety for people.

Of the overall ratings for maternity services under our current assessment framework:

- 8% were rated as inadequate
- 43% were rated as requires improvement
- 49% were rated as good.

None have been rated as outstanding overall.

We continue to stress the critical need for a faster pace of improvement nationally, particularly around the safety of maternity services. We owe it to all those affected by failures in maternity and neonatal care to act on the recommendations in the reports from Donna Ockenden, Baroness Amos, and Lady Justice Thirlwall and ensure that this leads to meaningful, lasting change.

As an organisation, we recognise that we have more work to do to strengthen our approach to assessment and regulation. It is vital that our regulation of maternity care is effective, and that through our inspection and monitoring of services we ensure robust oversight, and that there is genuine learning and support to enable services to improve.

As part of this work, and in line with our commitment as a learning organisation, we are considering the implications of recent national reviews and inquiries to determine with stakeholders how we can strengthen our regulation of maternity services, identify opportunities to improve our existing oversight, detect risks early and drive better outcomes for women and families.

Focus on safety

Too many women are still not receiving the high-quality, safe maternity care they deserve. Our national review identified widespread issues affecting the safety of maternity services in England. Looking specifically at the safe key question, at the end of our programme, we had rated:

- 18% as inadequate
- 47% as requires improvement
- 35% as good.

No hospitals were rated as outstanding for the safety of maternity services.

Of the 51 services rated to August 2026 under our current assessment framework, for the safe key question we have rated:

- 14% as inadequate
- 53% as requires improvement
- 33% as good.

No hospital has so far been rated as outstanding for the safety of maternity services.

In the 2025 maternity survey, the results show improvement in many areas of maternity care, but women still report poorer experiences in certain areas that are affecting their safety. For example:

- 72% of respondents who went through triage to have their symptoms assessed said they ‘definitely’ got the advice they needed the last time they contacted the telephone triage line, 21% said they got it ‘to some extent’.
- Most (91%) respondents who went into labour said they were not sent home while worried about themselves or their baby, but 7% said this happened once, and 3% said it happened more than once.
- Just over three-quarters (76%) said they were not left alone at a time when it worried them. By contrast, 12% said this happened during early labour, 7% during the later stages of labour, 3% said it happened during the birth, and 9% said it happened shortly after the birth.

- While the majority of respondents (82%) felt their concerns were taken seriously if they raised a concern during labour and birth, nearly a fifth (18%) did not feel that their concerns were taken seriously.

Our national maternity review raised worrying issues such as being left alone during labour, which was often a result of staffing pressures. We also called out the issue of safety risks presented by inherent inequalities in women's access to maternity services, their experience and outcomes from care.

This year we take a closer look at the impact of staffing and culture on the safety of maternity services. We also look at the inequalities facing some women who have protected characteristics under the Equality Act 2010 in relation to maternal readmissions.

Staffing, culture and safety

Our national review of maternity services in England enabled us to highlight concerns that many women were not receiving safe care because of the pressures on staff.

This concern was echoed in the final report of the Ockenden review, which noted that low staffing levels was the most serious and pressing issue.⁴⁸ Persistent workforce pressures were also highlighted in the Amos review, which referenced staff shortages, continued reduction in the workforce, gaps in rotas, high absence rates and too little protected time for training, learning and improvement.⁴⁹

In last year's State of Care report, we highlighted how we expect services to make sure there are appropriate levels of staff and skill mix in order to keep people safe and ensure they receive consistently safe, good quality care.

The NHS maternity services survey asks people about their experiences of antenatal care, labour and birth, and care on the ward after birth. The overall results from the 2025 survey for questions relating to the availability of staff and amount of time during appointments were broadly positive. However, a substantial proportion of respondents said they did not always get the care they needed. We found:

- nearly three-quarters (74%) reported that they were 'always' given the help they needed from their midwifery team during pregnancy, but 20% reported that this only happened 'sometimes', with 3% saying they did not get the help they needed and 3% saying they were unable to contact their midwifery team
- 75% said they were 'always' given the help they needed if they contacted the midwifery team for the postnatal care period, with 5% saying they did not get the help they needed
- 66% of respondents reported that they were 'always' able to get help from a member of staff when they needed it during labour and birth, while 12% said that a member of staff was with them 'all the time'; however, 5% said they were unable to get help when needed

- following birth, 57% reported that they were ‘always’ able to get help from staff when needed while in hospital, with 10% of respondents said they were unable to get this help.

Our analysis of responses to the NHS staff survey shows that those services where midwives report more strain on staff, concerns about retention of staff, and poorer safety cultures typically receive a worse rating for the safe key question.

We found responses to the following survey questions were notably different by ratings for the safe key question:

- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again – services rated as inadequate had a median score of 62% compared with 79% for services rated as good.
- My organisation acts on concerns raised by patients / people who use services – services rated as inadequate had a median score of 66%, compared with 82% for services rated as good.
- If I spoke up about something that concerned me I am confident my organisation would address my concern – services rated as inadequate had a median score of 38% compared with 53% for services rated as good.

We also saw that questions related to teamwork and good workplace culture varied by rating:

- Relationships at work are never or rarely strained – services rated as inadequate had a median score of 30%, compared with 44% for services rated as good.
- Teams within this organisation work well together to achieve their objectives – services rated as inadequate had a median score of 46%, compared with 59% for services rated as good.

In our national review of maternity services, we highlighted the importance of an open and positive culture on the safety of services. We noted how a healthy culture enables staff to feel supported and empowered to thrive, with better staff retention, which is crucial to ensuring high-quality, safe care for people. However, during our national review staff spoke of low morale and described a blame culture, where managers did not listen to their concerns. When staff do not feel empowered to speak up, or their concerns are dismissed it can be indicative of a closed culture, in which people are more at risk of deliberate or unintentional harm.

These findings have again been supported by the findings of the final report of the Ockenden review, which highlighted that many members of staff reported a fear of speaking out as well as a culture of ‘them and us’ between midwifery and obstetric staff. Similarly, the Amos review found evidence of challenging cultures, with fear, staff feeling blamed, hierarchical structures, inequity in leadership structures, racism and discrimination undermining speaking up, teamwork and learning.

It is important to note that while the assessment of culture remains largely subjective, progress is being made through initiatives such as the COMPASS project from the Maternity and Newborn Safety Investigations (MNSI) programme. This aims to develop a standardised approach to assessing organisational culture. But ultimately, a cultural shift is needed. System partners must consider how to better involve families and representative groups within accountability structures to ensure all women receive the information they need to make informed decisions.

Impact of inequalities in care

As we reported in last year's State of Care and in our national review of maternity services, some women with protected characteristics under the Equality Act 2010 remain at greater risk of harm.

Latest data for England from [MBRRACE-UK](#) shows ongoing inequalities, with stillbirths over 24 weeks almost twice as likely for women from the most deprived areas (4.18 per 1,000 in the most deprived areas compared with 2.21 in the least deprived areas). These women were also nearly twice as likely to die as those from the least deprived areas (18.1 per 100,000 in the most deprived areas and 9.32 in the least deprived areas).

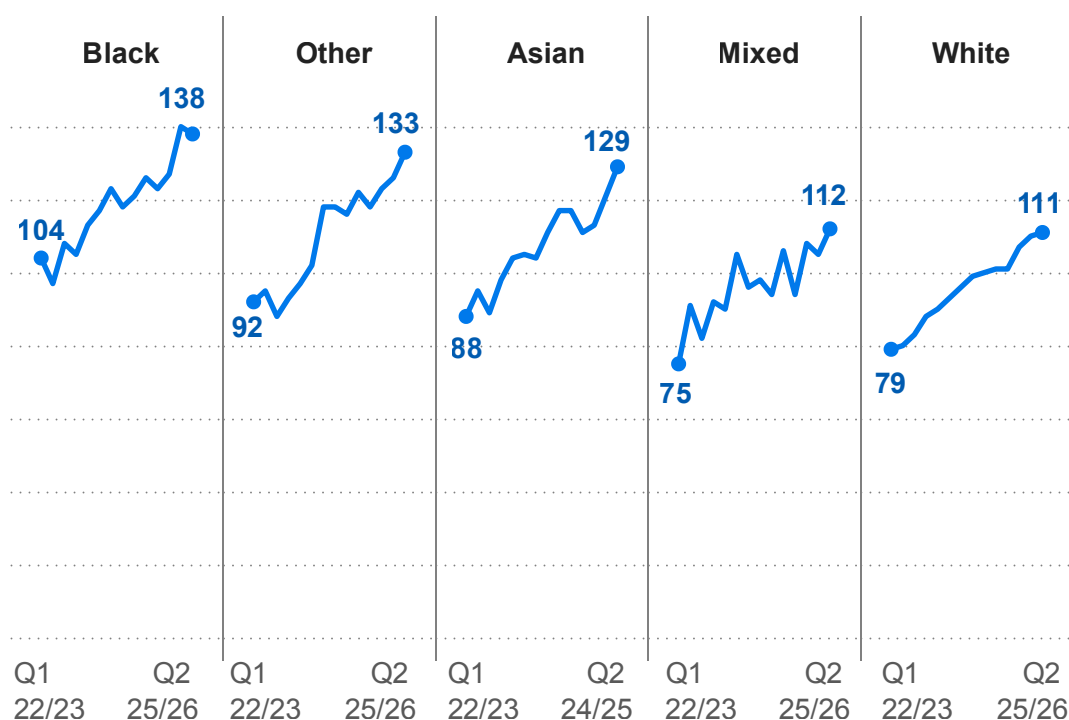
Babies from Black ethnic groups were twice as likely to be stillborn than babies from White ethnic groups (5.34 per 1,000 compared with 2.56 per 1,000). Maternal mortality rates were also more than double for Black women than for women of White ethnicity (32.42 per 100,000 compared with 11.93 per 100,000).

In her report, Baroness Amos highlighted that racism, discrimination and structural inequalities are embedded throughout the maternity and neonatal system, with profound implications for the quality of care women and babies receive and the outcomes of that care. The report describes how women, birthing people and families told the review about experiencing racism and discrimination, including receiving unfair or unequal treatment, leading to delays and unsafe care with, at times, devastating outcomes.

This inequality in care is reflected in our analysis of maternal readmissions, which highlights variation between ethnic groups and levels of deprivation. We have previously raised concerns in our [2022 Safety, equity and engagement](#) report and [2022/23 State of Care](#) reports about Black women consistently having the highest rate of readmission to hospital during the 6-week postpartum period. Our analysis of NHS England's Hospital Episode Statistics from 2022/23 to 2025/26 found that rates of maternal readmission within 6 weeks of birth have continued to rise for all groups, but remains highest for women from Black ethnic groups (138 per 1,000 compared with 111 per 1,000 for people from White ethnic groups for Q2 2025/26) (figure 31).

Figure 31: **Women from Black ethnic groups continued to experience the highest readmission rates**

Maternal readmission rates per 1,000 women by ethnic group, Q1 2022/23 to Q2 2025/26



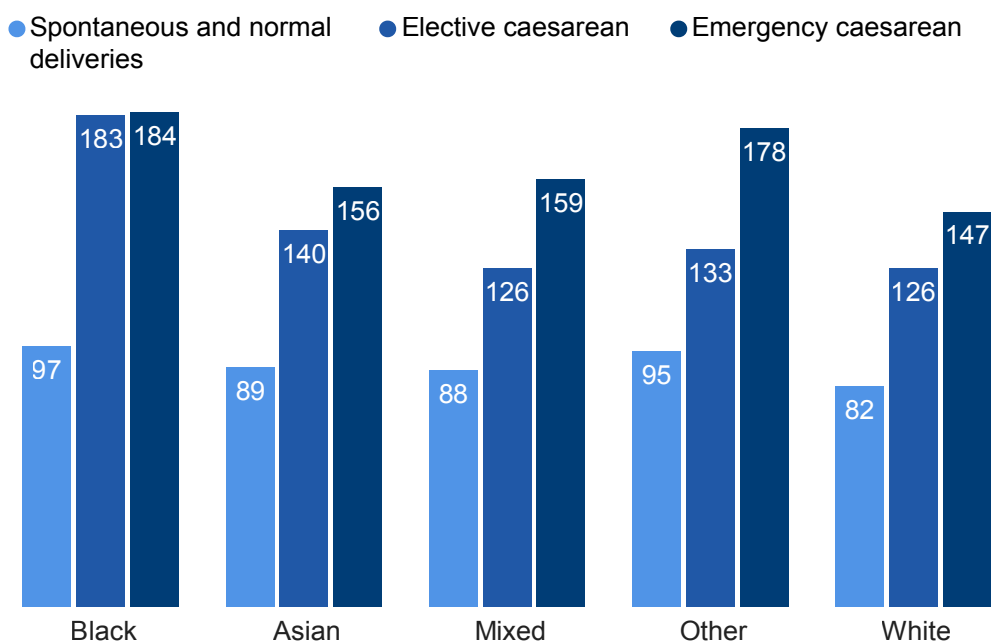
Source: NHS England, [Hospital Episode Statistics](#)

The disparity between Black women and those in other ethnic groups is even more stark for maternal readmissions by the method of delivery.

In the first half of 2025/26, readmission rates varied by ethnicity and delivery method: the smallest differences were between ethnicity groups for spontaneous and unassisted births. For women whose ethnicity was recorded, 97 per 1,000 Black women were readmitted following a spontaneous and unassisted birth, compared with 82 per 1,000 White women (who had the lowest rate). The difference between ethnicities increased for emergency caesareans (184 per 1,000 for Black women and 147 per 1,000 for White women). The difference is particularly stark for elective caesareans, where 183 per 1,000 Black women were readmitted, compared with 140 per 1,000 Asian women as the next closest group, and 126 per 1,000 White women, who have the lowest readmission rate.

