Healthwatch Mental Health Services Insight Report – Hampshire, Portsmouth, Isle of Wight and Southampton

A partnership report - Healthwatch Hampshire, Healthwatch Isle of Wight, Healthwatch Southampton & Healthwatch Portsmouth

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Contents

Section One

1. Executive Summary

This report brings together insight from four local Healthwatch organisations across Hampshire and the Isle of Wight – Healthwatch Hampshire, Southampton, Isle of Wight and Portsmouth. While the volume and sources of feedback vary between areas, there is strong consistency in the themes identified.

Across all four areas, feedback highlights **significant challenges in accessing timely mental health support, with long waiting times, high eligibility thresholds, and fragmented care pathways** being the most common concerns. These issues are evident **across both adult and children's services.**

Overall sentiment is predominantly negative across all areas, particularly in Hampshire (80% negative) and Isle of Wight (92% negative), with similar themes reflected in Southampton and Portsmouth data.

Despite these challenges, there are isolated examples of positive care, particularly relating to individual staff members and specific services. However, these are outweighed by systemic issues affecting access, continuity, and patient experience.

2. Methodology and Evidence Base

This report draws on:

- Individual Healthwatch Client Record Management (CRM) feedback collected between **1 July and 31 December 2025**
- Healthwatch Engagement activity, including meetings, group discussions and social media feedback
- Previously published Healthwatch reports where explicitly referenced for **contextual intelligence:**

    - **Healthwatch Portsmouth - Mental Health Experiences of Children and Young People in Portsmouth** - https://www.healthwatchportsmouth.co.uk/mental-health-experiences-of-children-and-young-people-in-portsmouth-report
    - **Healthwatch Southampton - Exploration into Community Mental Health Teams in Southampton** - https://healthwatchsouthampton.co.uk/wp-content/uploads/2025/10/HWS-Community-Mental-Health-Team-Report-final.pdf

The feedback represents **lived experience** rather than a statistically representative sample, but provides rich qualitative insight into **system pressure points, barriers to access and quality of care**.

3. Overview of Feedback Volume and Sentiment

Area	Total Feedback	Predominant Sentiment	Key Notes
Portsmouth	5 + wider CYP dataset	Predominantly negative	Low volume but consistent with wider evidence
Hampshire	50	80% negative	Focus on Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health in Schools (TaMHS) and Community Mental Health Teams (CMHT)
Isle of Wight	123	92% negative	High volume, strong themes across services
Southampton	13 (recent Client Relationship Management (CRM) data + historic dataset	Predominantly negative	Longstanding systemic concerns

4. Key System-Wide Themes

Individual Healthwatch themes are contained within Appendix One.

Across all four Healthwatch areas, the following **recurring themes** were identified:

4.1 Access to Services and Waiting Times

Access remains the most significant concern across all four areas.

- Long waiting times for assessment, diagnosis, and treatment are consistently reported

- Delays often extend to months or years (e.g. 2-year waits for Attention Deficit Hyperactivity Disorder (ADHD) assessment, 4-year waits for trauma therapy.
- Support is frequently only provided at crisis point rather than early intervention
- Difficulty accessing crisis services, particularly out of hours
- Delays are frequently linked to **deterioration of mental health before support is received**

Impact:
Delays can contribute to deterioration in mental health, increased crisis presentations, and reduced trust in services.

4.2 Thresholds and Eligibility Criteria

High thresholds for accessing services are a common barrier.

- Individuals report being told they are "too unwell" for some services but "not unwell enough" for others
- Neurodivergent individuals and those with complex needs are particularly affected
- Children and young people often do not receive support until conditions worsen significantly

Impact:
People fall through gaps in provision, leading to unmet need, presentations elsewhere in the system and escalation of conditions.

4.3 Navigation and Fragmentation of Services

Across all areas, people describe the system as difficult to navigate.

- Confusion about referral pathways and available services. Lack of clarity around:
    - Referral routes
    - Eligibility criteria
    - What support is available at different levels of need
- Poor coordination between services (e.g. GP, Child and Adolescent Mental Health Services (CAMHS), Community Mental Health Team (CMHT)
- Lack of clear communication and information
- Repetition of information to multiple professionals

- People often feel passed between services, repeating their story multiple times

Impact:
Patients and families experience frustration, delays, and disengagement from services.

4.4 Crisis-Led System

- Feedback suggests a system that **responds more readily at crisis point**
- Preventative, early help and step-down support are perceived as limited or non-existent
- Individuals and families report being told they do not meet thresholds until risk escalates

4.5 Crisis and Out-of-Hours Support

Concerns about crisis support are particularly strong in Isle of Wight and Southampton.

