Rising demand and pressures on the system

Key points

- Demand for mental health care has continued to rise throughout 2024/25 with an average of 453,930 new referrals to secondary mental health services every month.
- Our Mental Health Act (MHA) reviewers are finding that people are becoming more unwell before they are referred for assessments under the MHA, and are also waiting longer to be assessed meaning they are often more unwell when they are admitted to hospital. This can be worse for certain groups of people, such as those living in areas of deprivation.
- Between 2023/24 to 2024/25, we have seen a 17% increase in the use of community treatment orders, compared with an increase of 9% in the previous year.
- On average in 2024/25, the bed occupancy rate (for all mental health overnight beds) has remained above the recommended 85% threshold at 90%. Providers have told us about higher thresholds for admission, delayed discharges and fewer beds are adding to this pressure and the difficulties for people in getting hospital care.

- Inconsistent provision of community care, the need for better funding of mental health services and challenges around collaboration and communication between services can leave people without the proper care and support they need after being discharged and can increase the risk of being readmitted to hospital.

In 2024/25, the rising demand for mental health care has continued to put pressure on mental health services. Data from NHS England shows that during the year there was an average of 453,930 new referrals to secondary mental health services every month – an increase of 15% from 2022/23.

In this context we are continuing to report that people are facing lengthy waits for treatment. A third of respondents (33%) to the 2024 Community mental health survey said they waited 3 months or more, and 40% of respondents said they felt the waiting time between their assessment and first appointment for treatment was too long. This is supported by the findings of the 2024 Independent investigation of the NHS in England, which highlighted how long waits have become normalised.

Our engagement events with mental health service providers were part of our focused review of community mental health services for working-age adults. Through these events, we have also heard how people's needs are becoming increasingly complex.

When people are not able to access the care they need when they need it, it can lead to their conditions worsening and/or reaching crisis point. The feedback from our 2024 Community mental health survey found that the longer people waited, the more they reported that their mental health got worse. For some, this led to them needing urgent and emergency care:

> "When I get a crisis come on I get unwell very fast and it seems like the help is not accessible at the first instance and it escalates quickly, and I end up having to go to A&E

> and this was very distressing."

As we highlighted in last year's report, this can be worse for certain groups of people, such as those living in areas of deprivation. We have again heard this year how socio-economic challenges, such as difficulties finding housing and employment, are exacerbating this.

In July 2023, the previous government published the National Partnership Agreement, which is based on the Right Care Right Person (RCRP) model initiated by Humber Police in 2020. The framework aims to support people in crisis to get compassionate care that meets their needs, and to end cases of inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs. It sets out a national commitment from the Home Office, the Department of Health and Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England. Local areas were tasked with agreeing a joint multi-agency plan for implementing and monitoring the RCRP approach.

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

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

When this threshold is not met, partners in local areas will agree the best health-based approach to support people in crisis. The aim is to ensure that the right person responds, who has the right skills, training, and experience to best meet the person's needs. However, as previously highlighted by NHS Confederation, this reduction in support from police adds to the already rising demand and pressure on mental health services, increasing the risk of peoplenot receiving the protection, care and support they need and coming to harm themselves or causing harm to another.

In the focus groups, we heard how our MHA reviewers are continuing to see people becoming more unwell before they are referred for assessments under the MHA. They are also waiting longer to be assessed once a MHA assessment has been requested, whether they are in their homes, in health-based places of safety or in emergency departments. As a result, people are more unwell when they are admitted to the wards. As highlighted in last year's report, this can lead to a longer recovery time in hospital, meaning bed occupancy rates remain high.

As we reported in our 2024/25 State of Care report, the number of urgent and very urgent referrals to crisis services has continued to rise over the last 2 years. Data from NHS England's Mental health services data set (MHSDS) shows 77% more very urgent referrals in 2024/25 compared with 2023/24 (rising to 60,935 from 34,455). There are known quality concerns with this data, as a small number of trusts contribute a large proportion of these very urgent referrals. Data quality and reporting will therefore need to improve to give us a confident picture of the pressure on crisis care services.

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

Over the last year, we have seen more people with higher levels of risk being managed in the community. Data from MHSDS shows that the number of people with serious mental illness accessing community services increased by 11% between 2023/24 and 2024/25, rising from a monthly average of 576,081 to 640,619.

We have also seen an increase in the use of community treatment orders (CTOs) or conditional discharge. Figures from NHS England's Mental Health Act statistics show that the number of CTOs increased from 5,618 in 2023/24 to 6,575 in 2024/25, an increase of 17%, compared with an increase of 9% between 2022/23 and 2023/24. These increases follow 2 years of falling rates (including a fall of 7% between 2021/2022 and 2022/23, and a fall of 9% between 2020/21 and 2021/22). Over the same time period, the number of people detained under the MHA (excluding short-term orders) saw a slight rise of 0.5%, increasing from 52,458 to 52,731.

Caution is required when comparing values over time as trend comparisons can be affected by changes in data quality. Again, data quality and reporting will need to improve in order to give us a confident picture of use of the MHA.

Pressures on hospital beds

The pressure on beds in inpatient services continues. On average in 2024/25, the bed occupancy rate (for all mental health overnight beds) was 90%, remaining above the recommended 85% threshold. For services such as acute admission wards, usual occupancy rates are higher than the average.

Through our engagement events with providers, held as part of our focused review of community mental health services for working-age adults, we also heard that higher thresholds for admission, delayed discharges and fewer beds are contributing to difficulties in people getting hospital care.

As we highlighted in our 2021/22 MHA annual report, if people are not admitted to hospital when needed, they can be left in vulnerable and unsafe positions. This can also lead to people being cared for in unsuitable environments, such as health-based places of safety, for prolonged periods.