Figure 32: **Readmission after elective caesarean is much higher among Black women**

Maternal readmission rates per 1,000 women, split by ethnicity and delivery method, April to September 2025



Source: NHS England, [Hospital Episode Statistics](#)

We are not able to draw firm conclusions to account for this finding, which needs to be explored in greater depth. Possible factors influencing the higher rates for maternal readmissions could be that that Black women disproportionately experience traumatic deliveries, which are more likely to result in complications, and/or that they do not receive the same level of community postnatal care preventing the need for readmission, that other women are able to access. Evidence, for example from the Health and Social Care Committee’s report on [Black Maternal Health](#), strongly indicates that structural racism within medical systems can lead to Black women being less likely to be listened to and their concerns – including postpartum symptoms – being dismissed.

Workforce in NHS trusts

Workforce Race Equality Standard

The 2021 Nuffield Trust report Attracting, supporting and retaining a diverse NHS workforce, clearly sets out the importance and benefits of having an ethnically diverse workforce including:

- improved quality of care for patients
- a more sustainable workforce supply
- increased efficiency of services.⁵⁰

Through our inspections, we look at how well organisations are monitoring and managing equality, diversity and inclusion in their workforce under the well-led key question. This year, as part of work to improve how we assess and report on workforce equality, diversity and inclusion, we reviewed 15 assessments of the well-led key question in NHS trusts that were completed between January 2025 and January 2026.

In services where we saw poor performance, this was in areas such as:

- workforce equality, diversity and inclusion, with issues including race inequalities and disability inequalities
- weak governance, including poor board oversight and ineffective mechanisms for identifying, escalating and acting on workforce risks
- insufficient resourcing of equality, diversity and inclusion work
- slow progress on implementing the Patient and Carer Race Equality Framework (PCREF).

Whereas trusts that performed better had effective staff networks, clear and monitored equality action plans that were monitored, and strong engagement from executive levels.

As part of our monitoring of the NHS workforce, we look at the NHS Workforce Race Equality Standard (WRES). WRES monitoring was introduced in 2015 and is designed to help NHS organisations identify improvements in managing and monitoring inequalities through 9 workforce indicators.

Last year, we reported seeing an improvement in the representation of people from ethnic minority groups in the NHS workforce, including in senior leadership roles and boards. But we noted that representation at a senior level was still low, and that staff felt equal opportunities for career progression or promotion was still lower than for staff in White ethnic groups.

This year, while we have continued to see signs of improvement, inequalities in recruitment, career progression and staff experience remain widespread across the NHS. Between 2024 and 2025, the proportion of all NHS staff from ethnic minority groups rose from 28.6% to 30.7%. At the same time, the proportion of staff from ethnic

minority groups in senior roles has also improved slightly from 12.7% in 2024 to 14.1% in 2025, but remains 16.7% lower than the overall workforce at 30.7%.

In 2025, staff from White ethnic groups have continued to report better opportunities for career progression or promotion than staff from ethnic minority groups. Around 1 in 2 (49.6%) staff from ethnic minority groups said they had equal opportunities for career progression, compared with around 3 in 5 White staff (59.1%). White applicants were also more likely to be appointed from shortlisting than applicants from ethnic minority groups. In 2025, around 1 in 4 (25.9%) White applicants were appointed compared with around 1 in 7 (14.6%) applicants from ethnic minority groups.

Staff from ethnic minority groups have continued to report higher levels of harassment, bullying or abuse from either patients, relatives or the public than those in White ethnic groups, with almost 3 in 10 (28.6%) staff from ethnic minority groups reporting these experiences compared with almost 1 in 4 from White ethnic groups (23.6%). Similarly, staff from ethnic minority groups continued to report higher levels of harassment, bullying or abuse from colleagues than White staff, with around 1 in 4 ethnic minority staff (24%) reporting these experiences compared with around 1 in 5 White staff (19.9%).

Furthermore, staff from ethnic minority groups remained over twice as likely than those in White ethnic groups to report discrimination from managers, team leaders, or colleagues, with around 1 in 7 (15%) reporting this compared with around 1 in 15 (6.7%) White staff.

In July 2026, the government introduced new standards that will hold NHS employers formally accountable for how they treat their workforce on key issues, including tackling racism. Developed in partnership with NHS England, NHS trade unions and staff representatives through the Social Partnership Forum, the new standards aim to improve staff experience in 6 key areas:

- violence prevention and reduction
- championing sexual safety
- tackling racism
- promoting flexible working
- line management
- health and wellbeing support.⁵¹

Workforce Disability Equality Standards

As we noted in last year's report, some NHS staff groups continue to experience inequalities at work, and some members of staff who have more than one equality characteristic experience multiple forms of discrimination or workforce inequality.

Introduced in 2019, the Workforce Disability Equality Standard (WDES) is a set of 10 specific measures to enable 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. Findings from WDES data show that the experience of disabled staff across the NHS continues to vary. While the numbers of staff reporting that they have a disability has increased over the last year, disabled staff continued to report fewer positive experiences than non-disabled staff across many aspects of working life.

The WDES data shows some positive improvements including:

- a rise in the number of NHS staff declaring a disability from 5.7% in March 2024 to 6.7% in March 2025
- more board members declaring a disability, increasing from 5% in 2024 to 7.3% in 2025
- three quarters of disabled staff (75.3%) reporting that they had received the reasonable adjustments they needed to carry out their work.

However, disabled staff continued to report fewer positive experiences than non-disabled staff across many aspects of working life. Across almost all organisations, disabled staff were less likely to say that their organisation provided equal opportunities for career progression or promotion, with 51.8% of disabled staff saying this, compared with 57.9% of non-disabled staff.

Disabled staff consistently reported higher levels of harassment, bullying and abuse than non-disabled staff as:

- 29.6% reported harassment, bullying or abuse from patients, relatives or the public, compared with 23.4% for non-disabled staff
- 23.4% reported harassment, bullying or abuse from colleagues, compared with 15.1% for non-disabled staff
- 13.9% reported harassment, bullying or abuse from managers, compared with 7.6% for non-disabled staff.

Disabled staff were also more likely to report feeling pressure from their manager to attend work despite not feeling well enough – in 2025, 25.3% reported this experience compared with 17.6% of non-disabled staff.



Health and care services for children and young people



State of Care

Health and care services for children and young people

Key points

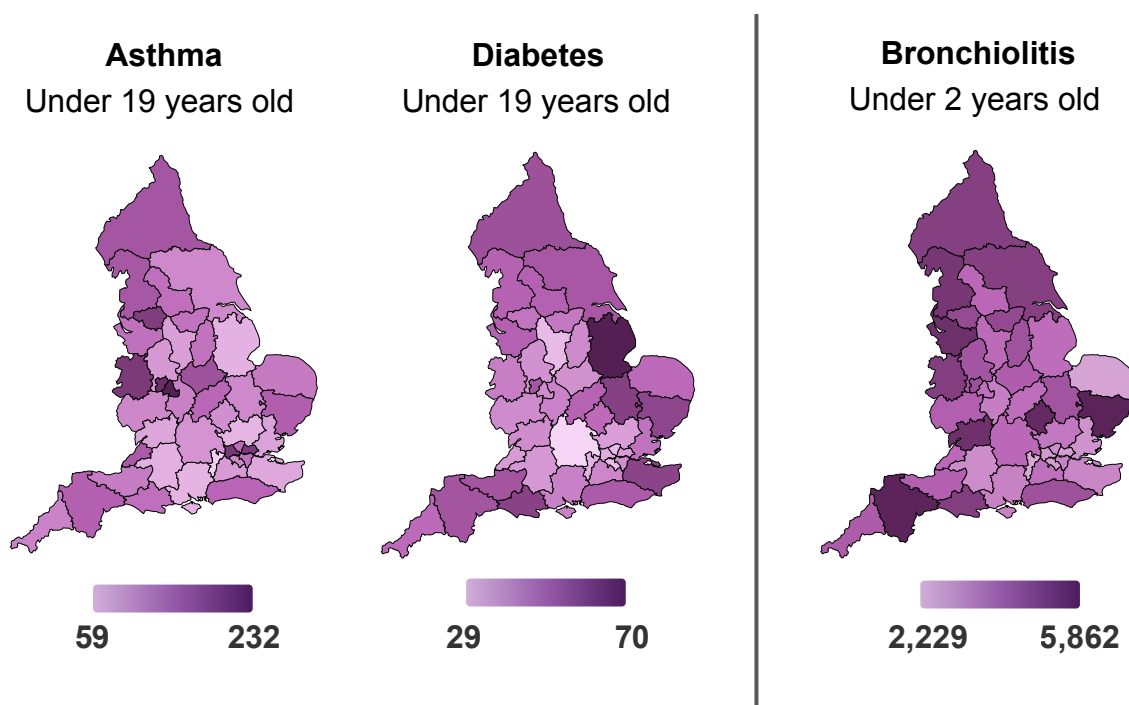
- Our focus on health and care services for children and young people shows that where they are born and where they live has a dramatic influence on their health outcomes, with large variations depending on the area and levels of deprivation. The Core20PLUS5 approach for children and young people includes asthma, diabetes and oral health as 3 of its clinical areas of focus.
- Although hospital admission rates for diabetes in children and young people have been reducing, there is regional variation. The North East and Yorkshire region has higher rates of admissions whereas rates in London have been consistently lower than the England average since 2013/14.
- Bronchiolitis is a common cause of hospitalisation in children under 2 years. Although bronchiolitis admission rates have reduced slightly in the last 2 years, they remain over 50% higher than a decade ago. London and the South East show lower rates than regions in the North.
- Oral health outcomes for young children continue to show substantial geographic and socioeconomic variation across England. On average, children living in the most deprived communities experienced more than twice the level of tooth decay compared with those in the least deprived communities.
- Health visiting and school nursing services are central to safeguarding, identifying needs, and enabling access to wider health support for children and young people, including those with special educational needs and disabilities. But despite a growing demand for these services, staffing levels continue to decline.
- We continue to be concerned about long waiting times for children and young people's mental health services. The length of time children and young people have been waiting for their first contact with services has doubled from 5.8 months in April 2023 to 12 months in March 2026.
- Improving access to mental health services for children and young people is one of the 5 clinical areas of focus in NHS England's Core20PLUS5 approach. Our work with the Nuffield Trust to find out more about the actions integrated care boards (ICB) are taking to improve health and care services found that mental health was most consistently rated as a clinical priority for children and young people, with 11 out of 13 ICB respondents saying it was a high priority.

Primary and community care services for children and young people

Primary care services have a key role in tackling health inequalities. Our focus on health and care services for children and young people shows that where they are born and where they live has a dramatic influence on their health outcomes, with large variations depending on the area and levels of deprivation (figure 33). The Core20PLUS5 clinical areas of focus for children and young people are asthma, diabetes, epilepsy, oral health and mental health. Bronchiolitis is a common cause of hospitalisation in children under 2 years, and health visiting for families with infants continues to be under real pressure.

Figure 33: **Hospital admission rates for children and young people differ markedly across ICB areas**

Asthma, bronchiolitis and diabetes admission rates per 100,000 children and young people by integrated care board area, 2024/25



Source: Department of Health and Social Care, Fingertips tool (based on NHS England and Office for National Statistics data)

Asthma

A variety of factors can affect the prevalence and severity of asthma in childhood, including poor housing conditions and exposure to air pollution. People in deprived areas and ethnic minority communities tend to experience higher levels of air pollution therefore increasing the risk of childhood asthma.⁵²

Nationally, admission rates for asthma in children and young people have reduced since 2013/14.

However, looking at the regional picture, London, the Midlands and the North West have higher rates of admissions for asthma in children, with the rates in the North West being consistently higher than the England average. These regions have some larger urban areas and some of the areas with the highest levels of deprivation. Conversely, the South East, South West and East of England have had lower than average rates of admissions since 2013/14.

Primary care service improving asthma review rates in deprived areas

A primary care service, rated as outstanding, runs GP practices across a city in the North of England. The practice worked together with a primary care network that had experienced low attendance rates for childhood asthma reviews. Most missed appointments were for families living in the most deprived areas, where parents working in low-income roles were unable to take time off during the week.

To address this, a paediatric respiratory nurse was assigned to deliver a 9-hour Saturday clinic every fortnight at one of the extended access hubs to improve access for families. As a result, the number of children who needed an asthma review decreased significantly – by approximately 40%. To further support engagement with people, a multilingual social prescriber telephoned parents to arrange appointments. In one social prescriber session alone, 14 parents were reached, with 9 children attending their review the following day. Additionally, the service developed child-friendly, pictorial invitations for asthma reviews to help educate and engage children in their care.

(From a CQC inspection and [Learning from practice case studies](#))

Diabetes

Like asthma, hospital admission rates for diabetes in children and young people have been reducing.

But again, there is regional variation, with the North East and Yorkshire having higher rates of admissions for diabetes in children and young people than the national average. The North West and South West also had higher rates of admissions than the England average, although in 2024/25 rates in these regions reduced to near average.

Rates of admission in London have been consistently lower than the England average since 2013/14.

Epilepsy

A national objective for children and young people with epilepsy is to improve their access to epilepsy specialist nurses. This includes ensuring autistic children and young people, and those with a learning disability, have access to an epilepsy specialist nurse in their first year of care.

Epilepsy12, the national clinical audit of seizures and epilepsies for children and young people in England and Wales, has found that the proportion of children and young people who had access to epilepsy specialist nurses in their first year of care has steadily improved since 2018.

However, there has been little improvement in the proportion of eligible children and young people who had received support from a paediatric neurologist or a referral to a childhood epilepsy surgical service within a year of diagnosis, which was only 48% in the most recent audit. This falls to just 42% of eligible children who live in the most deprived areas (compared with 56% in the least deprived areas).

Bronchiolitis

Bronchiolitis is a common cause of hospitalisation in children under 2 years. It is a viral respiratory infection of the lower airways, predominantly affecting children under 1 year, but occasionally up to the age of 2. Risk factors for severe bronchiolitis include exposure to second hand smoke, poor housing conditions and overcrowding, and living in a more deprived area.