- Reports of inability to access crisis lines within advertised hours
- Redirection to NHS 111 perceived as inadequate
- Limited or no out-of-hours support for children and young people
- Emergency Departments used as default due to lack of alternatives

Impact:
Increased pressure on acute services and unsafe experiences for individuals in crisis.

4.6 Continuity of Care and Workforce Pressures

Continuity of care is a widespread issue.

- Delays in being assigned care coordinators
- Poor follow-up and infrequent reviews
- Transitions (e.g. CAMHS to adult services) poorly managed
- High staff turnover and overstretched teams affect continuity of care
- Care coordinators are often described as compassionate, but constrained by workload with delays in being assigned care coordinators
- Missed, cancelled or rearranged appointments are particularly distressing for people in crisis

Impact:
Breakdown in therapeutic relationships and reduced effectiveness of care.

4.7 Quality of Care and Patient Experience

Feedback highlights concerns about the quality and appropriateness of care.

- Perception of being "not listened to" or dismissed
- Over-reliance on medication without therapeutic support
- Lack of personalised, patient-led care
- Negative experiences with communication and attitudes of staff

However, some positive feedback was noted:

- Individual staff described as caring and supportive
- Some positive experiences of Cognitive Behaviour Therapy (CBT) and community mental health support

4.8 Children and Young People (CYP)

Insights from Portsmouth and Hampshire provide additional depth in this area.

Key findings include:

- 90% of parents reported unmet needs at first contact
- 92% rated experiences as unsatisfactory
- Long waits for CAMHS support are common
- Young people often prefer informal or online support due to barriers
- Transition to adult services is a critical gap for individuals

Impact:
Delayed intervention during formative years, with potential long-term consequences for whole life mental health outcomes.

5. Cross-System Implications

Across the Hampshire and Isle of Wight Integrated Care Board footprint, feedback highlights:

- A **gap between demand and capacity** in both children's and adult mental health services
- Persistent **inequalities in access**, particularly for:

    - Neurodivergent individuals
    - People with complex or trauma-related needs
    - Those transitioning between services
- A need to strengthen **early intervention, preventative support and pathway clarity**
- The importance of **communication, continuity and compassionate engagement** to patient experience
- Variability of service quality and access

7. Key Messages for the System

- People value mental health services but experience them as **overstretched, fragmented and difficult to access**
- Crisis thresholds are perceived as too high, placing individuals at potential considerable risk before support is available
- Improving pathway clarity, access points, better information and early help could significantly improve experiences
- Workforce pressures are visible to the public and directly affect continuity and trust

8. Opportunities for Improvement

Based on the insights gathered, the following opportunities emerge:

- **Early Intervention:** Expand preventative and early help services
- **Clear Pathways:** Simplify and clearly communicate referral routes
- **Integrated Care:** Improve coordination between services
- **Crisis Support:** Strengthen accessibility and responsiveness of crisis services
- **Workforce Investment:** Address staffing pressures and continuity issues
- **Patient-Centred Care:** Embed personalised, trauma-informed approaches

Continues…

Section Two - System Recommendations

Based on combined Healthwatch intelligence from across the Hampshire and Isle of Wight Integrated Care Board area, the following recommendations aim to address the most persistent and recurring issues identified in people's experiences of mental health services.

These recommendations focus on **access, pathways, early intervention, continuity and communication**, and are intended to support system-wide improvement rather than place-specific solutions and achieve a more consistent and comprehensive mental health service offer.

1. Rebalance the System Towards Early Intervention

Recommendation:
Shift investment and capacity upstream to ensure timely access to early help and preventative mental health support.

Actions:

- Expand community-based and voluntary sector provision for low–moderate need
- Commission open-access models (e.g. self-referral, drop-in hubs, digital access)
- Increase availability of support while people are on waiting lists ("waiting well" offers)

Rationale:
Current insight shows support is often only available at crisis point, driving escalation and higher system cost.

2. Review and Redesign Access Thresholds

Recommendation:
Undertake a system-wide review of eligibility criteria to reduce gaps between services.

Actions:

- Introduce more flexible, needs-led access models rather than rigid thresholds

- Develop more “no wrong door” approaches across services
- Pilot blended service models for people with complex or overlapping needs (e.g. neurodivergent + mental health)

Rationale:
People are frequently falling between services, leading to unmet need and worsening conditions.

3. Simplify and Integrate Care Pathways

Recommendation:
Improve navigation and service integration across the mental health pathway.

