



Trauma Informed Learning Event
June 2025

healthwatch
Isle of Wight

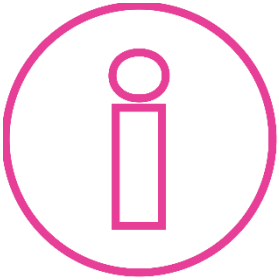
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Introduction

Introduction



Healthwatch Isle of Wight convened a collaborative learning event following a serious incident involving multiple Island services, including the Police, Isle of Wight NHS Trust, Hampshire & IOW Healthcare NHS Foundation Trust, the IOW NHS Trust Ambulance Service, and the Isle of Wight Council. The incident resulted in inadequate care and treatment for a person living with dementia.

When was this event?

We held the event on Friday 20th June at the Riverside Centre, Newport.

Who did we invite?

We invited a senior representative from each of the services above, and also welcomed a representative from the Hampshire & IOW Integrated Care Board (ICB).

The aim of the event was **not to assign blame**, but to **reflect collaboratively** on what happened, examine the systemic issues that contributed to the incident, understand its impact on both the individual and staff involved, and identify actionable improvements to inform better, trauma-informed practice going forward.

We would like to thank all organisations involved in attending the event.

What we did

Three members of the Healthwatch Isle of Wight Board and the Healthwatch Isle of Wight manager met with representatives from the following:

- Hampshire & IOW Police
- IOW NHS Trust
- IOW Council
- IOW NHS Trust ambulance service
- Hampshire & IOW Integrated Care Board
- Hampshire & IOW Healthcare NHS Foundation Trust



We discussed the incident that had occurred, focusing on the impact on the person, but reviewing the perspectives from each organisation.



Key themes and insights

Snapshot of themes

1. Pathways of care

- There were multiple breakdowns in the care pathway, leading the individual to reach crisis point.
- There is a need for earlier interventions and clear, responsive care pathways that prevent crisis escalation.

2. Access to services

- Several services were contacted but did not or could not respond in person.
- Some services (e.g., Ambulance and Emergency Department (ED)) are perceived as the default response during crises, though they may not be the most appropriate or equipped to manage complex dementia-related needs.

3. Constraints on emergency responders

- Paramedics are limited in their ability to manage behavioural crises due to restrictions (e.g., they cannot chemically sedate in the community).
- This constraint increases reliance on ED or police interventions, which may not align with the person's needs.



Snapshot of themes

4. Understanding dementia and trauma responses

- Greater understanding is needed of how dementia affects communication, behaviour, and cognition. People with dementia may lack short term memory, their attention span may be very limited, and they may be unable to think logically. Approaches made to them need to be tailored accordingly.
- Services must also consider how trauma or unmet physical health needs might manifest as distress or confusion..



5. Hospital as default

- There is a persistent misconception that hospital is the best or only place for people in distress.
- Families and carers often don't know where else to turn for help, leading to overuse of ED.

6. Support for carers

- Situations arise where the person with dementia is taken to hospital because their unpaid carer needs treatment, not because the individual themselves needs acute care.
- There is a gap in contingency planning for such scenarios.

Snapshot of themes

7. Police and mental health

- Police often struggle to secure appropriate mental health support for individuals not in immediate crisis.
- The use of powers under the Mental Health Act can be misinterpreted as criminalising mental illness, leading to tension around appropriate use.

8. 'No wrong door' process isn't working

- The principle of “no wrong door” is not being realised in practice – people are often “bounced around” services without clear ownership of care.
- The system must be redesigned to ensure coordinated responses and shared accountability.

9. Culture and capacity

- Many professionals are going above and beyond, but systemic issues are placing strain on services.
- There is a need for culture change toward greater tolerance, empathy, and trauma-informed decision-making.
- We must also recognise that not everyone asking for help needs to be admitted to hospital – a nuanced, person-centred approach is vital.





Next steps and recommendations

Recommendations

We recommend the following actions for the IOW Council, Hampshire & IOW ICB, Hampshire & IOW Police, IOW NHS Trust and the Hampshire & IOW Healthcare NHS Foundation Trust:

1. Increase training in trauma-informed and dementia-aware practices across frontline services.
2. Strengthen joint working protocols between police, ambulance, and mental health services.
3. Capture and share learning from positive interventions to prevent future incidents.

Recommendations for the IOW Hampshire & IOW ICB:

4. Separate the commissioning of dementia services, as it is a physical health issue, from mental health services. Where this is not practicable then we would expect that all practitioners demonstrate a much greater awareness of dementia to enable them to arrange the most appropriate pathways of care and support for individuals.
5. Develop integrated care pathways for dementia that include crisis planning and proactive community support.

Recommendations

Recommendations for the IOW NHS Trust and the Hampshire & IOW Healthcare NHS Foundation Trust :

6. Review the need for a mental health Emergency Department.
7. Review the number of ambulance conveyances to hospital, and also attendances at ED, where there is a non-medical condition and publish alternative routes for care to improve public and carer awareness of non-ED options for support.

Recommendations for the IOW Council

6. Establish clear contingency support for unpaid carers who are hospitalised.

Recommendations for the Hampshire & IOW Healthcare NHS Foundation Trust

9. Revisit the "No Wrong Door" principle to make it a meaningful and operational standard.

Next Steps

We plan to follow up event by:

- Sharing this report with key agencies to promote learning across the system
- Contacting the agencies that contributed to the event, to ensure that the recommendations are taken forward.



For more information

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