The admission rates for bronchiolitis in children under 2 increased by 81% in the decade between 2013/14 and their highest level in 2022/23, although there has been a small decrease in the last 2 years of data. However, even with this decrease, admission rates in 2024/25 remain over 50% higher than a decade earlier.

When looking at admissions rates for ICB areas there are large differences. The highest rate nationally is 5,862 admissions per 100,000 children under 2, compared with the lowest at less than half the amount of 2,229 per 100,000. An overview of the picture in England shows a distinct national divide, with regions in London and the South East showing lower rates than regions in the North (figure 33). It is notable that official statistics show that the prevalence of smokers was highest in Yorkshire and the Humber and lowest in the South East.

Tooth decay in children

As highlighted in last year's State of Care report, oral health outcomes for young children continue to show substantial geographic and socioeconomic variation across England.

The Oral health survey of 5 year old schoolchildren shows that nationally, around 22% had visible signs of tooth decay, with 3.7% of children experiencing advanced decay and 1.8% showing signs of severe dental infection.

There was considerable variation in oral health outcomes between ICB areas, ranging from 12% of 5-year-olds showing signs of tooth decay to 33%, representing nearly 3 times the level of tooth decay.

Nearly a third (32%) of 5-year-olds living in the most deprived areas have some level of tooth decay. This is over twice the level in 5-year-olds living in the least deprived areas (14%).

These findings demonstrate persistent inequalities in children's oral health outcomes across England, with deprivation remaining strongly associated with higher levels of dental disease.

Tooth extractions where tooth decay was recorded as the primary diagnosis also increased overall – from 31,165 extractions in 2022/23 to 33,976 in 2024/25 – an overall increase of 9%. This indicates that preventable oral disease remains a major contributor to hospital activity among children and young people in England.

Regionally, rates of decay-related tooth extraction are 4 times higher in the North East and Yorkshire, with 485 extractions per 100,000 children and young people, compared with a rate of 116 per 100,000 in the South East.

And rates of decay-related extractions are 3 times higher for children and young people living in the most deprived areas, with 403 extractions per 100,000 compared with those living in the least deprived areas at 121 per 100,000.

Health visitors

Health visitors are registered nurses or midwives who have undertaken additional training in community public health nursing to provide individual support and advice for families with a new baby, from late in the antenatal period up to 5 years of age.

Through our joint inspections with Ofsted of services across education, health and care for children and young people with special educational needs and disabilities, we saw how health visiting, as well as school nursing services, remain central to early identification of needs, safeguarding and access to wider health support.

Our inspections of community health services also highlight the positive and compassionate spirit within health visiting, which is reflected in feedback expressed by people using services. For example, one inspection report stated that, *“They described health visitors as amazing, supportive and compassionate. Other comments gave particularly high praise for personalised work that families felt staff regularly went above and beyond and genuinely cared.”*

In our State of Care report 2 years ago we highlighted that, despite their importance, the number of qualified health visitors has seen a sustained decline of 45% in the period 2015/16 to 2023/24. Yet demand for this vital area of health care has continued to increase, with the added pressures of an ageing workforce.

The volume of new referrals to health visiting services recorded on the Community Services Data Set has increased by 16% from 1,498,055 in 2021/22 to 1,739,015 in 2025/26. Set against the 12% reduction in the number of qualified health visitors, the ratio of new referrals per health visitor full-time equivalent (FTE) has increased by 31%.

This group is more dependent on older staff compared with nursing overall. As at March 2026, only 4% of qualified health visitors were

under 30 years old, compared with 15% of nursing overall, and 44% were over 50, compared with 28% of the overall nursing workforce.

Further evidence of increased demand comes through feedback from practitioners in the last Institute of Health Visiting (IHV) survey, with 84% of respondents reporting increased demand on their teams and 71% of respondents in England noting fewer qualified health visitors where they worked.

The survey provides reasons for the increased demand, including:

- a significant need for support for parental mental health issues
- increasing numbers of infants showing evidence of symptoms associated with ADHD and autism, with long waits for diagnosis and support (one provider inspected by CQC described the growth in demand for ADHD-related services as “unprecedented”)
- increased involvement of health visitors with child protection and child poverty plans.

We have also seen evidence of the impact of declining numbers of staff and rising need for health visiting services in our inspections, with higher caseloads causing longer waiting, using staff across very wide geographic areas, greater use of ‘loaning’ midwives and registered nurses from other teams, and use of bank and agency staff. During one inspection, we saw that caseloads were double those recommended by the Institute of Health Visiting (IHV). Staff reflected that they felt a lot of pressure in their roles as a result, and the level of contact with families was reduced. Inspections also highlighted that staff were working longer hours to meet statutory requirements, and sustaining current commitments was having an impact on their wellbeing.

We have also seen the impact of workforce pressures through our joint inspections with Ofsted. For example, gaps in people’s contact with antenatal care have reduced opportunities to identify emerging need early, which have contributed to later demand for specialist services.

There is also variable provision of the 5 visits that health visitors are mandated to deliver. Provisional figures for 2025/26 from the Office for Health Improvement and Disparities show a relatively high level of delivery and consistency for new birth visits. However, across local authorities, providing reviews for children aged 2 to 2.5 years varied across a 73% range.

As the following story shows, consistency of staff is an important aspect of personalised care, but only 45% respondents to the 2024 IHV survey in England felt they were providing this all or most of the time.

A personal story – invaluable support from a health visitor

The health visitor provided invaluable support throughout my daughter's early years. She offered guidance on breastfeeding, shared balanced information about immunisations to help me make informed decisions, and provided practical advice on weaning, potty training, and keeping my daughter safe, both at home and during periods of extreme weather.

One of the things I valued most about the service was the consistency of care. I was able to see the same health visitor at each appointment, which allowed us to build a strong rapport and trusting relationship. Appointments were always tailored to my individual needs, and I never felt rushed. No question was ever dismissed as a 'silly question', and my concerns were always taken seriously and treated with compassion and respect.

A particularly memorable example of this support was when my daughter suffered from severe colic. I found her excessive crying incredibly distressing and often felt overwhelmed, isolated, and worried that I was somehow failing as a parent. When I raised my concerns, the health visitor listened attentively, validated my feelings, and provided practical advice and coping strategies. Most importantly, she reassured me that my daughter's colic was not my fault. She also gave me details about a support group for parents of babies with colic, which helped me feel less alone during a very challenging period.

Looking back, I am incredibly grateful for the support I received from my health visitor. Without her encouragement and guidance, I do not believe I would have continued breastfeeding for a full year – an achievement that I remain extremely proud of. Her advice around weaning also helped me establish healthy eating habits for my daughter from an early age. As a result, my daughter now enjoys a varied and nutritious diet that includes fruit, vegetables, healthy fats, nuts, seeds, and protein-rich foods.

In addition to supporting my daughter's physical health, the health visitor also provided a wealth of ideas for activities that would support her development. From encouraging crawling and walking to developing her pincer grasp and other key milestones, her suggestions gave me confidence and practical ways to support my daughter's growth and development at home.

Overall, my experience with the health visiting service was overwhelmingly positive. The support, reassurance, and practical guidance I received made a significant difference to both my confidence as a parent and my daughter's development. It is a service that I will always be grateful for.

(A person's experience of a health visiting service as told to CQC)

Many of the issues in health visiting services also applied to school nursing and 0-19 services. For example, the number of all school nursing staff (monthly average FTE) fell 30% between 2015/16 to 2025/26. In the 2024 practitioner survey by the School and Public Health Nurses Association (SAPHNA), only 18% of respondents reported that the service they worked in was adequately staffed.

Demand for school nursing services – measured in new referrals from the Community Services Data Set – has increased by 25% between 2021/22 to 2025/26. Like health visiting, respondents to the SAPHNA survey reported increasing workloads, especially in mental health, neurodiversity and safeguarding issues. From our inspections, we found that the unavailability of school nursing staff meant that some schools did not have a named nurse, and some school nurses had more schools to cover as part of their caseload. Staff therefore had to prioritise schools with a higher level of need. One provider told us that nursing staff were less fulfilled and motivated following changes to working practices that de-prioritised school drop-in sessions with students.

Children and young people's mental health

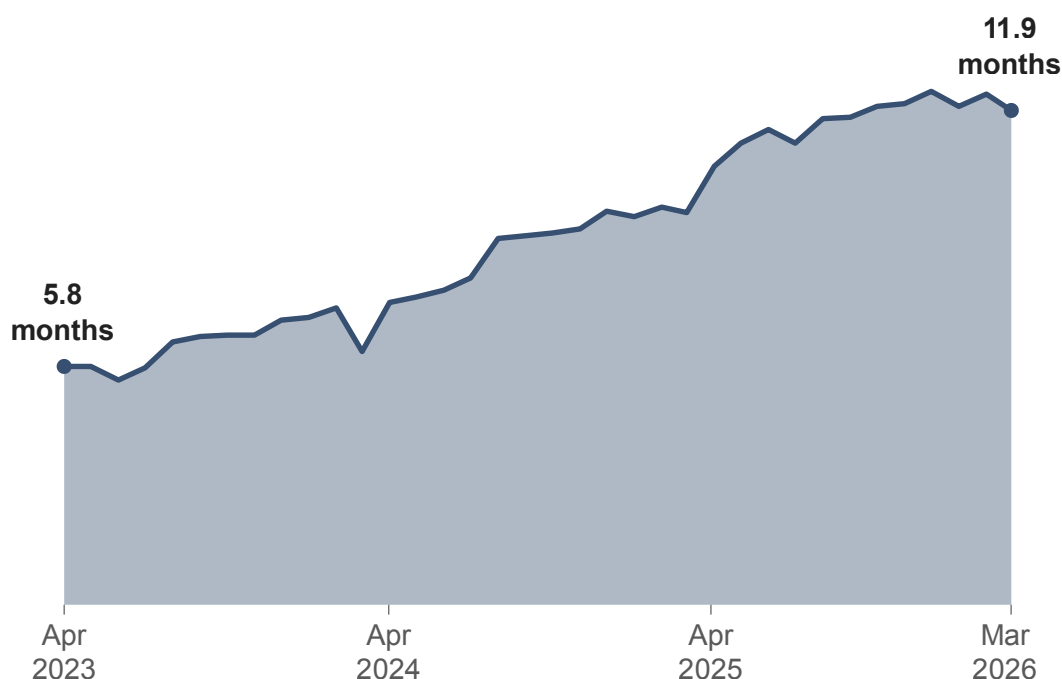
The rising need for mental health services for children and young people is critical as they have a higher rate of referrals to secondary mental health services than working-age or older adults. Data from NHS England shows that in 2025/26, children and young people aged 0 to 17 had the highest rate of referrals with 10,828 per 100,000 people, compared with 9,978 per 100,000 people for those aged 18 to 64, and 8,022 per 100,000 people aged 65 and over.

The latest report from the Children's Commissioner highlights how demand is rising faster, with over 1 million children having active referrals to children and young people's mental health services in 2024/25. The report notes that this demand is growing particularly for children referred with suspected autism and neurodevelopmental conditions. In the primary and community care section of this year's report, we also describe long waits for community paediatric services. These services provide diagnosis and support to infants and children with a wide range of physical and mental health issues, including diagnosis of suspected neurodevelopmental conditions, such as autism and ADHD.

With more children and young people needing mental health care, we continue to be concerned about the long waiting times for children and young people's mental health services. Between 2023/24 and 2025/26, the number of children waiting for their first contact with services at the end of the reporting period rose by 31% from a monthly average of 237,590 to 311,070. Furthermore, the average (median) length of time children and young people had been waiting for their first contact following a referral has doubled over the same period (figure 34).

Figure 34: **Waiting times for children and young people to access mental health services have doubled over the last 3 years**

Median waiting time for children and young people still waiting for first contact for NHS funded mental health care, April 2023 to March 2026



Source: NHS England, [Mental Health Services Dataset Monthly Statistics](#)

Results from the 2025 Community mental health survey showed that 46% of respondents using children and young people's mental health services had waited 3 months or more between their assessment and first appointment for treatment. Over half (54%) of these respondents had not received any support while they were waiting.

These findings are supported by the report from the Children's Commissioner. This highlights that waits of over a year are common, with 16% (60,041) of children who were still waiting to receive treatment at the end of 2024/25 waiting longer than 2 years – an increase from 14% (44,881) over the previous year. Children referred for autism assessment and those presenting with potential neurodevelopmental conditions faced the longest waits. Thirteen per cent of children referred for autism assessment and only around 1 in 5 (19%) children presenting with a potential neurodevelopmental condition went on to receive treatment in 2024/25.

A February 2026 report from the NHS Alliance discussed the impact of these waits on children and young people in its report [Transforming access to children and young people's mental health support](#). The report highlights the importance of early intervention, and how young adults aged 16 to 25 who have mental health conditions are nearly 5 times more likely to be economically inactive compared with their peers who do not have a mental health condition.

System response

Improving access to children and young people's mental health services for 0 to 17- year-olds is one of the 5 clinical areas of focus in NHS England's [Core20PLUS5](#) approach.

This year, we have again worked with the [Nuffield Trust](#) to find out more about the actions that [integrated care boards](#) (ICBs) are taking to improve health and care services – with a focus on neighbourhood health, health inequalities, and children and young people. While the findings are not representative of all ICBs, they give an indicative picture of the system response to children and young people's services.

In line with Core20PLUS5, Nuffield Trust's survey of chief executives and directors within ICBs found that mental health was most consistently rated as a clinical priority for children and young people, with 11 out of 13 respondents saying it was a high priority. Ten out of 13 respondents said that looked-after children and care leavers, and children and young people with a learning disability or autism were high-priority population groups (one of the 13 respondents selected N/A for children and young people with a learning disability or autism).

There was an equal split between those who said children and young people's oral health was a high priority at their ICB over the next 12 months (4 respondents) and those who said it was a low priority (4 respondents). Three out of 13 respondents said children and young people with epilepsy and young carers were low-priority areas for reducing health inequalities (again, one of the 13 respondents selected N/A for these 2 questions).