Actions:

- Create a single, clearly communicated access route in each place (front door model)
- Improve interoperability and information sharing between services
- Reduce duplication of assessments and handoffs in to another service
- Co-produce clear pathway maps with service users and carers

Rationale:
Fragmentation is a major contributor to poor experience, inefficiency, and delays in care.

4. Strengthen Crisis and Out-of-Hours Provision

Recommendation:
Ensure crisis support is consistently accessible, responsive, and trusted.

Actions:

- Review reliability and accessibility of crisis lines and urgent mental health services
- Strengthen alternatives to A&E (e.g. crisis cafés, safe havens, home treatment)
- Improve out-of-hours provision, particularly for children and young people
- Clarify the role of NHS 111 within crisis pathways

Rationale:
Current gaps are leading to unsafe experiences and increased pressure on emergency services.

5. Improve Continuity of Care and Care Coordination

Recommendation:
Strengthen models of care coordination to improve continuity and outcomes.

Actions:

- Ensure timely allocation of care coordinators/key workers
- Reduce caseload variability and support workforce stability
- Introduce clear standards for follow-up and review
- Improve transitions, particularly from CAMHS to adult services

Rationale:
Lack of continuity is undermining therapeutic relationships and system effectiveness.

6. Invest in Workforce Capacity and Experience

Recommendation:
Address workforce pressures as a core enabler of system improvement.

Actions:

- Develop targeted recruitment and retention strategies
- Expand multidisciplinary teams, including peer support roles
- Provide training in trauma-informed and person-centred care
- Support staff wellbeing to reduce burnout and turnover

Rationale:
Workforce constraints are a key driver of delays, inconsistency, and poor experience.

7. Embed a Consistent Person-Centred Approach

Recommendation:
Ensure care is consistently delivered in a way that is personalised, trauma-informed, and co-produced.

Actions:

- Embed shared decision-making and personalised care planning
- Ensure people feel listened to and involved in their care

- Reduce over-reliance on medication as a default response
- Strengthen family and carer involvement where appropriate

Rationale:
Variation in experience suggests person-centred care is not yet consistently embedded.

8. Prioritise Children and Young People (CYP)

Recommendation:
Treat CYP mental health as a priority area for system transformation improvement.

Actions:

- Expand early intervention and school-based support
- Reduce CAMHS waiting times and improve access to neurodevelopmental pathways
- Strengthen transition pathways into adult services
- Co-design services with young people

Rationale:
High levels of unmet need in Children and Young People (CYP) services are driving long-term demand and poorer outcomes.

9. Strengthen System Communication and Public Understanding

Recommendation:
Improve how the system communicates with the public about mental health support.

Actions:

- Provide clear, accessible information on available services and how to access them
- Regularly update the public on changes to services (e.g. crisis access routes)
- Use multiple channels, including digital and community outreach

Rationale:
Confusion about pathways is a major barrier to access and engagement.

10. Further Embed Patient Insight in Decision-Making

Recommendation:
Strengthen the role of patient insight and lived experience in system planning and improvement.

Actions:

- Routinely triangulate Healthwatch data with other insight sources
- Involve people with lived experience early on in service design and evaluation
- Establish feedback loops to demonstrate "you said, we did"
- Use insight to proactively identify emerging risks

Rationale:
Consistent themes across all areas highlight the value of insight as a strategic tool.

11. Focus on Reducing Inequalities

Recommendation:
Ensure system improvements address inequalities in access and experience.

Actions:

- Identify and target underserved groups (e.g. neurodivergent individuals, men, rural communities)
- Tailor services to meet diverse needs
- Monitor access and outcomes data by population group

Rationale:
Current models risk widening inequalities due to thresholds and system complexity.

12. Develop a Whole-System Transformation Approach

Recommendation:
Align mental health improvement with wider ICB priorities and system transformation programmes.

Actions:

- Integrate mental health with primary care, social care, and Voluntary and Community Sector (VCS) partners
- Align with prevention, population health, and neighbourhood working
- Use place-based approaches to reflect local variation

Rationale:
The challenges identified are systemic and require coordinated, cross-sector solutions.

Closing Note

The consistency of insight across all four Healthwatch areas provides a clear mandate for change. These recommendations are not about isolated service improvements, but about **reshaping how the system responds to mental health need—earlier, more simply, and more person-centred**.

Response from Hampshire and the Isle of Wight Integrated Care Board

We welcome the report which articulates well the challenges faced by the NHS. While this report is based on the feedback of a relatively low number of patients, the detail of their experiences is invaluable, and we agree that unwarranted variation in quality, service provision and experience is unacceptable and should be eliminated. As a strategic commissioner our plans are focused on addressing these issues, and we will weave these recommendations into that work.

