

Health and Social Care Committee

Oral evidence: Mental health: Right Care, Right Person, HC 1836

Tuesday 19 September 2023

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Members present:

Health and Social Care Committee: Steve Brine (Chair); Paul Blomfield; Paul Bristow; Amy Callaghan; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris; Taiwo Owatemi.

Guest Committee attendees:

Home Affairs: Dame Diana Johnson (Chair); Tim Loughton.

Questions 1 - 77

Witnesses

[I](#): Chief Constable Paul Anderson, Humberside Police; Jonathan Evison, Police and Crime Commissioner, Humberside; and Chief Constable Craig Guildford, West Midlands Police.

[II](#): Dr Sarah Hughes, Chief Executive, Mind; Adrian Elsworth, General Manager, Urgent and Emergency Mental Health, Humber Teaching NHS Foundation Trust; and Roisin Fallon-Williams, Chief Executive, Birmingham and Solihull Mental Health Foundation Trust.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Chief Constable Paul Anderson, Jonathan Evison and Chief Constable Craig Guildford.

Q1 Chair: Good morning. This is the Health and Social Care Select Committee live from the House of Commons in London on Tuesday 19 September. We are a cross-party Committee of MPs and obviously we scrutinise the Department of Health and Social Care and related arm's length bodies. In our session today we are joined by Dame Diana Johnson, Chair of the Home Affairs Select Committee, and Tim Loughton MP, also a member of that Committee.

We are looking at Right Care, Right Person, which is a new approach to responding to mental health crises, following publication of the national partnership agreement to the roll-out across England and Wales. In our first panel, we are looking at how the approach has been working in Humberside, where it was originally developed, and how it is now being developed in the west midlands. In our second panel, we will be talking to a charity and the NHS.

To introduce those we have before us, we have the chief constable of Humberside police, Paul Anderson; the police and crime commissioner for Humberside, Jonathan Evison; and Craig Guildford, chief constable of West Midlands police. Thank you very much for your time and for joining us. Does anybody have any interests they wish to declare? Excellent. Chief Constable Anderson, to what question was this the answer?

Chief Constable Anderson: When we started in 2019, people said to me, "Look, Paul, where did Right Care, Right Person come from?" Something I am really clear about is that it came from my officers. Day in, day out our officers and staff were saying to us that they were dealing with an increased demand from mental health, but they felt they did not have the skills or ability to help the people. The question is, who is better to deal with a patient going through crisis? In many of these circumstances, and in many of the daily incidents we were attending, someone with training—a mental health doctor or nurse—has to be a better person for someone going through trauma than a police officer. We have always been very clear that, when you speak to patients afterwards, the feedback you get is that they do not want to see a police officer. Not only do they not want to see a police officer, they find it traumatic. I work with police officers and I know how that feels, but the point I am making is that a police officer is trained as a cop. They are there to deter and detect crime. When dealing with someone going through mental health trauma we are not talking about people who are bad; we are talking about people who are ill, so we are not the right people to deal with the patient.

Q2 Chair: You mentioned the prevention and detection of crime. If we go back to Sir Robert Peel's founding principles of policing—to prevent and detect crime; to keep the King's peace; and to protect life and property—



clearly, there are crossovers, because you can very easily make the argument that somebody who is facing a mental health crisis could be a threat to life, mostly their own, and property.

Chief Constable Anderson: There are two points I would like to make. Yes, you are 100% correct. Going back to 2019 and what we saw from the two years before, with concern for welfare calls, for instance, there was a 25% rise in those calls. When you look at calls related specifically to people going through mental health trauma, we saw that to policing—forgive me, it is not an exact figure—there was a 30% rise over those two years. The position that led to in policing was that we could not fulfil our own article 2 issues. We had officers—sometimes double figures, and sometimes in the high teens—waiting in mental health facilities for patients to be triaged. I am not talking about an hour or so, but hours and hours. We could not fulfil our day job. If that rise continued, in effect the system of policing would be broken.

To go back to your original point, this is never about the police not attending. I have never said that the police will not attend mental health calls. Of course we will, because there is a place for it, but when we get a call we look at two or three key elements. No. 1 is whether there is an immediate risk to life, going back to the key Peelian principle you alluded to. No. 2 is whether there is a crime being committed. No. 3 is whether there is a possibility of degrading or inhumane treatment, for example, contrary to article 3 human rights. If those conditions are not met, the real question is whether it is a policing incident. It divides fairly neatly, but we take hundreds and hundreds of calls on a daily basis and each will be dealt with on a case-by-case basis.