Through interviews with chief executives and directors working within ICBs, Nuffield Trust found variation in how well ICBs had embedded a focus on children and young people. This was largely influenced by organisational maturity and funding levels. In some areas, the integrated care board had long-established partnerships, or children and young people's services were a priority at board level. In these areas, the integrated care board was able to build layered, integrated offers, moving pilots into commissioned services and co-ordinating system-wide programmes.

Example of multi-organisational joint working: Children and Young People's Health Equity Collaborative (CHEC)

Aim: To build evidence for the health and social care system's ability to reduce inequalities and improve health equity among children and young people through action on the social determinants of health and demonstrate the value of collaboration across integrated health and care systems.

Input: The CHEC engaged with over 300 children and young people throughout the 3 ICSs, who were aged 7 to 24 and had different demographics and protected equality characteristics, to gain

insights into their lived experience and the factors that influence their lives and wellbeing.

Activities: Responses from this work have allowed an understanding of the key views and priorities of children and young people involved. The findings from this engagement were incorporated into the development of a Child Health Equity Framework to ensure children and young people's views and lived experiences inform and are embedded in it.

Outcomes: Development of the Child Health Equity framework, and list of priority data indicators, mapping to the different domains of the framework. These are intended to be used by local areas to monitor child health, which can support integrated care systems to make links between the social determinants of health and the priority areas within the areas of NHS Core20PLUS5 and support action on those areas.

"The ... Child Health Equity Partnership has been a real force for good in terms of children and young people [...] Our two neighbourhood health national pilots are helping. Seeing some national mapping of the performance against Core20PLUS5 and its impact on healthier lives and secondary care activity would be a big help to promote these agendas."

(ICB survey response)

However, other areas that were either facing organisational change or had a very small health inequalities team, had a narrower, more reactive approach. Some interviewees also highlighted a concern that commissioning of children and young people's services could be overshadowed by commissioning of adult services.

Of the respondents to the Nuffield Trust survey of ICBs, 85% (11 of 13) said funding constraints were the most anticipated barrier to progress, with a further 54% (7 of 13) stating misaligned financial incentives as a potential barrier. Some interviewees noted serious concerns about the survival of children and young people's services delivered by local authority and voluntary sector partners due to a range of factors including funding reductions, a shifting political landscape, and shrinking capacity alongside organisational upheaval. One interviewee described an intention to focus on prevention for children and young people's services, on the basis that "if you prevent earlier, you prevent more". Interviewees described 4 key features as enablers of progress on work related to children and young people, including:

- long-standing partnership infrastructure
- board-level commitment and clinical leadership
- good data and community insight
- cultural factors, including permission to act and non-financial resources.



Deprivation of Liberty Safeguards



State of Care

Deprivation of Liberty Safeguards

Key points

- The operation of DoLS over the last decade has been characterised by an increasing volume of applications and sustained backlogs. Our notifications data suggests a continued increase in the use of DoLS in 2025/26.
- We continue to find variation in the way health and social care settings apply and understand DoLS, with issues identified around training, communication, and record keeping, as well as recognising and reviewing restrictions.
- In June 2026, the Supreme Court judgment set out a revised approach to establishing whether a person is deprived of their liberty. This brings significant implications for how DoLS will be applied now and in the future.
- As the legal and policy landscape around deprivation of liberty continues to evolve, it is important that the system remains focused on delivering rights-respecting and person-centred care.

Article 5 of the Human Rights Act 1998 safeguards people's right to liberty and security, so that individual freedom is protected from unreasonable detention. This means that people can be deprived of their liberty only in specific situations and if the correct legal procedures have been followed.

One way to authorise a deprivation of liberty in health and social care settings is through the Deprivation of Liberty Safeguards (DoLS) framework. DoLS form an important part of the Mental Capacity Act 2005 (MCA) and apply to people aged 18 and over in a care home or hospital.

The DoLS process provides a crucial safeguard for the human rights of people who lack the mental capacity to consent to their care arrangements. It ensures that arrangements that may amount to a deprivation of liberty are independently assessed, authorised and regularly reviewed to confirm that they are necessary, proportionate and in the person's best interests.

Applications to deprive a person of their liberty under DoLS must be authorised by a 'supervisory body'. In England, local authorities act as supervisory bodies and are responsible for arranging assessments to make sure that a deprivation of liberty is only authorised if certain requirements are met.

We have a duty to monitor the use of DoLS in all hospitals and care homes in England and to report annually on our activity and findings. In successive State of Care reports, we have highlighted how the operation of DoLS over the last decade has been characterised by an

increasing volume of applications. In many cases, this has resulted in local authorities facing assessment backlogs, leaving some people at the heart of this process without the key human rights safeguards that the DoLS system was intended to offer.

In 2025/26, our notifications data suggests a continued increase in the use of DoLS, while the way health and social care settings apply and understand the safeguards remains varied. In an evolving policy landscape, the sector must not lose focus on providing person-centred care that protects people's rights.

The changing landscape of DoLS

In March 2014, a landmark judgment by the Supreme Court brought greater clarity to the concept of deprivation of liberty. In *P v Cheshire West and Chester Council and P and Q v Surrey County Council*, the Court clarified that a person is deprived of their liberty if 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 became known as the 'acid test'.

Since then, applications to deprive a person of their liberty have increased far beyond the levels expected when the safeguards were designed.

In June 2026, the Supreme Court handed down its judgment in *A Reference by the Attorney General for Northern Ireland*. This judgment set out a revised approach to establishing whether a person may be deprived of their liberty.

The Department of Health and Social Care then published an update, which summarised key points from the judgment. This clarified that the 'acid test' from the Cheshire West Supreme Court judgment should no longer be applied. Instead, there should be:

- a multifactorial assessment of the proposed arrangements
- a consideration of whether a person can validly consent to the arrangement.

The court held that a person may be able to give valid consent to a deprivation of liberty, even if they lack the mental capacity to consent to their care and residence under the MCA.

The 2026 judgment, which came in with immediate effect, has significant implications for how DoLS will be applied now and in the future. Here, we are reporting on findings from our monitoring activities and assessments of local authorities from April 2025 to March 2026, as well as government statistics from April 2024 to the end of March 2025, before the judgment was delivered. The following findings should therefore be viewed in this context.

Continuing high demand for DoLS

The DoLS system continues to operate at a level of demand that is higher than anticipated when the safeguards were introduced. As we have consistently reported in State of Care, the number of DoLS applications has continued to increase since the Supreme Court's 2014 Cheshire West judgment clarified and broadened the definition of what constitutes a deprivation of liberty. Official government statistics for 2024/25 provide further evidence of this, with local authorities receiving 364,900 DoLS applications, a 10% increase on the previous year.

Our notifications data suggests that demand for DoLS continued to rise during this reporting year. In 2025/26, we received 205,205 notifications from providers – a 10.3% increase over the previous year.

In previous State of Care reports, we identified concerns about some potential duplication in our notifications data. These issues, coupled with a discrepancy between the number of completed applications reported by official government statistics and notifications we received in 2024/25, suggest that DoLS notifications may be considerably under-reported to us. As well as indicating potential gaps in providers' understanding of regulatory requirements, this has implications for our ability to gain an accurate view of how DoLS are being applied across services and the scale of demand.

Providers have a legal duty to formally notify CQC when they know the outcome of an application for a deprivation of liberty. This must be done without delay for applications made both under DoLS and the Court of Protection, which considers applications to deprive someone of their liberty in other settings such as their home or supported living arrangements. It includes when an authorisation has not been granted, or the application has been withdrawn.

The Department of Health and Social Care (DHSC) produces age standardised rates of the number of DoLS applications per 100,000 adults. 'Age standardised' means that the rate for each region or local authority is adjusted, taking into consideration population size and age structure to effectively even them out. This allows us to make fair comparisons between areas with different age demographics.

The number of DoLS applications received varies considerably between different age groups and regions. Official government statistics from 2024/25 show that the highest rates of DoLS applications are made in respect of people aged 85 and over, where there were 10,220 applications per 100,000 people. This was more than 3 times greater than the next highest rate, 2,951 applications per 100,000 people aged 75 to 84. As outlined in the government's LPS draft impact equalities assessment, this is likely because "a much higher number of older adults" are cared for in care homes compared with younger groups. It goes on to explain how this is compounded by the fact that age-related conditions like dementia can significantly affect people's mental capacity.

Regional figures show that application rates ranged from 656 applications received per 100,000 people, to 1,540 per 100,000 people – almost double the national rate. Having a higher or lower rate of DoLS applications does not necessarily indicate a negative or positive trend. A range of factors could be contributing to this variation, including the nature of individual care arrangements and whether services seek an authorisation when required.

A variety of service types can submit DoLS applications to a local authority, including care homes, nursing homes, acute and community hospitals or mental health hospitals. In 2024/25, almost 6 in 10 (59%) DoLS requests came from nursing and care homes, with 3 in 10 (31%) from acute hospitals. This pattern was replicated at a local level, apart from the South West, where 46% of requests came from care homes and nursing homes, and 47% from acute hospitals.

Where a person urgently needs to be deprived of their liberty before the necessary assessments have been completed, providers can give themselves an urgent authorisation that lasts for 7 days and can be extended for a further 7 days. The DoLS Code of Practice explains that urgent authorisations should be used mainly in response to sudden, unforeseen needs, although they may also be used in some care planning scenarios, for example when delays could adversely affect a person's care.

In 2024/25, 58% of DoLS applications for standard authorisations were accompanied by an urgent authorisation, indicating that urgent authorisations may have become a routine element of DoLS practice. These numbers varied widely across the country, from just under 4 in 10 (39%) in Yorkshire and the Humber to more than 8 in 10 (82%) in the South West.

A higher proportion of requests made by acute hospitals and a higher number of urgent authorisations may reflect wider capacity pressures within the adult social care sector in the South West region. As we report in the adult social care chapter, we know that the South West has the second-lowest number of care home beds in the country. Limited capacity in care homes could contribute to delays in discharging a person from hospital, with most hospital discharge delays due to lack of available care home beds in the North West and South West. regions This may increase both the volume of applications originating from acute hospital settings and the proportion of applications that are accompanied by an urgent application.

The government considers an application to be 'completed' when enough information has been gathered to enable a decision to either grant or refuse a standard authorisation. The applications must also have been completed and signed by the relevant person at the local authority. During 2024/25, 353,935 DoLS applications were completed (this may include applications received in previous financial years). This represents a 9% increase in the number of applications completed, compared with the previous financial year.

The rate of DoLS applications completed per 100,000 adults varied widely between regions in 2024/25. For instance, the age standardised rate of applications completed and fully assessed per 100,00 adults was 706 in the North East, but only 161 in the South West. The rate of applications received in the South West (760) was close to the national rate (785), so the comparatively low rate of applications completed and fully assessed may indicate that local authorities in this region are struggling to keep up with demand.

Ongoing backlog

Despite continued efforts by local authorities to increase assessment activity, the DoLS system remains under significant pressure. While there has been an increase in the number of applications completed by local authorities, official government statistics⁵³ highlight that the numbers of applications are growing faster than they are completed. In 2024/25, there were 10,965 more applications received than completed. When combined with incomplete applications from previous years, this means that there were 118,850 DoLS applications still incomplete at the end of the financial year.

The consequences of this backlog are not merely administrative. DoLS exists to provide an independent safeguard for people whose liberty is being restricted in health and social care settings. As a result of the backlogs, a significant number of people may experience delays in having a deprivation of their liberty independently reviewed and authorised. This can affect their human rights and limit opportunities to reduce unnecessary restrictions.

These pressures are reflected in responses to the Association of Directors of Adult Social Care (ADASS) 2026 spring survey, which show that directors' confidence in being able to deliver their duties in relation to DoLS remained a concern, with over half (54%) having partial or no confidence in meeting their legal duties for safeguarding in 2026/27. The survey provides further evidence of the system struggling to keep up with demand. Results showed that out of the 96,780 people who were waiting for a DoLS assessment on 21 March 2026, 45,387 (47%) have been waiting for 6 months or more. As highlighted by ADASS, this is far greater than the proportion of people waiting for a Care Act assessment (11%) or an occupational therapy assessment (15%).

Standard DoLS applications should be completed within 21 days. In 2024/25, only 1 in 5 applications were completed within this timeframe. While this is a slight improvement from 2023/24, the average length of time from receiving an application to completion was 6 times longer than the statutory timeframe at 126 days. This varied across the country. The South West had some of the longest mean completion times, where the average (mean) length of time taken to complete a DoLS application ranged from 265 to 412 days, depending on the application's urgency and outcome. This compares with regions such as the North East, where mean completion times were substantially shorter, ranging from 38 to 75 days.

During 2024/25, 3,980 DoLS applications were completed and fully assessed but not granted. In 31% of these cases (1,240) the reason the application was not granted was that the person concerned had died. Although we cannot know what the outcome of those applications would have been, these cases highlight the human impact of delays. It is possible that some people may have spent the final months of their lives subject to restrictive practices without being able to access legal safeguards designed to protect their rights.

The Supreme Court judgment in June 2026 represents the most significant case law development in relation to deprivation of liberty since Cheshire West. At the time of writing, the full implications for demand for DoLS and for people using health and care services remain unclear. Some stakeholders have expressed concerns that many people will no longer benefit from the independent scrutiny and safeguards provided through the DoLS system, which would in turn have an impact on the volume of applications.

However, it is too early to determine the scale of the judgment's impact on the operation of DoLS. Data on application volumes over the coming financial year is expected to provide a clearer indication, and we will continue to monitor this and consider implications in future reporting. Regardless of national trends, it is essential that providers continue to consider each person's circumstances on a case-by-case basis to determine whether their care arrangements amount to a deprivation of liberty, so that people have access to the safeguards and legal protections they are entitled to.

Managing DoLS applications

Analysis of our inspection reports shows evidence of delays in progressing DoLS applications, and of some providers delaying submitting the required documentation to the relevant authorities, with records not consistently maintained or updated to reflect people's current circumstances. Some services did not always ensure that local authorities were kept informed of changes.

