



Patient Experience Bulletin

February 2026

The aim of this current awareness bulletin is to provide a digest of recent guidelines, reports, research and best practice on patient experience in the NHS.

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Latest Evidence

Monitoring the Mental Health Act

Monitoring the Mental Health Act is CQC's annual report on the use of the Mental Health Act 1983 (MHA). It looks at how providers are caring for patients, and whether patients' rights are being protected. See [here](#).

Source: Care Quality Commission (CQC)

The INTEGRATE report

The INTEGRATE report outlines a practical approach to integrating psychological support for common mental health difficulties during pregnancy and after birth within universal services. While specialist services exist for those experiencing moderate to severe mental health challenges, those with common difficulties often encounter fragmented systems and gaps in care. This report calls for urgent action to integrate psychological support within universal services, such as midwifery, health visiting, and general practice so that everyone receives timely, compassionate, and effective care. See [here](#).

Source: Anna Freud

Transforming access to children and young people's mental health support

Evidence and insight on the importance of early intervention for children and young people with mental health issues. See [here](#).

Source: NHS Confederation

Digital platforms recommended to help people manage their asthma

People with asthma could benefit from digital tools on their phones or tablets to help them better manage their condition, states NICE's draft [guidance](#).

Source: National Institute for Health and Care Excellence (NICE)



AI in NHS care: what's the impact, and what do people think?

As the Government attempts to 'make the NHS the most AI-enabled care system in the world', the public's early experiences show it may be causing as many issues as it aims to solve. See [here](#).

Source: Healthwatch

Study warns of risks in AI chatbots giving medical advice

The largest user study of large language models (LLMs) for assisting the general public in medical decisions has found that they present risks to people seeking medical advice due to their tendency to provide inaccurate and inconsistent information. See [here](#).

Source: NIHR Oxford Biomedical Research Centre

Accident and emergency (A&E) waiting times

Accident and emergency (A&E) departments treat people with urgent illnesses, from minor injuries to life-threatening conditions. Type 1 A&E departments are what we typically think of as A&E – based in major hospitals – and account for around two thirds of A&E attendances. Speciality and minor injury A&E departments (type 2 and type 3) account for the remaining third of attendances. See [here](#).

Source: The King's Fund

Corridor care and long waits: what are people experiencing in A&E?

Our insight into A&E experiences during a busy winter period found long waits and care in unsuitable spaces left people suffering an emotional and physical toll. See [here](#).

Source: Healthwatch

A&E nightmare: Shelley's 26-hour ordeal

Shelley's story shines a light on the crisis affecting emergency departments across England. See [blog](#).

Source: Healthwatch

NHS key statistics: England

Summary of NHS demand, performance, backlogs, and capacity of services in England. It covers A&E waiting times, hospital waiting lists, cancer waiting times, ambulance response times, staffing levels including doctors and nurses, vacancies, and more. See [here](#).

Source: House of Commons Library

One year on, have 'crack teams' cut NHS waiting lists?

In October 2024, 'crack teams of top clinicians' were deployed to 20 hospitals in England in areas with the highest numbers of people off work sick. These teams



aimed to support trusts to bring down the elective waiting list by improving productivity and reducing avoidable demand for elective care, in areas with high numbers of people out of work. See more [here](#).

Source: The Health Foundation

Global State of Patient Safety 2025

This second report on the global state of patient safety will inevitably be compared to the first, published two years ago. At first glance, the headline findings seem very similar, with Norway retaining top spot in our patient safety ranking and the UK remaining 21st out of 38 Organisation for Economic Co-operation and Development (OECD) countries. [See report](#).

Source: Imperial

Prioritising patient safety: Winter 2026

This blog shares two cases involving patients with disabilities and highlight the improvements one Trust has made, summarise the key themes emerging from recent casework, and provide updates on external patient safety activity from NHS Resolution, the Freedom to Speak Up Guardian, and HSSIB. See [here](#).

Source: Parliamentary and Health Service Ombudsman

Improving patient experience and enhancing access to cancer services for people with learning disabilities

People with learning disabilities experience inequities in cancer care including diagnosis and treatment delays, less access to services and therapies, and higher mortality. The Cancer Experience of Care Improvement Collaborative (CIC) brings together healthcare professionals, charities and people with lived experience to improve cancer services in a structured way. This article describes a CIC quality improvement project undertaken at two hospital trusts in England with the aim of reducing diagnosis and treatment delays for people with learning disabilities who have cancer. The authors explore the relevant evidence base and discuss how using data from the National Cancer Patient Experience Survey and CIC quality improvement methodology can drive improvements in cancer services based on what matters to people who use these services. See [article](#).