Q3 Chair: You said in answer to my very first question, about the question to which this is the answer, that it came from your officers. Only a couple of months ago, in July 2023, the Government published the new national agreement on Right Care, Right Person, signed by health and policing bodies: the Department of Health and Social Care, the Home Office, NHS England, the National Police Chiefs' Council, the Association of Police and Crime Commissioners and the College of Policing. They were all playing catch-up with you. What conversations did you have with Ministers at the time, before you decided to go down this road?

Chief Constable Anderson: For us, going back to 2019, it was clear that we needed to act if it came to a point where we could not discharge our core policing duties. The gentleman to my left, Jonathan, has the job of holding me to account; he is my accountability processing face. However, this was not something we did to partners, but with partners. I know you are speaking to a number of them later today. We consulted with our local chief execs and our MPs but, most importantly, we consulted with the public.

Q4 Chair: Did you consult the Minister?



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Chief Constable Anderson: The Minister of Health, no. This was something we did locally.

Q5 **Chair:** The Minister of Policing?

Chief Constable Anderson: No, we conducted this locally.

Q6 **Chair:** Interesting. Jonathan Evison, what is the biggest misconception that maybe we in here and the public out there have about Right Care, Right Person?

Jonathan Evison: That it is demand reduction. It is getting the right person to the right care. In the media, and probably this Committee, your thought would be that it is all about mental health, but the biggest aspect of this process is concern for welfare and AWOL—people walking out of healthcare facilities. The concern for welfare is when somebody perhaps does not attend an appointment with the NHS or does not see social service personnel and the police are called to check on their welfare. I have to say that often a call comes in at half-past 3 on a Friday afternoon. When you ask the individual who is calling the police—the officer in an authority or the NHS—when the person had missed the appointment, they say, “Tuesday at 10 o’clock.” There wasn’t a need at 11 o’clock on a Tuesday, Wednesday or Thursday, but all of a sudden, on a Friday, there is a need for somebody to go and check on them. The whole process disproportionately affects neighbourhood policing and response.

Humberside police has about 2,300 officers, but not all of them are in neighbourhood or in response, so the whole weight of this falls on those significant, but not majority, parts of policing. We all know what neighbourhood does; they protect our neighbourhoods. We all know what response does; that protects our neighbourhoods. If there is a vacuum, because police officers are stuck at a hospital, or looking for somebody who is perhaps missing, or has been reported missing by hospital security and they go to the hospital and find them having a cigarette at the back of the hospital, that is a waste of police resources and it needs to be sorted, and it is being sorted. Of course, all the other parties agree with that.

Chair: Thank you for that. Craig Guildford, I assure you that we will bring you in; you are not just observing.

Chief Constable Guildford: I am listening.

Chair: I am going to bring in the Chair of the Home Affairs Select Committee, Dame Diana Johnson.

Q7 **Dame Diana Johnson:** The Home Affairs Select Committee had a very good presentation from Humberside earlier this summer when we looked at how this had come about. In 2019, how long did it take for Humberside to develop this model and get all the partners to sign up for it?



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Chief Constable Anderson: The process of implementing the four phases of Right Care, Right Person took just in excess of three years. Because every incident needs to be dealt with on a case-by-case basis, you could sub-categorise them into many different buckets of examples. We looked at four broad phases. This was not something we did to health; we did it with health. It was clear from colleagues—they agreed—that it was the ultimate wicked problem. Everybody agreed that it was a problem, but no one could agree on the solution to that problem.

We started with concern for welfare. The reason we started there—Jonathan has alluded to what the cases consist of—is that it can be controlled, from the policing point of view, in a control room setting to make sure that the person who puts in the call gets the right support from the right professional at the beginning. That is really powerful because it is better for the patient. Subsequently it was phase after phase. The strategy in doing it that way was that it gave health, in the different component parts, time to prepare. We also adapted our timescales according to feedback from health.

Q8 Dame Diana Johnson: Three years is quite a long time. It is now being rolled out nationwide very quickly. Obviously, you were the pioneer and you had three years to get it right. How realistic is it to roll it out so quickly now in other police forces, with other partners to bring on board?

Chief Constable Anderson: That is a really good comment. I have a number of comments on that. I have experience of working extensively across the UK. What I know is that, first, I see the area. One board area will be different from another. There are different strains in different areas, so it is hard to say, "This is the time you should put in." My second point is that a lot has changed in three to four years. Because of Right Care, Right Person, we have worked very closely with Rachel Bacon and the national team in the roll-out. We have worked very closely with health to pull together toolkits and legal advice, and to garner a national position on policing through the National Police Chiefs' Council. That has now been achieved, so there is consistency and support from health, which is reassuring to see. Health has also apportioned more money to parts of the system. I am delighted to see that. I have further comments, but I probably will not go there.