In one case, we found that the management team lacked a good understanding of DoLS. This meant that some people were subjected to restrictive practices that were not linked to their support plans or risk assessments, and contributed to a breach of regulations in relation to safeguarding, person-centred care, and good governance. We also heard from our adult social care inspectors that some local authorities did not offer enough support to providers, including not providing clear communication on the progress of applications.

Local authorities' approach

Evidence from the ADASS 2026 spring survey highlights how, faced with sustained backlogs, local authorities have increasingly had to prioritise the highest-risk applications to try to respond to immediate safeguarding concerns. The results note that while changes introduced

through the recent Supreme Court judgment will change the process, safeguarding and the protection of people's human rights must be at its core.

In both our 2023/24 and 2024/25 State of Care reports, we highlighted wide variation in how local authorities were managing DoLS applications. Evidence from our local authority assessments, showed a similar picture, as increases in demand and challenges in workforce recruitment were noted as leading to delays in processing applications. Some local authorities had implemented measures to help mitigate these pressures, for example by:

- using a mix of internal and external best interests assessors (BIAs) to assess applications
- using the ADASS screening tool to help prioritise applications.

Some local authorities had vast numbers of adults waiting for DoLS assessments to be allocated to a worker. This increased the risk of people's liberty being restricted unnecessarily and unlawfully. Others approached these challenges flexibly and provided upfront investment in agency BIAs in some cases, which cleared the backlog and enabled people to be assessed more quickly. In another example, a local authority strengthened workforce capacity and developed training partnerships to increase the number of staff able to undertake assessments.

The accuracy of recording DoLS applications by local authorities was another concern from our assessments, and had a significant impact on the people involved:

“This lack of accurate recording potentially risked missing where people's human rights may be infringed as part of Care Act duties, such as in assessments, care planning and reviews.”

(From a CQC local authority assessment report)

Some local authorities did not record or have data on how long it took to process and authorise a DoLS application, and there were not always systems to review DoLS information and trends over time. This could mean they did not have the required oversight of DoLS authorisations, of what restrictions were being placed on people or whether DoLS conditions were met, which increased the risk of people being unnecessarily deprived of their liberty.

In March 2026, the Local Government and Social Care Ombudsman upheld a complaint against a local authority in a case where a man was deprived of his liberty without the legal safeguards he was entitled to in a care home that was unsuitable for him. It highlighted issues with processes, including checking that DoLS applications had been received, and following up on their progress:

“The Council’s assessment of Mr Z’s needs showed its adult social care team was aware of the need for a DoLS assessment. However, neither the Provider nor the Council’s social work team asked the Council’s DoLS team what was happening, until prompted by Mrs X in early November 2022. This indicates a failure to have proper regard to Mr Z’s human rights to liberty and a fair hearing. At this point, the DoLS team confirmed it did not have an application from the Home, and the Home re-sent it. I have seen no evidence the Provider and the Council had processes in place to check receipt of DoLS applications and follow up on their progress.”

(From the Local Government and Social Care Ombudsman)

These concerns are supported by comments received through our online Give feedback on care service, which highlighted issues including:

- poor record keeping of medical notes and of family views
- poor care planning and instances where care plans were not followed
- poor record keeping leading to uncertainty about whether people with a DoLS authorisation in place are due to have a reassessment.

Regardless of the impact of the Supreme Court judgment on future demand for DoLS assessments, local authorities should maintain effective arrangements to fulfil their responsibilities under the Mental Capacity Act (MCA) and Care Act 2014. This applies irrespective of whether they meet the threshold for a DoLS authorisation and includes:

- ensuring that people who may be subject to restrictive care arrangements that amount to a deprivation have access to appropriate safeguards
- identifying and responding to concerns where restrictions may place people at risk of abuse or neglect
- seeking assurance that people’s human rights are being appropriately protected.

Any changes in DoLS activity should therefore be accompanied by strong MCA practice, effective safeguarding arrangements and appropriate local oversight.

Skills and knowledge of staff

A skilled and capable workforce remains central to the effective application of both the MCA and DoLS across health and care settings. However, findings from our activity suggest that there is still variation in how providers and professionals understand this area and apply it in practice. This has been a longstanding concern, as highlighted in previous State of Care reports.

For those who are no longer considered as being deprived of their liberty following the Supreme Court judgment, weaknesses in MCA practice could also lead to people being subject to unnecessary and significant restrictions without external oversight over individual arrangements. Therefore, it is important for providers to ensure that staff are supported to develop the knowledge, skills and confidence to effectively meet legal requirements, including assessing capacity, making best interests decisions, and identifying any potential deprivation of liberty.

However, the judgment does not diminish the importance of the MCA. Providers and professionals need to be confident in assessing capacity properly, supporting people to make their own decisions wherever possible and identifying when consent is genuinely valid and freely given. A strong understanding and application of the MCA will therefore become increasingly important to protecting people's rights in practice.

Our analysis of a sample of inspection reports for urgent and emergency care services found variation between them in whether staff had completed training on the MCA and DoLS, and how well they applied this training.

Similarly, our adult social care inspectors described instances where staff did not recognise what constituted restrictive practice, did not know a person's DoLS status and expressed a sense of nervousness around whether they could put restrictions in place when necessary.

As well as this, our analysis of experiences submitted online through Give feedback on care, showed how workforce challenges were leading to issues including:

- people not having appropriate supervision and leaving their care home without staff noticing
- low ratios of staff to people using a service, affecting their access to personal care
- overuse of physical restraint despite having one-to-one care in place (see also section on restraint)
- lack of adequate supervision for people with additional needs, such as people living with dementia.

One adult social care inspector in our focus group gave an example of an inappropriate placement that led to unnecessary and abusive restrictive practices, and the impact of a lack of awareness of the MCA on the care provided to the person:

“... the person who they were supporting had significant mental health needs and they weren’t registered for mental health... They had some physical health needs as well ... he was a person with paraplegia, so he couldn’t get out of bed. [If] he didn’t act in the way that they wanted him to act, they would take his devices off him... [The provider] thought it was proportionate because he had his music on loud. But there was no sort of exploration as to why he was having the music loud. There was no conversation. It was just “be quiet”. ... the justification that the inspector got just demonstrated their complete lack of awareness of the Mental Capacity Act and that staff really also didn’t recognise that their practice was restrictive and they thought that they were doing things in the person’s best interest, when really it was the furthest away from his best interest as possible.”

(From a focus group with adult social care inspectors)

Analysis of comments submitted through Give feedback on care also highlighted some concerns from family members that DoLS authorisations weren’t being appropriately reviewed, including when an authorisation was due to be renewed or needed to be reviewed because people’s circumstances changed. For example, some people raised concerns about forms not being sent off or being out of date, and DoLS authorisations lapsing. Other people described requesting a review of their DoLS authorisation because they no longer felt it was appropriate, but which never happened.

“The company did not notice that my son’s DoLS had lapsed last December it was me that got social services to admit they had not sent the forms off.”

(Online submission through Give feedback on care)

Experiences of people with a DoLS authorisation in place

DoLS are designed to protect people's human rights. They ensure that there is a legal process to challenge any unnecessary restrictions on their care to prevent harm, are not proportionate and are not in the person's best interests. As a result, it's important that when people have a DoLS authorisation in place, they, their families, carers and advocates understand:

- what these safeguards are
- what they mean for the person's legal rights
- why they are being put in place
- how to challenge an authorisation.

People who are subject to a DoLS authorisation should be fully involved in discussions about their care and in the DoLS process, including through the support of family, carers or advocates.

This year, we reviewed 130 comments received online through our Give feedback on care service about people's experiences of DoLS. While we heard some positive examples where staff in services gave clear explanations about what DoLS means for people, other people often expressed concerns about the quality of communication and limited explanation around DoLS:

"She is on a DoLS but doesn't know why she is on a DoLS, and also doesn't know why she cannot go back to her own home now, as this was only supposed to be short term. She is concerned about the state of her actual home, that she doesn't know what her plan for care is or that she cannot leave the home when she wants to."

(Online submission through Give feedback on care)

Other comments submitted highlighted instances of poor record keeping, where it was unclear if a DoLS authorisation was in place or if an application had been submitted. This could mean that people are deprived of their liberty without necessary legal protections in place, despite this being a requirement to protect their human rights. It is vital that staff are confident in applying the MCA to support good practice around DoLS.

"Appears to be a negative and restrictive culture in place by most of the staff, with multiple restrictions in place upon most patients there – unsure if DoLS in place"

(Online submission through Give feedback on care)

“The residents who have a DoLS may not have every restriction listed, may not be kept up to date and/or may have expired. The trackers are difficult to follow.”

(Online submission through Give feedback on care)

In another case, we heard that a person receiving inpatient care in a hospital had to ask multiple times if a DoLS authorisation was in place for them before their restrictions were lifted. While this person was aware of the limitations around the safeguards, other people may not know to ask these questions. This can lead to unnecessary restrictions if people are not aware of their rights or do not feel able to challenge the restrictions placed on them:

“Locked in hospital bed on corridor, no way to get out of bed myself. Asked multiple times if I had DoLS in place, took over an hour for someone to release me. Also asked for access to my care plan, and for name of ward sister/nurse in charge.”

(Online submission through Give feedback on care)

Quality of care for people subject to DoLS authorisations

In our analysis of comments submitted through Give feedback on care we found concerns about the quality of care for people who are subject to a DoLS authorisation. These included people being left on their own when they should have been under observation and having frequent checks, as the following comment shows:

“Mr X was last seen by nursing staff at approximately 15:20, and it was not noticed that he was missing until around 17:15, a gap of nearly two hours. During this time, he had managed to leave the hospital premises, board a bus..., and continue walking alone.”

(Online submission through Give feedback on care)

We also found multiple concerns relating to people subject to a DoLS authorisation not receiving appropriate food and water, including being given the wrong food according to their care plan. In another example, we heard about a person being left with rancid food. They were reported as having “delusions” relating to being poisoned, but through Give feedback on care, we heard concerns about milk left in their room.

“I could hear X shouting for help and asking for a drink. On entering the room I could see a spouted beaker on her table with rancid milk in that had separated into cloudy fluid at the top and lumpy bits at the bottom. In the spout was one of the lumpy bits so she had obviously tried to drink it. There was a litre carton of UHT skimmed milk next to the beaker and, on smelling this, it was also rancid. Next to these was a cold mug of tomato soup that had not been touched”.

(Online submission through Give feedback on care)

Some comments submitted raised concerns about the attitudes of staff. We also heard about people subject to a DoLS authorisation not receiving personal care, which could compromise their dignity, for example not being washed. In one example, we heard that a member of staff not only refused to wash the person, but was also verbally abusive:

“She has said that she is verbally abused by staff and has to wash herself as staff won’t do it”.

(Online submission through Give feedback on care)

We also found one instance where a person had developed pressure sores, but was not given appropriate pressure-alleviating cushioning for their wheelchair, and heard concerns from some relatives that staff showed a lack of empathy for people in these types of situations.

Use of restrictive practices

As highlighted in our mental health section, we continue to be concerned about the use of restrictive practice. This year, through our analysis of adult social care inspection reports, we have continued to find evidence of people being subjected to a range of restrictive practices. This includes environmental restrictions, such as:

- restricting people’s movement by using locked rooms and doors
- using bedrails without clear authorisation
- putting restrictions on access to personal items
- using CCTV.

Staff in these services did not always recognise these as restrictive practices. In many cases, the use of restrictive practices was not supported by assessments of a person’s mental capacity or whether it was in the person’s best interest, and restrictions had been put in place without clear rationale or legal authority. This meant people’s freedom and autonomy were limited without legal justification.

“Where staff restricted access to personal belongings or areas of their homes, they did not recognise this as a restrictive practice, and the person’s capacity to consent to these arrangements had not been assessed, nor had staff followed a best interests process.”

(From inspection report of a homecare provider)

To ensure that people’s rights are not breached, any restrictions must be lawful, be for a legitimate aim and use the least restrictive approach to meet that aim. Severe restrictions may also breach human rights if they result in inhumane or degrading treatment.

We also found several examples of physical restraint being used without appropriate authorisation, planning or oversight in inspection reports of adult social care services, for example:

- staff restraining a person in order to take a blood sample without clear evidence of best interest decision-making
- people being restrained using non-approved techniques
- managers of services who did not know about or had no oversight where restraint had been used.

Other examples from our adult social care inspections showed where recording of restraint was poor and incomplete, with incident records lacking details of the type, duration and location of restraint. In these examples they did not provide evidence that de-escalation strategies were attempted first, or that restraint was proportionate and used for the shortest time possible.

The use of chemical restraint, including PRN medicines (medicines taken as needed) to manage people’s behaviour was identified as another concern. Often there was no clear justification for the use of chemical restraint, or that using medicine was the least restrictive option. We also found a lack of clear guidance around covert administration and approval processes.

Rights-based care in a changing landscape

As the legal and policy landscape around deprivation of liberty continues to evolve, it is important that the system remains focused on delivering rights-respecting and person-centred care now and in the future.

The recent Supreme Court judgment represents a significant shift in case law, with potentially far-reaching consequences for the operation of DoLS. The extent to which this judgment will affect individual people at the heart of the system remains to be seen. However, these changes do not lessen the responsibility of providers, professionals and local authorities to uphold and protect people’s rights. As we noted in our [initial statement](#) following the Supreme Court judgment, care providers should continue to ensure that they meet the requirements of the MCA, irrespective of whether people are deprived of their liberty. This

includes consistently delivering rights-respecting and person-centred care that is informed by people's views, wishes and preferences.

Through our reporting on DoLS, we have continued to identify concerns about inconsistent MCA practice, delays in authorisation processes, weaknesses in record-keeping, workforce capability issues and poor communication with people and their families. These challenges risk undermining how effectively people's rights are protected and can lead to poor experiences of care, regardless of whether people are cared for under arrangements that amount to a deprivation of liberty. At the same time, we are already seeing providers and local authorities adapting to the changes introduced by the recent Supreme Court judgment and responding to the evolving landscape.