Under sections 135 and 136 of the MHA, patients may be admitted to a health-based place of safety (HBPoS) for up to 24 hours. However, we are continuing to find evidence of this time limit being breached because of delays in accessing an inpatient bed.

In March 2025, our MHA reviewers visited 6 HBPoS across 2 NHS trusts as part of our comprehensive programme of inspections of community mental health services for working-age adults, crisis services, and HBPoS. We found that both trusts had an average length of stay over 24 hours, and in many cases, people were in the HBPoS for over 72 hours.

One trust was operating a 'swing-bed' system, where the HBPoS can be designated as a bed on the neighbouring admission ward. This allowed the trust to formally admit patients to the HBPoS itself under MHA section 2 or section 3 and avoid any gap in formal powers of legal detention. As a result, staff and patients were clear about the legal status of their detention.

While swing-bed arrangements can provide a legal solution to the holding power running out of time, they do not address the underlying problem of delays in access to admission wards and can prevent further admissions to HBPoS. Through our review, we found examples of people being diverted to emergency departments in acute hospitals as the HBPoS were occupied. Services should ensure that bed managers do not de-prioritise patients held under swing-bed arrangements for a ward bed, both in the interests of the patient's admission experience, and to free up the HBPoS for further use.

Participants in our focus group for our Service User Reference Panel (SURP) discussed the consequence of not being able to get a bed in hospital. One person described how their sibling has often been detained in the emergency department due to a lack of beds. This has created complex situations leading to their sibling not receiving timely care.

Analysis of our MHA monitoring reports shows that pressures on bed availability continue to result in people being placed in a service outside of their local area despite the government's ambition to eliminate inappropriate out of area placements in mental health services for adults in acute inpatient care by 2020/21. Looking at the data from MHSDS for 2024/25, more people were placed out of area inappropriately: the number of new inappropriate out of area placements increased by 5% from 5,392 in 2023/24 to 5,649 in 2024/25. This is still too high.

As we have highlighted previously, and illustrated by Grace's story in our 2023/24 report, being placed out of area can be isolating and makes it more difficult for people to have regular contact with friends and family, which can have a significant impact on their care and recovery.

As well as being placed far from home, analysis of our MHA monitoring reports also continues to show how a lack of beds is resulting in people – including children and young people – being placed on an inappropriate ward (see also section on children and young people). This can lead to difficulties for patients and staff, as people with different needs are placed together. For example, during our focus groups, a MHA reviewer spoke about how they had seen older patients with dementia being placed on a functional older person's ward. We heard how the environments on these wards can be unsuitable for people with dementia, as there were problems with noise, lighting and high levels of stimulus, which can make people feel unsafe (see also section on inequalities).

On another ward that was over the bed occupancy rate, we found that people who asked to take overnight leave were being told they may not be able to return to the ward due to new admissions. Staff understood that this would be detrimental for some people and could cause a setback in their treatment and recovery. However, they did consider the impact on those who were most unwell and sometimes beds would be reserved.

Another issue resulting from a lack of beds is where people can be admitted into or kept in services where they experienced more restrictive conditions than they required. Examples include a lack of beds in step-down wards or community treatment services, which leads to delays in discharging people from hospital (see section on discharge).

System-wide challenges

Inconsistent provision of community care, the need for better funding of mental health services and the impact they have on people – particularly around discharge – has been a recurring theme across the last 5 Monitoring the Mental Health Act reports. Our MHA monitoring visits continue to illustrate the impact of these shortfalls, with one report highlighting the following example:

> "One patient told us how cutbacks in community services had contributed to them relapsing, including reduced availability of respite services and the closing of a community hub they used to visit."

Extract from MHA monitoring visit report

In last year's report, we highlighted new statutory guidance from NHS England that outlines how organisations should work together to ensure effective discharge planning and the best outcomes for people when they are discharged from hospital. However, analysis of our MHA monitoring reports from 2024/25 shows that challenges around collaboration and funding continued to affect people when being discharged from hospital.

The reports showed that for a small number of people, waiting for an assessment or where there was a lack of agreement over who would take on psychiatric and social supervision had prevented them from being discharged when they were ready to leave. However, we did see a few examples where the ward maintained regular contact with both community-based services and trust-wide bed management to obtain updates on proposed discharges and transfers from the ward.

But we also heard how poor communication and collaboration has an impact on people's experience of care, how their care is co-ordinated and their transitions between pathways. For example, participants in our focus group of CQC Experts by Experience, which informed our focused review of community mental health services for working-age adults, described how poor communication could lead to indecisiveness about who would provide care, which could lead them feeling left in limbo.

Through our engagement events with providers, held as part of the same focused review, we heard that good communication was particularly vital when a person is discharged back to primary care. Providers spoke of the need to ensure all discharge notes are available to a person's GP – ideally immediately. They told us this was important to reduce both risk and the potential for people's wellbeing to deteriorate, and possible future hospital admissions or crisis.

We also heard that when discharged back into the community, it can be difficult for people to get the support they need from their GP. Experts by Experience in our focus groups told us that GPs are often happy to take on simple medication regimens, but are less likely to take on complicated medicines, making it much harder to get them changed. We heard how, in some instances, community mental health services had advised GPs not to make any changes to a person's medicines. In other cases, GPs were said to be pushing back on medicines prescribed by community mental health services.

To better understand the challenges for each sector more widely, we held a workshop with GPs and hospital pharmacy leads in February 2025. At the workshop, GPs described how their workload was increasing and how they felt that shared care protocols were often intended for patients with medically complex conditions, which they did not have the knowledge to manage. They were concerned about patient safety and how shared care protocols increase the burden on already stretched resources.

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

As highlighted by our Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust, disengagement with services is common for people with mental health problems. However, not managing people who struggle to engage with services can have serious safety implications.