

Connecting mental health care with communities

Healthwatch Islington
Mental health impact report 2026



Executive summary from our CEO

Healthwatch Islington's Mental Health Partnerships team worked from January 2022 to July 2026, embedded within North London NHS Foundation Trust's Islington Core Teams. Working alongside clinicians, the team connected residents with community-based, non-clinical support to sustain recovery, build confidence and reconnect with everyday life.

We worked at the point at which clinical mental health care meets the wider social conditions that shape well-being: housing, isolation, physical health, confidence, digital exclusion, relationships, meaningful activity and connection to community. By bringing our staff into clinical discussions, we created space to think about those needs alongside clinical care and draw directly on support already available across Islington.

That was particularly valuable at points of transition. Just under a quarter of the people the team worked with were supported around discharge, linking them with existing community provision to help create safer and more sustainable transitions from Core Team support.

The team could also respond quickly to emerging need. Physical health became a substantial strand of the work, from health and blood pressure checks with Population Health nurses to sessions on sleep and menopause, alongside sustained work to help people take up physical activity. Partnerships with Arsenal, the Council and other local organisations created routes into exercise for people who might otherwise have struggled to access it. The same responsiveness led to targeted work including the Boost project and digital inclusion support, with the team securing additional resources where it saw an opportunity to meet a need differently.

Crucially, those connections worked in both directions. The team took mental health work out into communities, working through trusted organisations to reach groups who face barriers to accessing mainstream services. At the same time, it brought community knowledge back into the Trust, giving clinical teams a much stronger understanding of the organisations, activities and informal support available around them.

Our team had the space to build relationships, understand where gaps existed, bring people together and act where there was an opportunity to do something differently. That left something more lasting: clinicians knowing where else they could turn, community organisations having a clearer route into mental health services, and a much stronger connection between the two.

Clinical feedback consistently reflected this. As one senior consultant put it:

"I've found that your holistic and life-broadening perspectives have complemented our endeavour to help people on their own recovery journey, encouraging them towards greater meaning in their lives. Your contributions in MDT meetings are valued, and you've helped us to maintain an outward-looking stance."

As pressure on clinical mental health provision continues, sustainable recovery depends increasingly on what sits around formal treatment. Over four and a half years, the Mental Health Partnerships team gave the Core Teams a practical way of reaching into that wider infrastructure and bringing it into people's care.

This report comes at an important point of change in mental health provision in the borough. The integrated Core Team work is moving to a new VCS provider, creating a risk that this community-facing element could be diluted or lost. This report sets out what Healthwatch Islington's work with the Trust achieved, and the case for retaining that connection between clinical services and the wider community infrastructure around them.



Laura Saksena
Healthwatch Islington CEO

Contents

Overview in numbers	5
Highlights	6
How the team creates impact	7
Supporting discharge and reducing escalation	8
Connecting residents to meaningful community support	9
Case study 1	10
Activity spotlights	11
Reducing inequalities through trusted community outreach	12
Case study 2	13
Strengthening practice	14
Impact summary	15
What must not be lost	16
Recommendations for the new model	17



Leading the Mental Health Partnerships Team has been a rewarding challenge. By working closely with NHS mental health services, voluntary organisations, residents, and community groups, we promote care that meets the wider needs of the person. Through engagement, workshops, and co-production, we strengthen partnerships, amplify diverse voices, identify service gaps, and drive continuous improvement across Islington.

Philippa Russell

Senior Mental Health Partnerships Co-ordinator

Overview in numbers

Over the past four years, the Mental Health Partnerships team has supported over **7750** residents and built strong links between clinical services and local community organisations.

Connecting residents with support:



The team provided signposting support for **5,797** residents. Requests came through Multi-Disciplinary Team (MDT) discussions and individual enquiries from Core Team colleagues, GPs, other health professionals and voluntary organisations. The team considered each person's circumstances and identified suitable community-based options, rather than simply providing a list of services.

Supporting clinicians and community partners:



The team attended **5** MDTs each week, alongside other Core Team meetings, bringing community knowledge directly into clinical discussions. It also invited clinical colleagues to regular meetings in community settings, including Bright Lives Alliance, Inequalities Toolkit sessions and Muslim Welfare House. Across the four years, the team worked with more than **60** voluntary and community organisations, helping strengthen links between clinical services and local support.