Further reform remains on the horizon, as the Liberty Protection Safeguards (LPS) have been expected to replace the current DoLS system for several years. While the timetable for implementing LPS is still uncertain, strengthening MCA practice across health and social care should remain an immediate priority. We will continue to use our role to monitor the operation of DoLS during this period of transition and to work with stakeholders to understand any longer-term implications of both recent and proposed changes.

Ensuring that the MCA and its principles are fully understood and consistently applied is fundamental to protecting people's rights, promoting autonomy and delivering positive outcomes for people, including for those who may no longer fall within the scope of the safeguards. In this context, an updated MCA Code of Practice would be a significant step towards supporting providers and professionals to apply the MCA more consistently, confidently and effectively in practice.

Appendix: CQC ratings charts

The data in this appendix are from ratings published under CQC's current assessment framework, as at 4 August 2026. We began implementing our current 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.

Throughout the report and this appendix, we do not compare current and previous ratings because:

- Our assessment activity during this time has been predominantly 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 current assessment framework are still too low to be representative of all services in that sector.
- Alongside the introduction of the current 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.

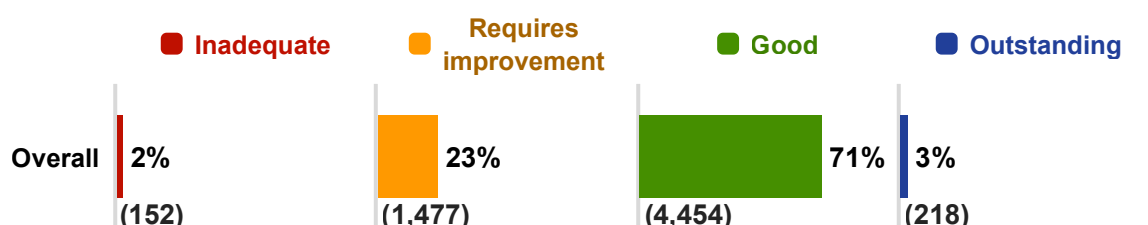
Our [website](#) provides data for all current ratings.

Adult social care

The charts in this section show the 6,301 ratings for adult social care services that we have published under our current assessment framework. There are 17,814 adult social care services whose current ratings were based on our previous frameworks.

As part of the changes introduced with the current assessment framework, 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 one location. For this reason, adult social care ratings published from assessments under the current assessment framework should not be combined with or compared with those under previous frameworks.

Figure A1: **Adult social care, overall ratings, 2026**

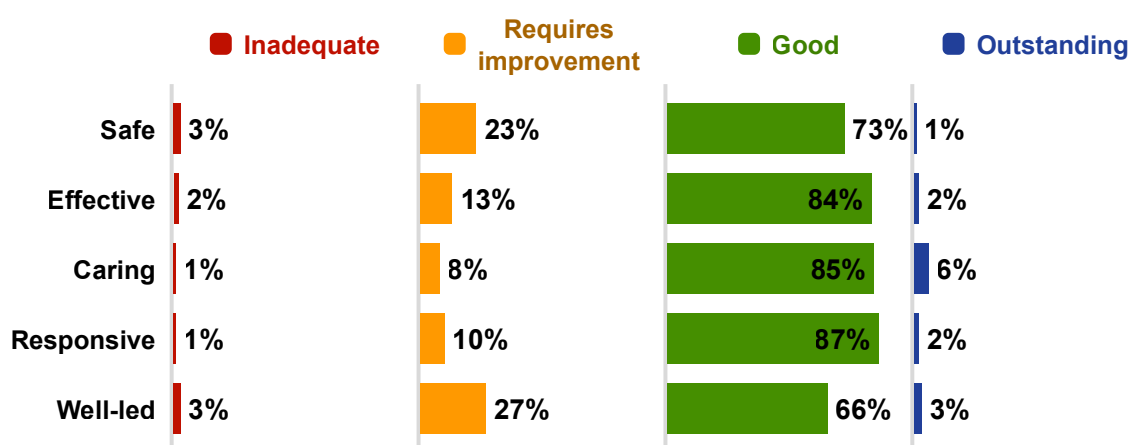


Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services.

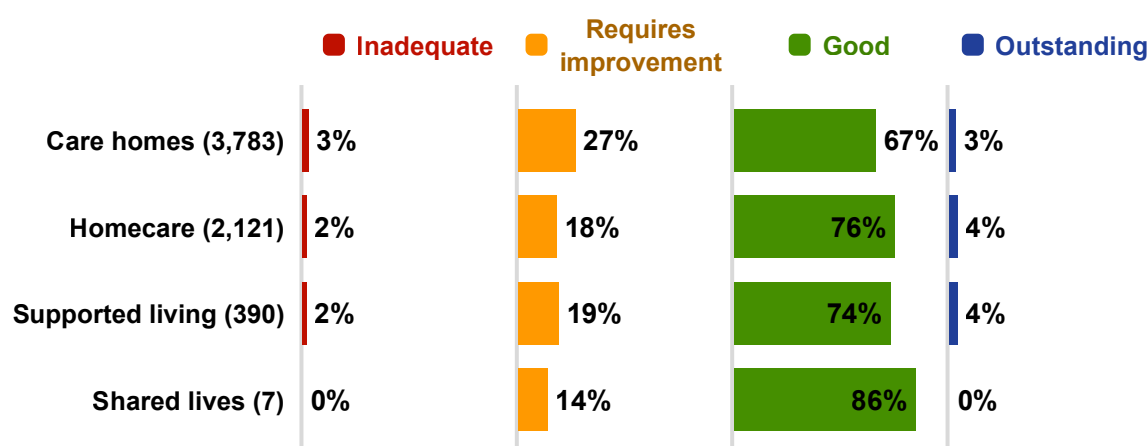
Figure A2: **Adult social care, key question ratings, 2026**



Source: CQC ratings data, 4 August 2026

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, 2026**



Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

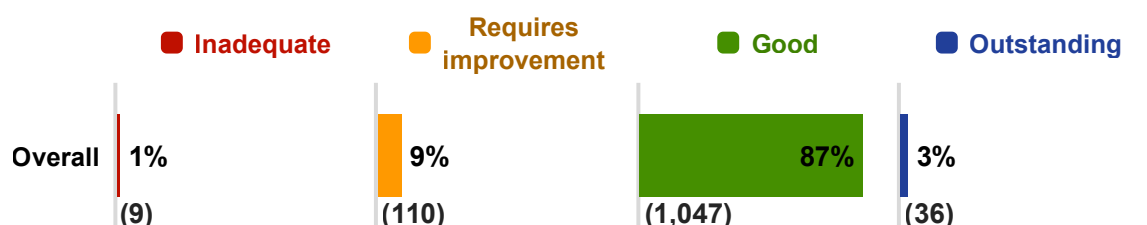
Numbers in brackets denote number of rated services. Chart is ordered by number of rated services, from highest to lowest.

GP services

The charts in this section show the 1,202 ratings for GP services that we have published under our current assessment framework. There are 4,842 GP services with current ratings from our previous frameworks.

As part of the changes introduced with the current 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 one location. For this reason, GP ratings published from assessments under the current assessment framework should not be combined with or compared with those under previous frameworks.

Figure A4: **GP services, overall ratings, 2026**

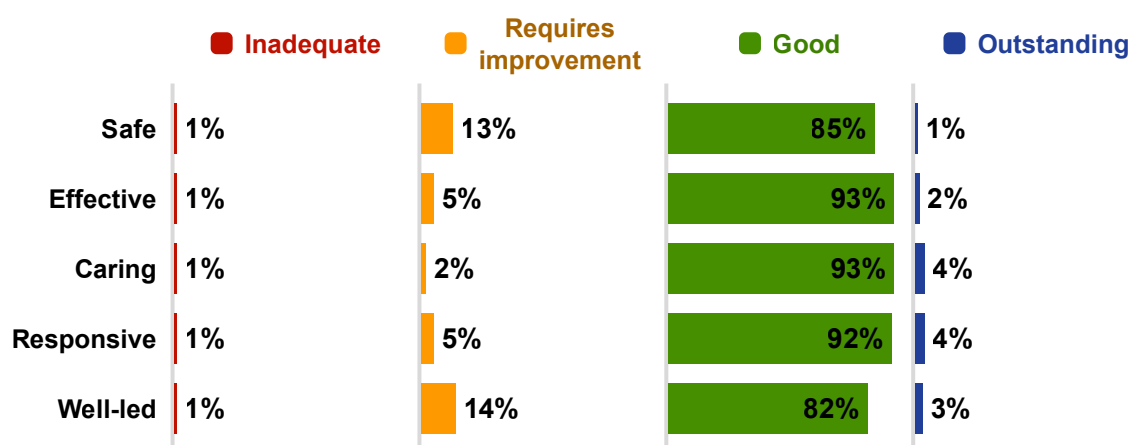


Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services.

Figure A5: **GP services, key question ratings, 2026**



Source: CQC ratings data, 4 August 2026

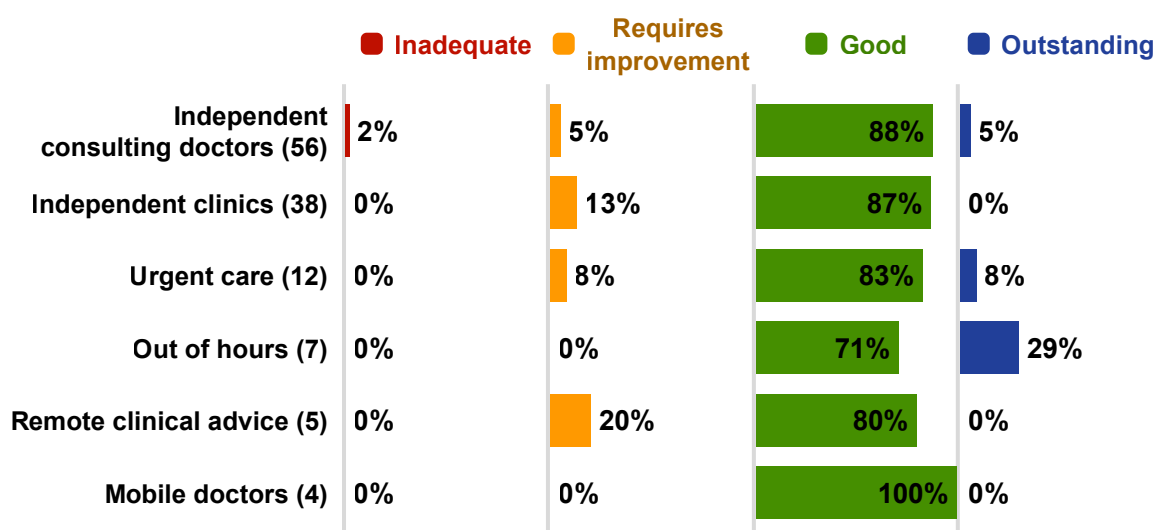
Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Other primary care services

The charts in this section show the 122 ratings for other primary care services that we have published under our current assessment framework. There are 943 other primary care services with current ratings from our previous frameworks.

As part of the changes introduced with the current assessment framework, specific primary 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 one location. For this reason, other ratings published from assessments under the current assessment framework should not be combined with or compared with those under previous frameworks.

Figure A6: **Other primary care services, overall ratings by assessment service group, 2026**



Source: CQC ratings data, 4 August 2026

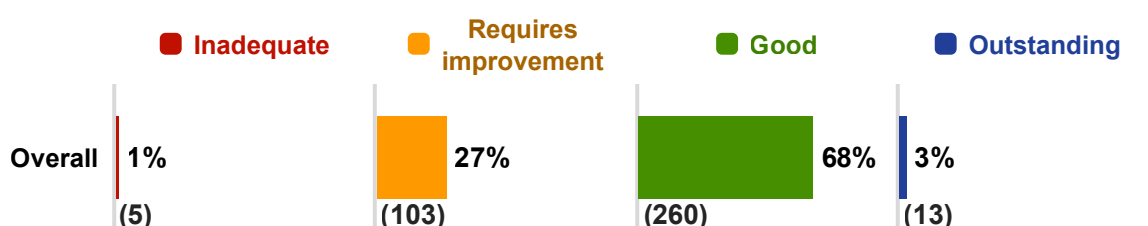
Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services. Chart is ordered by number of rated services, from highest to lowest.

NHS and independent mental health services

The charts in this section show the 381 ratings for mental health services that we have published under our current assessment framework. There are 698 mental health services with current ratings from our previous frameworks.

Figure A7: NHS and independent mental health services, overall ratings, 2026

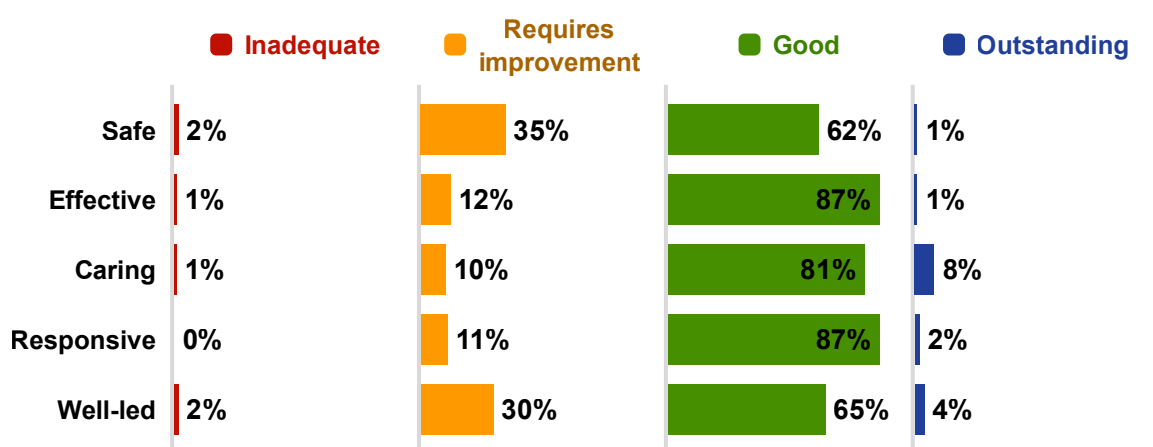


Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services.