Response from Hampshire and the Isle of Wight Healthcare NHS Foundation Trust

We thank local Healthwatch for this report, and the people with lived experience who shared their invaluable feedback.

Everyone deserves access to good mental health care that meets their needs, at every stage of their lives. The challenges highlighted in this report reinforce the need to continue developing and investing in these services, as well as focusing on prevention and the wider factors impacting on people's mental health.

Whilst these are national challenges, we are working with our partners, communities and people who use our services locally, to address exactly the themes highlighted in this report – to bring better access, more joined up care and earlier intervention. The findings of this report will help inform this important ongoing work.

Appendix One - Local Area Highlights

1. Portsmouth

Volume of feedback:

- 5 mental health feedback cases (July–December 2025)

Although recent feedback numbers were low, the themes closely align with **wider, previously published evidence**.

Key issues:

- Difficulty accessing timely mental health support
- Long waiting times leading to worsening mental health
- Confusing referral pathways and eligibility thresholds
- Lack of interim support while waiting

Additional contextual evidence:

NOTE: the data for the Children and Young People Mental Health report February 2026 (below) is out date scope for the reporting period for this 6 month - July to December 2025 insight report. However, it has been included as it demonstrates systemic issues around access, navigation and early intervention.

- Healthwatch Portsmouth's **Children and Young People Mental Health report (February 2026)** reviewed multiple datasets covering over **1,500 CYP and 125 parents/carers**. https://www.healthwatchportsmouth.co.uk/mental-health-experiences-of-children-and-young-people-in-portsmouth-report

  Findings included:

  - 90% of parents reported unmet need at first help-seeking
  - 92% rated their experience negatively
  - Neurodivergent children with comorbid mental health needs particularly affected by thresholds

Overall insight:
Recent feedback, although limited in volume, reinforces **long-standing systemic challenges in access, navigation and early intervention**.

2. Hampshire

Volume of feedback:

- 50 items (July–December 2025)
- 80% negative sentiment

Primary service areas:

- CAMHS / Targeted Mental Health in Schools (TaMHS)
- Community Mental Health Teams (CMHTs)

Key issues:

- Long waits for assessment and treatment across child and adult services
- Support often delayed until crisis
- People not feeling listened to or supported
- Disruption caused by staff turnover and poor continuity
- Limited availability of preventative and early support

Notable insights:

- Neurodivergent young people face long waits, misdiagnosis concerns and inconsistent understanding
- Adults report difficulty accessing support outside crisis, with six-session offers seen as insufficient
- Some positive feedback highlights caring staff, but this is outweighed by system constraints

3. Isle of Wight

Volume of feedback:

- 123 items (July–December 2025)
- 92% negative sentiment

Most reported service areas:

- Mental health crisis services
- Community mental health services
- CAMHS

Key issues:

- Restricted access to crisis lines and redirection to NHS 111, viewed as inappropriate
- Long waits for therapy and specialist care (including waits of several years)
- Poor joined-up care between GPs and mental health services
- Concerns about medication management and physical health impacts
- Lack of out-of-hours and weekend CAMHS provision

Transitions:
Young people report abrupt discharge from CAMHS at 18 with **no effective transition** into adult services.

Overall insight:
Feedback strongly suggests **insufficient capacity and limited access**, particularly in crisis and community provision, with significant emotional impact on individuals and families.

4. Southampton

Primary evidence:

Community Mental Health Team (CMHT) feedback September 25 – **NOTE**: **the data for the CMHT feedback September 25 report is out date scope for the reporting period for this 6 month - July to December 2025 insight report. However, it has been included as it demonstrates systemic issues around access, navigation and early intervention.**

- **Healthwatch Southampton - Exploration into Community Mental Health Teams in Southampton** - https://healthwatchsouthampton.co.uk/wp-content/uploads/2025/10/HWS-Community-Mental-Health-Team-Report-final.pdf

- CRM feedback June–December 2025 (13 items)

Key issues:

- Poor communication and fragmented referral processes
- Lack of structured and informed care planning
- Delays in accessing care coordinators and psychological therapies
- Confusion around eligibility criteria

- Individuals falling between service thresholds

Lived experience highlights:

- Repeatedly retelling experiences due to poor team communication
- Long waits (12–18 months) for CMHT input
- Perception that services are not designed for complex or enduring needs
- Positive feedback where care coordinators are responsive, but systems are not

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