Reaching residents through events and activities:



The team reached over **1000** residents across outreach sessions and meetings it led. Sessions were delivered in community settings and focused on well-being, prevention, access to support and stronger links between residents, services and local organisations.

Highlights

2022	Health and blood pressure checks with Population Health nurses for 102 people through mental health and community partners. 	Collated a Mental Health Community Links document with over 300 links reflecting 26 areas of need. Accessed by wider core teams, GPs, and social prescribers. 	1 team member
2023	Delivered 2 sessions on managing anxiety and sleep hygiene with 37 women from Islington Bangladesh Association. 	Led a session for 60 people through Autism Hub and Asperger London Area Group, offering practical tips on balanced eating, sleep and managing overwhelm. 	3 team members
2024	Working with Community Language Support Services and Better Lives, provided 24 women with information for parents about drug and alcohol addiction. 	A Five Ways to Well-being session brought together 80 residents, in partnership with Arachne, the Alzheimer's Society, Claremont, Elizabeth House and Islington Somali Community. 	
2025	A session with Kurdish and Middle Eastern Women's Organisation and Latin American Women's Rights Service brought 27 women together to discuss symptoms and management of perimenopause and menopause. 	The Partnerships team co-facilitated 10 Recovery College courses with mental health occupational therapists for Core Team Recovery and Rehabilitation groups, reaching 72 people. 	
2026	Across 10 monthly football sessions at Arsenal, 40 people were connected with community support and well-being resources. 	The team ran 3 women's groups for Recovery and Rehabilitation participants, covering menopause, the Five Ways to Well-being and an interactive quiz. 	

How the team creates impact

Inputs

- Embedded Partnerships team
- Local VCS knowledge
- Trusted community relationships
- MDT participation
- Links with GPs, social prescribers, community organisations and public health partners

Activities

- Discharge signposting
- Advice in MDTs
- Advice to GPs and VCS organisations
- One-to-one community linking
- Wellbeing events
- Professional up-skilling
- Targeted community initiatives

Immediate outputs

- Residents connected to and accessing local support
- Clinicians better informed about community options
- GPs and social prescribers supported with referral alternatives
- Community organisations better informed about mental health pathways

Short-term outcomes

- Improved confidence and independence of patients
- Reduced isolation
- Smoother transition from Core Team support
- Better use of non-clinical support
- Improved access for communities facing inequality or mistrust

System outcomes

- Reduce reliance on specialist services
- Stronger integrated pathways
- Better patient flow
- More preventative and community-based support
- More inclusive mental health access in Islington

Supporting discharge and reducing escalation

A large portion of the team's work focuses on helping people move safely from clinical mental health services into community-based support. Over the past three years, 22% of cases have involved support with discharge and signposting to local services.

This work starts with understanding each resident's circumstances, identifying suitable local support and helping clinical teams feel confident that meaningful help is available beyond NHS services. The team works with key workers and peer coaches to explore community options and support referrals into activities or local services. This helps residents move on from clinical care with greater choice and independence, supports a smoother transition and may reduce the need to return to specialist services unnecessarily.

The team also supports prevention by advising GPs, social prescribers and voluntary sector organisations on available options for residents. During the year, 8% of cases involved advice to GPs or VCS organisations. This helps ensure that residents can be supported earlier and more appropriately.

This function should be an explicit part of any future model. Without it, there is a risk that the new pathway becomes more clinically focused, with fewer routes into the wider community support that helps residents sustain recovery.



Connecting residents to meaningful community support

The team provided meaningful links for 5797 queries relating to ongoing support for patients. A significant proportion of this work focused on helping residents access activity, exercise and social connection, with 20% of queries relating to activities and exercise in Islington.

Residents often need support to reconnect with activities that build confidence, routine and a sense of belonging. The team helps identify options that are realistic and appropriate, including physical activity, wellbeing groups, peer support and local community provision.

Examples include the team's work with Arsenal in the Community, Shape Up and Move for Mood. These partnerships help make physical activity accessible, supportive and connected to wider wellbeing. The team also contributes to group sessions for residents with complex mental health needs, including through the Rehabilitation and Recovery pathway, where activity-based work supports rapport, peer connection and confidence.

Through Move for Mood, the team has worked with Islington Council, Public Health and community partners to better integrate mental and physical wellbeing support. This included developing a toolkit and leaflet on the benefits of activity and local options, alongside provider and resident-facing events. Taster sessions, including dance, boxing and yoga, helped match activities to individual abilities and made exercise more accessible.