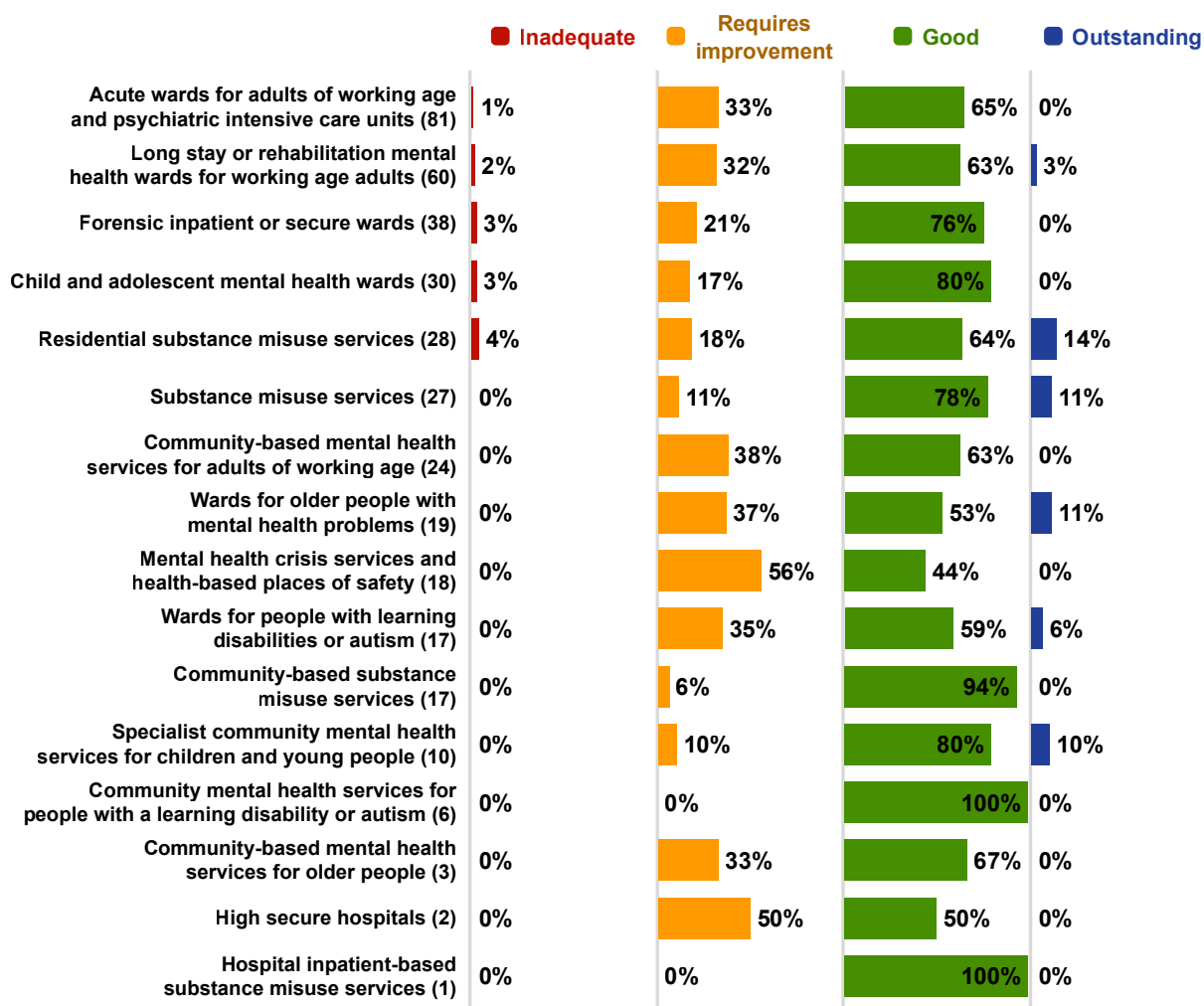
Figure A8: NHS and independent mental health services, key question ratings, 2026



Source: CQC ratings data, 4 August 2026

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 overall ratings by assessment service group, 2026



Source: CQC ratings data, 4 August 2026

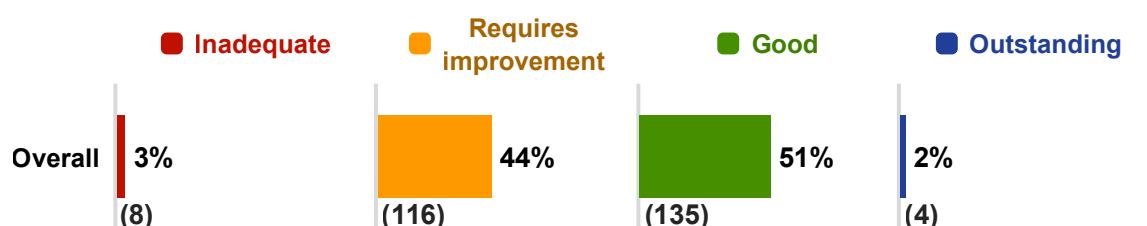
Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%

Numbers in brackets denote number of rated services. Chart is ordered by number of rated services, from highest to lowest.

NHS acute hospitals

The charts in this section show the 263 ratings for NHS acute hospital services that we have published under our current assessment framework. There are 1,416 NHS acute hospital services with current ratings from our previous frameworks.

Figure A10: NHS acute hospital services, overall ratings, 2026

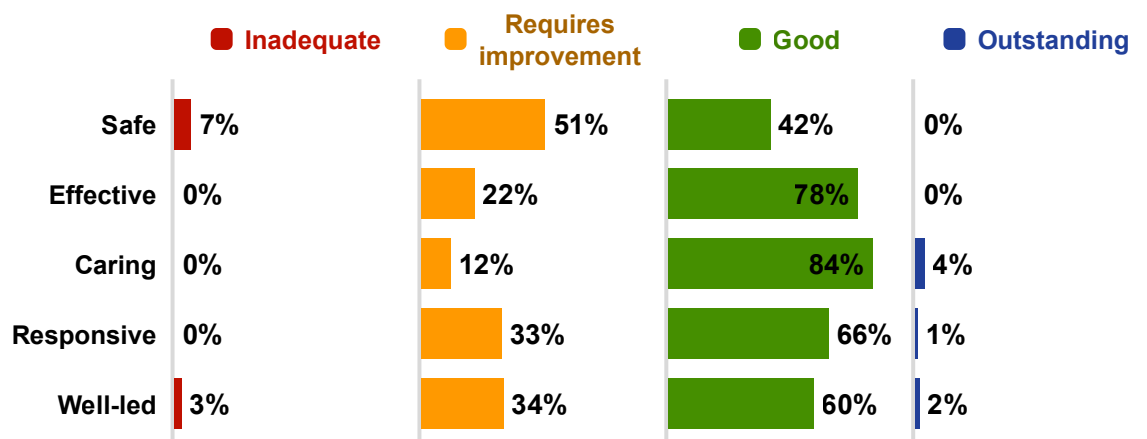


Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services.

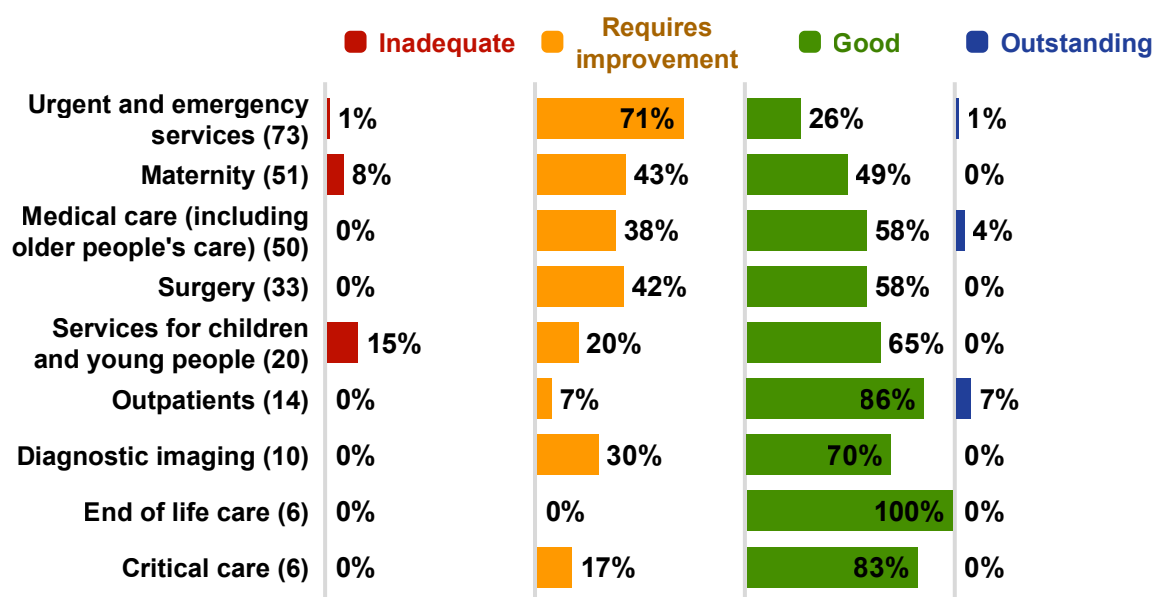
Figure A11: NHS acute hospital services, key question ratings, 2026



Source: CQC ratings data, 4 August 2026

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, overall ratings by assessment service group, 2026



Source: CQC ratings data, 4 August 2026

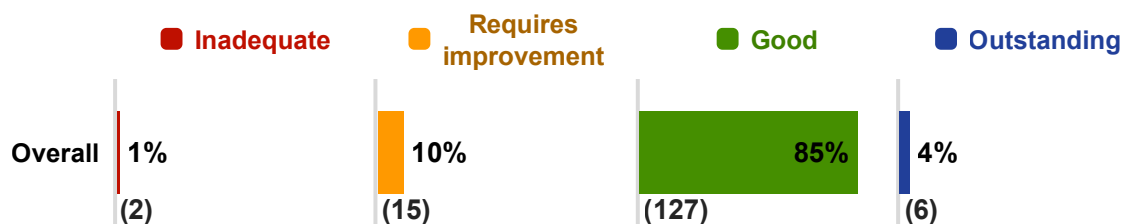
Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services. Chart is ordered by number of rated services, from highest to lowest.

Independent acute hospitals

The charts in this section show the 150 ratings for independent acute hospital services that we have published under our current assessment framework. There are 704 independent acute hospital services with current ratings from our previous frameworks.

Figure A13: Independent acute hospital services, overall ratings, 2026

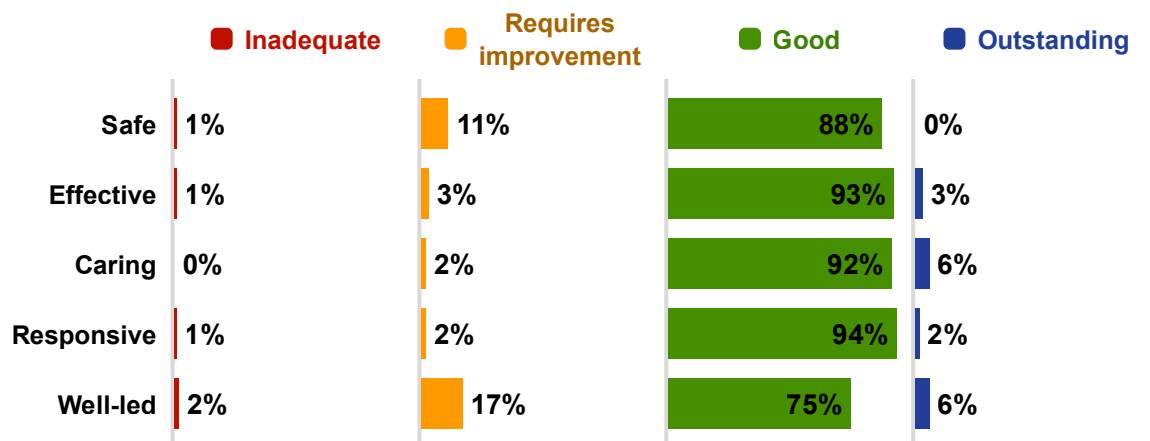


Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services.