Source: Bell D, Richardson M, Rarity A et al (2025) Improving patient experience and enhancing access to cancer services for people with learning disabilities. *Cancer Nursing Practice*. doi: 10.7748/cnp.2025.e1898

Red Flag Tracker from the Patient Experience Library

The Patient Experience Library's Responding to Challenge report reveals the patterns of behaviour that crop up time and again in healthcare disasters. It shows what poor cultures look like - in teamwork, compliance, accountability, organisational learning and more. This tracker can help to recognise the red flags for harmful healthcare cultures. It shows real-life examples, drawn from ten years of official inquiries in UK health and care settings. See [here](#).

Source: The Patient Experience Library



Staff experiences of implementing patient-initiated follow-up (PIFU) in the NHS in England: findings from a rapid qualitative evaluation

Objectives The NHS in England has introduced various innovations to keep up with the growing demand for elective care, one of which is patient-initiated follow-up (PIFU). This evaluation sought to understand staff experiences of implementing PIFU. **Methods** We conducted a rapid qualitative service evaluation between June 2022 and July 2023, based on semi-structured interviews (n = 36) with operational/managerial and clinical NHS staff from five English NHS Trusts, and an online workshop with 21 additional members of staff from the English NHS. We drew on the Non-adoption, Abandonment, Scale-up, Spread and Sustainability (NASSS) framework to structure qualitative data collection and analysis and to generate new insights into the adoption of the innovation of PIFU. **Results** We found that implementation of PIFU affected staff roles, workload, and job satisfaction. Levels of PIFU uptake, and experience with similar models, affected the extent to which participants experienced the impact of PIFU. How PIFU was implemented varied. Some staff saw changes in their role because of new administrative demands, safety-netting procedures (such as proactive measures by specialty teams to mitigate the risk of patients not initiating appointments when necessary), and selection of suitable patients. PIFU was felt by some staff to increase, and by others to decrease, workload. PIFU affected intensity of work, interrelated with other factors such as the size of waiting lists, and conditions experienced by patients. Whether staff were satisfied with PIFU related to its impact on their role and workload. Satisfaction was also affected by whether staff believed PIFU delivered benefits for patients, and by the aims they felt were driving rollout. **Conclusion** PIFU can significantly affect the experiences of staff and change staff roles and workload. However, the impact of PIFU is not uniform. Staff perspectives on PIFU from all parts of the health system should be better understood and considered during pathway design. See [here](#).

Source: Lobont C, Hutchings R, Bagri S, et al. Staff experiences of implementing patient-initiated follow-up (PIFU) in the NHS in England: findings from a rapid qualitative evaluation. *Journal of Health Services Research & Policy*. 2026;0(0). doi:10.1177/13558196261421165

The Model Acute Pathway: standards for care of acutely unwell patients in their first 72 hours in hospital

The Model Acute Pathway provides evidence-based standards to improve care during the first 72 of hospital care. Developed in partnership with the Royal College of Physicians, the Society for Acute Medicine and the British Geriatrics Society, the standards set out the practical actions needed to overcome persistent barriers and deliver meaningful improvement. See [here](#).

Source: NHS England

The Model Emergency Department: high performing urgent and emergency care pathways

This guidance sets out the core principles and components of high-performing emergency departments. It is accompanied by a detailed guide to the core operating principles for extended emergency medicine ambulatory care (EEMAC)



activity. Together, they offer a structured, actionable approach to improving urgent and emergency care pathways and patient experience, as well as reducing waiting times. See [here](#).

Source: NHS England

Teenager had to tell his Deaf mother that her father might die after hospital failed to provide interpreters

Hospital staff used a teenage boy to tell his Deaf mother that her father might die that day, an investigation by England's Health Ombudsman has found. See [here](#).

Source: Parliamentary and Health Service Ombudsman

Leaders in Health, a new podcast series brought to you by the Queen's Institute of Community Nursing.

Episode 2 – Emma Dodsworth and Sophie Julian – Researchers, Nuffield Trust. This episode examines the Nuffield Trust's latest findings on the decline of district nursing and what it means for the NHS's plan to shift more care into the community. Emma and Sophie explain the scale of the workforce shortfall, the importance of the District Nursing SPQ, and the actions needed to stabilise supply, improve retention, and manage rising demand. See [here](#).

Source: The Queen's Institute of Community Nursing