I now have a clearer understanding of the well-being support available, such as local organisations offering mental health resources, advice on managing stress, and community activities that promote social connections and physical health. This knowledge has helped me feel more confident in seeking support when needed.

- Community resident

Patients told us that the events opened up options they had not known about and encouraged them to try things they might not otherwise have considered. Being able to meet providers directly also mattered: it made activities feel more accessible and reduced some of the uncertainty about joining something new.

This work demonstrates that non-clinical support can be central to mental health recovery. For many residents, the ability to access activity, routine, confidence-building support and social connection is central to sustaining wellbeing.

Case study 1

Digital access and independence

Many residents experiencing complex mental health needs also face financial hardship and digital exclusion. Lack of access to a laptop can limit people's ability to study, apply for work, access online services and pursue opportunities.

The team successfully applied to the Good Things Foundation for refurbished laptops and secured **10** devices for residents with complex needs.

Digital access is key to being able to participate in everyday life and patients reported that this practical support contributed positively to independence, confidence and recovery.



Before I received the laptop, I had to rely on my phone to apply for jobs, which was really difficult. Now I can properly write applications and search for opportunities every day.

– Resident

Impact at a glance:



100%

of recipients reported improved access to online services and learning resources

75%

used the laptop regularly for job searching and applications

60%

reported increased confidence in using digital technology

Activity Spotlights

Being embedded within both the clinical teams and the community allowed the team to track and respond directly to live gaps in provision:

Bringing Recovery College into the community



Our Partnership Coordinators trained as Recovery College tutors, enabling the team to bring the Trust's free well-being courses closer to Islington residents. The team co-produced materials for **10** courses with **72** attendees and delivered sessions including Alone but Not Lonely, Food to Improve Your Mental Health and How to Cope with Traumatic Events.

By delivering courses in community settings, the team opened up another route for residents to access practical well-being support, build confidence and form social connections beyond clinical services. The courses also provide ongoing support for people moving on from the Core Teams, helping to connect recovery with everyday community life.

Supporting neurodivergent residents



Residents and carers highlighted gaps in support for neurodivergent people. In response, the team worked with Autism Hub and Asperger London Area Group to deliver a practical well-being session for **60** people, covering balanced eating, sleep and managing overwhelm.

The team also worked with the Transition Team psychologist and lead peer coach to explore barriers such as isolation, anxiety about joining groups and difficulty accessing new activities. This brought residents' experiences into wider discussions about gaps in provision and helped shape more accessible, person-centred routes into community support.

Reducing inequalities through trusted community outreach

The team plays a key role in reaching residents and communities who may not access formal mental health services directly. This includes work with communities where stigma, language barriers, trauma, migration experiences or mistrust of statutory services can make access more difficult.

In July 2025, the team partnered with Islington Faiths Forum at the Muslim Welfare House to support organisations working with migrants and asylum seekers. Core Team managers and the Partnerships team shared guidance on local NHS crisis services and GP-centred referral routes. Through collaborative case studies, participants explored trauma-informed and culturally aware approaches to mental health support.

The team also delivered **23** wellbeing sessions in trusted community settings. These sessions created space for residents to discuss difficult and sometimes stigmatised issues, including mental health, menopause, depression and addiction. Working through trusted community leaders and interpreters helped participants feel more confident to share concerns and access support.



The outreach work has been vital in supporting residents with accessible, preventative information, and its value to the community cannot be overstated.

- Community leader



Case study 2

The Boost Project

The project provided 15 young people with personalised one-to-one training and direct access to a well-being coach.

The Boost Project was developed by the Mental Health Partnerships team in collaboration with Lift Youth Hub, with support from Sport England funding.

The project was set up in response to an identified need for younger patients to access tailored, relationship based support in order to take the first step towards regular activity and social participation.

Over 12 weeks, participants were supported to build confidence, increase physical activity and engage in wider social and vocational opportunities. The project was designed to make activity feel achievable and supportive, particularly for young people who may have found it difficult to access mainstream provision.



When I started, I was just walking on the treadmill. Now I have built up stamina. There's no pressure or judging. Often things are offered that don't happen, but this happened. It takes time for me to get used to things so the number of sessions was just right. I am happy to try other gyms now.