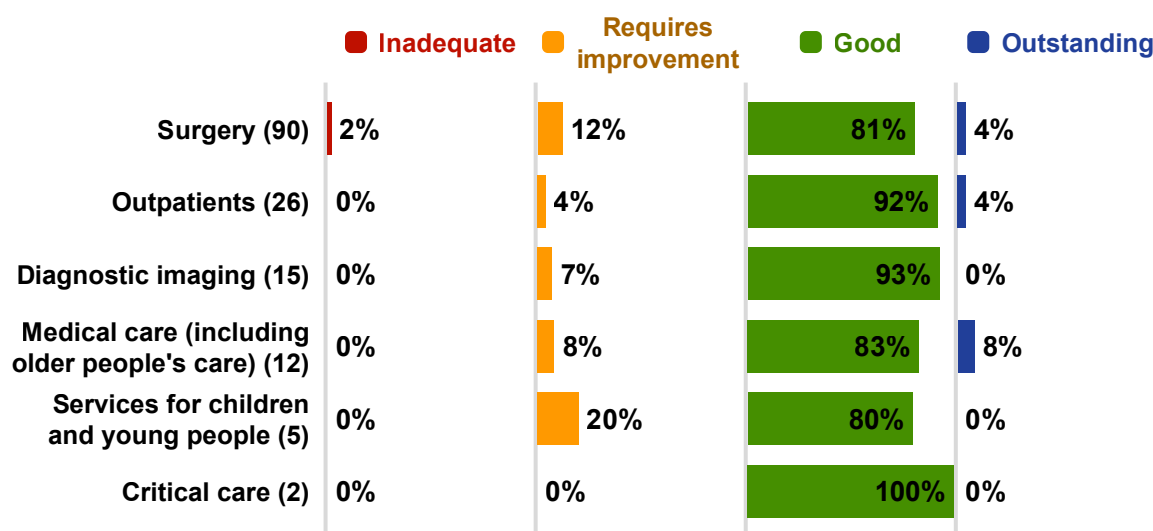
Figure A14: Independent health acute hospital services, key question ratings, 2026



Source: CQC ratings data, 4 August 2026

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, overall ratings by assessment service group, 2026



Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

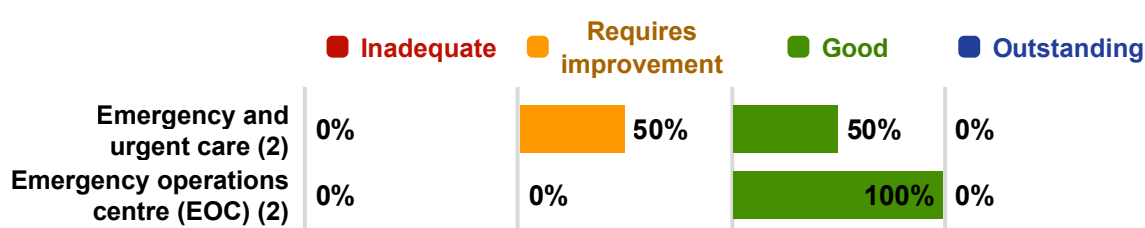
Numbers in brackets denote number of rated services. Chart is ordered by number of rated services, from highest to lowest.

NHS ambulance trusts

NHS ambulance ratings under our current framework are shown by the service delivered (assessment service group). Ratings under previous frameworks, as shown in previous State of Care reports, were shown by the overall rating for each NHS ambulance trust.

There are 4 published ratings for NHS ambulance services under the current assessment framework. There are current ratings for 8 NHS ambulance trusts under our previous frameworks.

Figure A16: NHS ambulance services, overall ratings by assessment service group, 2026



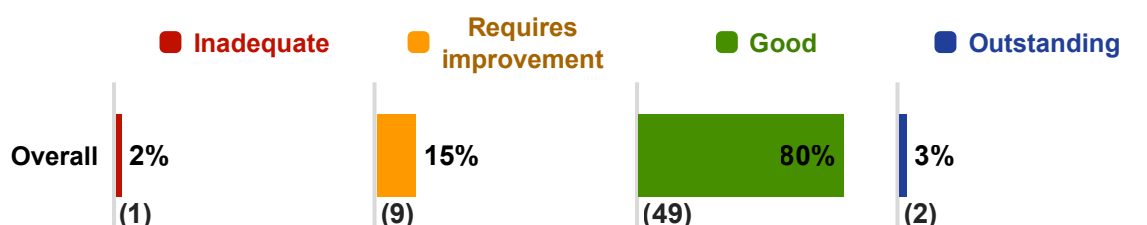
Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Independent ambulance services

The charts in this section show the 61 ratings for independent ambulance services that we have published under our current assessment framework. There are 122 independent ambulance services with current ratings from our previous frameworks.

Figure A17: Independent ambulance services, overall ratings, 2026

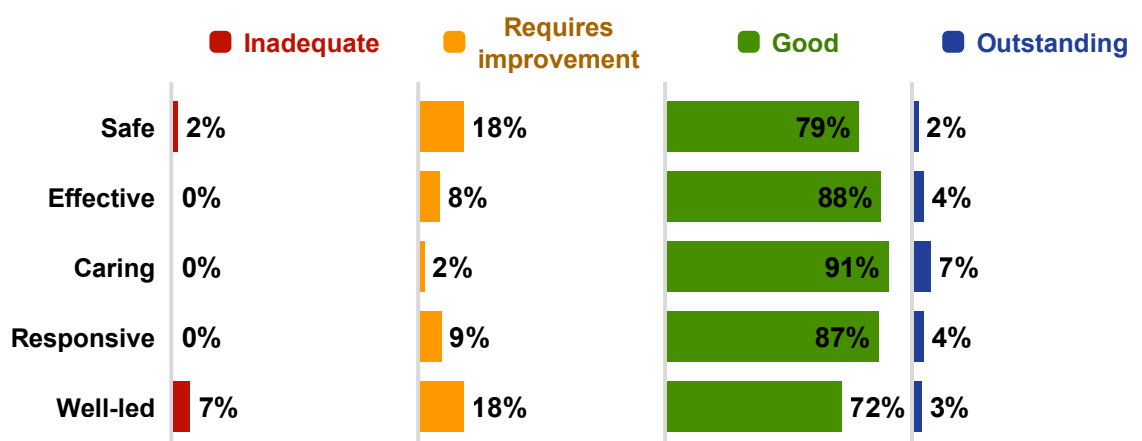


Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services.

Figure A18: Independent ambulance services, key question ratings, 2026



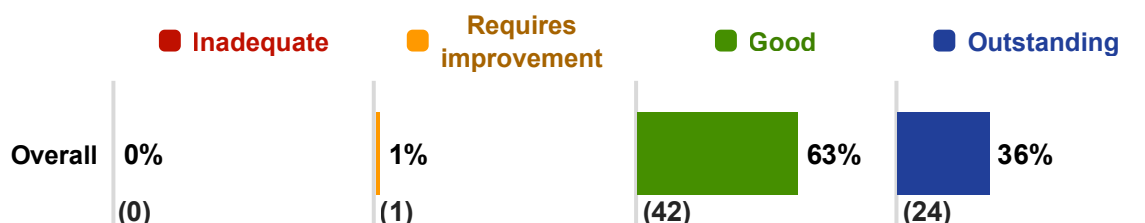
Source: CQC ratings data, 4 August 2026

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 67 ratings for hospice services that we have published under our current assessment framework. There are 79 hospice services with current ratings from our previous frameworks.

Figure A19: Hospice services, overall ratings, 2026

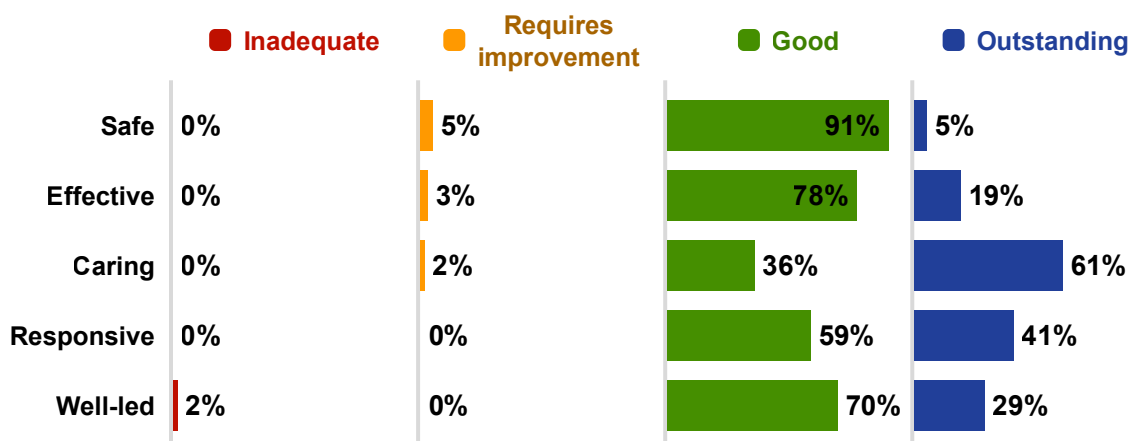


Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services.

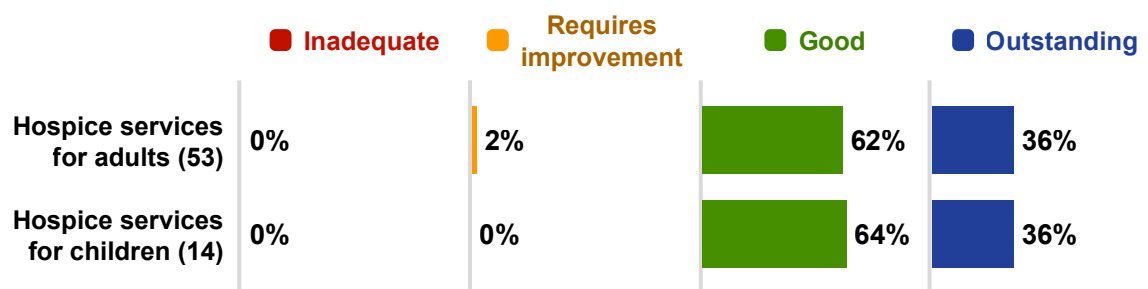
Figure A20: Hospice services, key question ratings, 2026



Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A21: **Hospice services, overall ratings by assessment service group, 2026**



Source: CQC ratings data, 4 August 2026

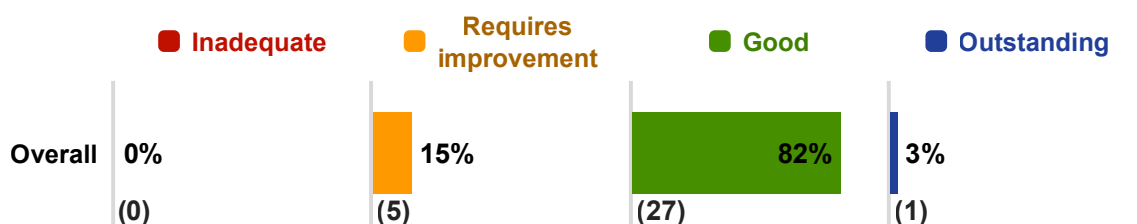
Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services. Chart is ordered by number of rated services, from highest to lowest.

Community health services

The charts in this section show the 33 ratings for community health services that we have published under our current assessment framework. There are 488 community health services with current ratings from our previous frameworks.

Figure A22: **Community health services, overall ratings, 2026**

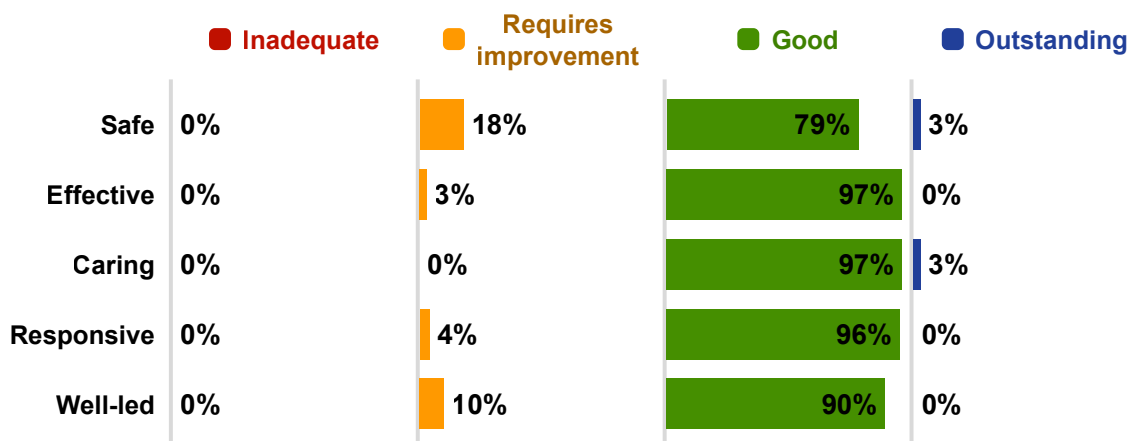


Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services.

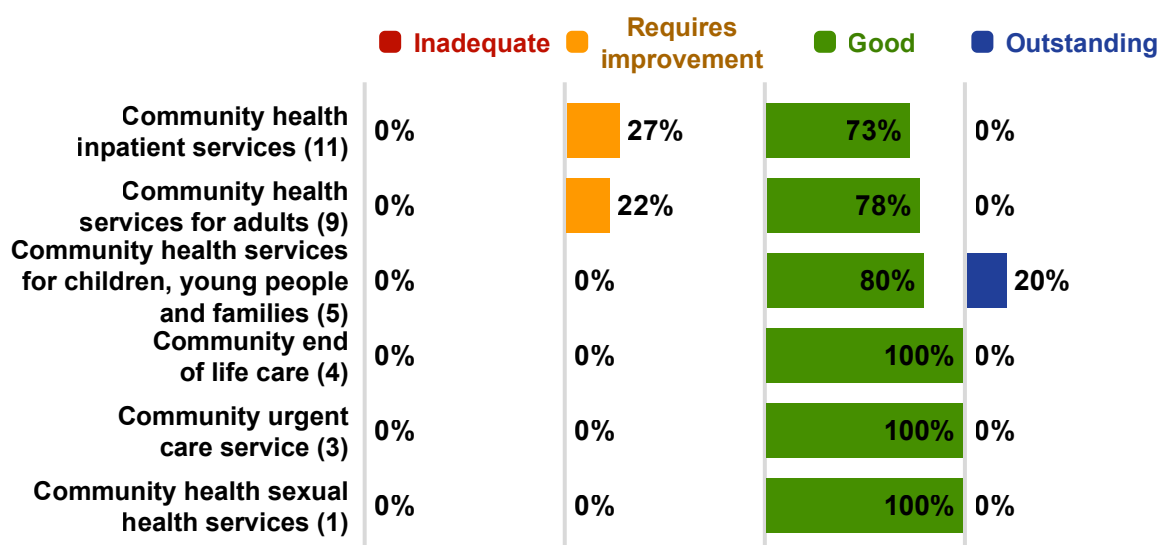
Figure A23: **Community health services, key question ratings, 2026**



Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A24: **Community health services, overall ratings by assessment service group, 2026**



Source: CQC ratings data, 4 August 2026

Percentages may not add up to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Numbers in brackets denote number of rated services. Chart is ordered by number of rated services, from highest to lowest.

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CQC-496-15-102026



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978-1-5286-6803-3