Finally, and this is a personal point of view, you do it with your partners. You listen to them and adapt accordingly. Not every conversation that I had at the beginning was easy. It really wasn't. Policing had to make its position clear, but our partners are great people doing a really hard job. We get on well with them. We worked with them closely and adapted accordingly.

Q9 Dame Diana Johnson: I want to ask about evaluation. When we had our presentation, I was slightly surprised that, while you knew how many police officer hours had been saved by this approach, there did not seem to be a built-in evaluation of wider police performance in the scheme. Could you say something about why there was never an evaluation of



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mental health outcomes for people who might previously have been dealt with by the police?

Chief Constable Anderson: In terms of pure outcomes and the outcomes that Humberside has realised from this, you will have seen from the evidence provided that we are looking at just over 1,400 policing hours a month. We are seeing a huge reduction in calls, and calls are going to the right place. I am not going to get into figures and KPIs; I don't think that would be appropriate.

What we have done is in policing. You talked about further policing outcomes, and I want to be crystal clear that we never said it was about demand reduction. We took that demand and reinvested it in other areas of vulnerability. We placed it in looked-after children who are missing and formed locate teams to work with care facilities and care homes. The results we have seen from that have been absolutely staggering. We are returning children to care, children with huge amounts of vulnerability, 70% quicker than we did in the past.

Q10 **Dame Diana Johnson:** That sounds good, but why did you not have an evaluation so that you could demonstrate it?

Chief Constable Anderson: We did.

Dame Diana Johnson: You did?

Chief Constable Anderson: Yes. We had an evaluation and fed it into the national productivity review, which at the time was under Sir Stephen House. That was the response looking at policing across the board. In a further evaluation, His Majesty's Inspectorate of Constabulary looked at Right Care, Right Person as a result of PEEL.

In respect of the outcomes for patients, we raised that with our health colleagues, and health nationally underwent a series of studies on patient outcomes, but it is certainly not appropriate for me to comment on the actual outcome for a patient. What you will have seen in the recent Channel 4 article—I know you have seen it recently—is that some of those patients have stood up and talked about the trauma of coming into contact with the police and how it made them feel. I am supremely confident that it is a better outcome for the patient.

Q11 **Dame Diana Johnson:** There is no clear evaluation around the Humberside model of Right Care, Right Person; it doesn't exist. You are saying that evaluations have taken place in looking at what Humberside is doing in terms of the PEEL approach.

Chief Constable Anderson: There is clear evaluation in relation to the policing outcomes. The evaluation in relation to the health outcomes will sit with health and it would not be appropriate for me to comment on that.

Q12 **Dame Diana Johnson:** But what you are saying is that it does not exist.



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Chief Constable Anderson: I don't know. When we have raised it at our joint working group, they referred to national surveys and national work that has been done.

- Q13 **James Morris:** Chief Constable Guildford, I know that in West Midlands it is not quite as advanced as in Humberside, but I have a specific question for clarification. The police have powers under sections 135 and 136 of the Mental Health Act, which are essentially about sectioning and detention. How does that work in relation to your evaluating the severity, or otherwise, of somebody's mental health condition at the level of a call handler? Historically, the police would have attended and made a decision about whether or not somebody would be sectioned under the Mental Health Act. How does the new scheme work in relation to the Mental Health Act?

Chief Constable Guildford: At the moment we are in the first stages, having got the national learning and benchmarked ourselves against Humberside. In answer to your specific question, it works in a variety of ways already because some of that legislation is used by healthcare professionals, some of it is used by police officers who come across people in the course of their duties in a public place, and sometimes we assist agencies when there is a warrant in place. The assessment process always starts with somebody in the control room. Paul will probably be able to explain how they went about the training, but we have benefited from some of that in giving more training to call handlers. We are just about to change our control room set-up to have more of a vulnerability hub, as Paul just alluded to, whereby some of our colleagues from health will be helping us to make some of those decisions.

In decision making, the call handler will assess the threat and the risk and will then deploy a police officer to the scene, if necessary, to deal with the incident. That decision-making process will be impacted by the training as a result of the learning from Humberside. It is focused on the call for service. If you think about a pyramid of need in the calls we get for mental health, the bottom two thirds of that pyramid are often calls where we will go and try to do our best, even though we are not the right agency. For the top third of those calls we will always need to go; we will always need to help our colleagues.

