Foreword

Our report this year highlights the ongoing challenges in mental health care that are compounding the pressures on mental health inpatient services.

The issues we raise will be all too familiar to many, including the shortage of staff and staff in post not always having the right training to meet the needs of all of the people they care for. This, combined with a lack of inpatient beds, means that people continue to be detained a long way from home, often in environments that don't meet their needs.

Through our conversations with thousands of patients, carers and staff, we have heard time and again how being detained in a hospital far from home can make people feel isolated from their support network and have a detrimental effect on recovery. Grace's story, told in greater detail in our report, highlights the impact of this, not just on those who are detained but their family and friends too:

> "Being placed so far from home meant that Grace did not have any visitors while she was in hospital…she felt she was taken away from everything she knew and was really scared. Not being able to see Grace had a significant effect on her children. She described how they went to bed crying and when she did see them… it was difficult to interact while they were being monitored."

Getting the right care, at the right time and in the right place is essential for everyone. However, findings from our Mental Health Act monitoring work reveal how certain groups still face significant barriers in accessing care, particularly people from ethnic minority groups and those living in areas of deprivation.

Our findings also reinforce concerns raised in both last year's report and our 2022/23 State of Care report about the significant and lasting impact that delays can have on children and young people. Without access to good, timely care, children with mental health needs are both at increased risk of harm and of becoming adults with relapsing mental health problems.

It is essential that we view the challenges faced by people in mental health inpatient services in the context of the significant pressures across the entire mental health pathway. We know that a growing number of people are in contact with secondary mental health services, and we have raised concerns in successive reports that community mental health services are struggling to support all the people who need it. We are increasingly concerned that the system is at risk of failing people in need of care, their families and in some cases, the wider society.

In our special review of Nottinghamshire Healthcare NHS Foundation Trust, we found evidence of people having to wait several months and in some cases several years for mental health treatment provided in the community. We identified systemic issues with community mental health care, including a shortage of mental health staff, and a lack of integration between mental health services and other healthcare, social care, and support services. We warned – and continue to warn – that without action these systemic issues pose an inherent risk to patient and public safety.

In 2023/24, many services told us that detained patients seemed to be more unwell on admission than in the past. This can lead to a prolonged recovery time, which is not only a significant toll on the individual person, but also makes it more difficult for services to admit new patients.

The increase in demand for inpatient beds also heightens the risk that patients will be discharged too soon, without the appropriate support in place, and then need to be readmitted. As a result, they may find themselves being bounced from service to service without ever receiving the level of care that they need.

We welcome the recent focus on improving mental health and learning disability care in the 2025-26 NHS operational planning guidance. We are hopeful that the introduction of the Mental Health Bill will strengthen this by bringing about long-awaited, important reforms that will enable the system to improve mental health care. However, we recognise that some of the provisions of the revised Mental Health Act may take years to implement.

We remain concerned about abuse and closed cultures in mental health services and ongoing problems with care pathways and lack of community provision for autistic people and people with a learning disability. We are continuing to embed our enhanced approach to inspecting specialist services and wards for autistic people and people with a learning disability to help us proactively identify potential closed cultures.

We will continue to use the insight and evidence gathered through our monitoring role, as well as our community mental health programme, to support our work in engaging and feeding into any changes in the passage of the Mental Health Bill. We are committed to using this insight and evidence to also help shape any subsequent changes to the Code of Practice and drive the improvements in mental health care across the system and provide better outcomes for patients.

Moving forward, we will ensure changes introduced by the Bill are reflected in our approach to monitoring the MHA. This will allow us to check whether the key aims of the reforms – including enhancing patients' rights and safeguards, giving them a meaningful voice in their care and treatment and reducing compulsion – are being met.

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