– Participant

Strengthening practice

The Mental Health Partnerships team strengthens the wider system by improving knowledge exchange between mental health services, primary care and the voluntary sector.

Through delivery of the Personalised Care Lead role with the GP Federation, the team coordinates monthly sessions bringing together social prescribers, care coordinators and NLFT link workers based within GP practices. These sessions support shared learning, improve awareness of local services and help practitioners provide more holistic support to residents.

Community organisations regularly present their current service offers, helping practitioners provide targeted support across areas including housing, substance misuse, mentoring and domestic abuse. This work improves referral quality, strengthens consistency across services and supports more integrated practice across primary care, mental health and community provision.

A particular highlight from this work was the collaborative session with Body & Soul suicide prevention charity where young people shared powerful insights into mental health recovery. Following this session, the Healthwatch team were invited to attend a reception at Parliament in February to discuss self-harm and suicide prevention.

Because the team did not hold caseloads, we had the capacity to do the outward-facing partnership work that clinical staff rarely have time to sustain themselves, freeing practitioners to focus on the work only they could do.



When someone is linked in with other support, clinicians are less likely to feel responsible for managing/advocating in areas we are not trained. This reduces burnout and makes the system more effective as patients are getting appropriate support from trained professionals.

– Clinician

This created capacity across the system as well as stronger connections: practitioners could draw more confidently on community-based support, while patients were connected to organisations with the right expertise to address needs beyond the clinical remit.

Impact summary

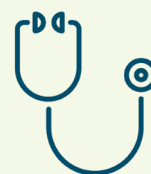
Residents

The team helps residents access practical, social and community-based support that can improve confidence, independence and well-being. This includes support with digital access, physical activity, social connection, community participation and trusted local advice.



Clinicians

The team brings local community knowledge into clinical discussions, improving understanding of the community offer and building in time for clinicians to focus on clinical support where more holistic and social care is covered. This helps maintain an outward-looking approach within Core Teams.



GPs, social prescribers and VCS organisations

The team provides advice and knowledge exchange, helping practitioners navigate local mental health and community support options more confidently. This supports earlier intervention, more appropriate referrals and a stronger connection between primary care, mental health services and local community provision.



The wider system

The team contributes to smoother discharge, more appropriate use of specialist services, improved patient flow and integration between mental health services, primary care and the voluntary sector. The Partnership team provides an integral link between community and statutory care with capacity to share information around changes and gaps and build meaningful partnerships.



What must not be lost

The Mental Health Partnerships team has provided a distinctive function within Islington's integrated Core Team model.

Its value has been in creating a bridge between clinical mental health care, primary care and the wider community infrastructure that supports recovery.

As the VCS integrated Core Team work moves to a new provider, there is a risk that this element of the model is diluted or lost. The evidence from these roles suggest that the community-facing, voluntary-sector function is not peripheral. It supports discharge, prevention, practitioner confidence, access for communities facing inequality and residents' ability to reconnect with everyday life.



You've got your finger on the pulse of an ever-changing landscape, providing bespoke ideas for support and linking-in for our patients. Moreover, you've established relationships with local groups, opening doors to people who had previously felt cut off from others, and you've expanded the options that are available to people in the community, helping them to find something that suits them. Your workshops and events have reached people who may not have come to seek help from mental health services.

- Senior consultant



Recommendations for the new model

As the VCS provision changes, we would make the following recommendations to support ongoing impact.



Retain the embedded community connector function. The new model should retain a clearly defined community-facing function within the integrated Core Team pathway. This should not be reduced to generic signposting. The role needs to remain close enough to clinical teams to contribute to MDT discussions and discharge planning, while also maintaining active relationships with local voluntary and community organisations.

Protect the focus on prevention, discharge and recovery beyond clinical care. The evidence from the project to date shows that the team supports smoother discharge, prevents unnecessary escalation and helps residents access the practical, social and community support that sustains recovery. The new model should explicitly include this function, including support around physical activity, social connection, digital access, culturally trusted services and other non-clinical routes to well-being.



Maintain structured links between mental health services, primary care and the voluntary sector. The current model strengthens the wider system by sharing knowledge between Core Teams, GPs, social prescribers, link workers and community organisations. The new model should preserve this structured knowledge exchange so that practitioners continue to understand local options and residents can be supported through the most appropriate route.



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