To go back to the first question, it is important that, nationally, the message is given to colleagues across the partnerships that the police service is not stepping away. For those in acute need, we will always be there.

- Q14 **James Morris:** I understand. On the specific point about the powers the police have to detain people under the Mental Health Act—

Chief Constable Guildford: They haven't changed.

James Morris: My concern is whether, under the scheme you have been running, it is possible that there have been serious issues of people not



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being sectioned under the Mental Health Act when they needed to be and that the application of the Act has not been working in the way it was meant to work, and it might get worse given the sort of scheme being rolled out nationally.

Chief Constable Guildford: That is a great question. Outside, before I came in, I spoke to a colleague who is chair of the integrated health board. The statistics I have been provided with indicate that, in a given month, about half the people against whom we would use that power to detain will, once they have gone through the system of assessment by a healthcare professional, be referred for further treatment. For the other half no further action happens. That is the process. Picture the triangle and think of the bottom two thirds and whether we are the most appropriate. In my professional opinion, and from learning elsewhere, arguably we are not.

Q15 **James Morris:** In relation to the application of the Mental Health Act provisions, has that issue come up over the last three years? Is it something about which there has been concern?

Chief Constable Guildford: To be fair, I echo Paul's comments. Over a period of time, I can see in my policing career that the demand has become exponential.

Chief Constable Anderson: On your question, we have not seen any change in the number of people where the powers have been exercised, but in Right Care, Right Person we have Mind integrated with us in our control room. That is part of our joint partnership arrangements. We have trained call takers who will help THRIVE and risk assess, but before we use our powers, unless there is something immediate—a situation in extremis—we put a call in to our local health board and our officers talk to a mental health professional, which helps to guide them on whether they need to use those powers.

Q16 **James Morris:** Mr Evison, do you have any reflections on the application of the Mental Health Act in relation to this new scheme?

Jonathan Evison: Nothing that has not already been said, but I would reiterate Mind being in the control room. The control room operators have a finite time. For regular control room operators, 10 minutes is perhaps the length of time, but they can be handed over to Mind. We find that a lot of the calls for what you would term mental health are not diagnosed mental health; they are more severe life stresses, so it would be somebody who is extremely anxious about something in their life, whether that is other family, financial or work related. Mind can stop with them and put them on to relevant services that can help with anxiety or serious stress.

Q17 **James Morris:** A lot of sectioning under the Mental Health Act happens as a result of potential or perceived threats in the public space; it could even be an emergency, for example somebody threatening to throw themselves off a high building. They are emergency situations that



require immediate response. How does your system deal with that?

Chief Constable Anderson: That one is really easy. Locally, we have the Humber bridge. There are many sad examples of patients throwing themselves off that bridge. If someone is there, it is an immediate threat to life; that is an article 2 issue. We immediately attend and we always will.

Chair: That is very interesting in cutting through the detail that we hear from the media. I want to bring in Tim Loughton, who is a member of the Home Affairs Select Committee.

Q18 **Tim Loughton:** Can I first comment on the scenario and then ask a question? Chief Constable Guildford, you might like to comment first. A little while ago I was out on patrol with my police in Sussex. We were called to a house where the family had called emergency services and asked for an ambulance. The father had, 24 hours earlier, been released from a secure mental health facility. He was sounding off, had grabbed a knife and was threatening to do harm, potentially to himself. The ambulance arrived but refused to attend and called the police; they said they would not attend until the police had gone in and, effectively, done a risk assessment and potentially taken a hit for the emergency services. Under Right Care, Right Person was that approach right?

Chief Constable Guildford: For somebody threatening with a knife, every day of the week, we need to be there on blues and twos to deal with it.

Q19 **Tim Loughton:** Even though the person involved was a health patient.

Chief Constable Guildford: Yes.

Q20 **Tim Loughton:** The family had asked for a health response and the ambulance had turned up but would not go in without the police.

Chief Constable Guildford: Yes.

Q21 **Tim Loughton:** That was a police duty?

Chief Constable Guildford: Yes. Every day of the week.

Q22 **Tim Loughton:** That doesn't change under the new scheme at all. The police were complaining to me that it happened frequently.

Chief Constable Guildford: What happens frequently—this is the value of coming together as services and working through some of these issues—is that ambulances have a risk assessment process. They will often stand off from an address because it has a previous marker in their command and control system. They will wait and then ring the police. Some of those markers change over time because people move house and change addresses. What we are trying to do is work together to make sure that we have a look on the system. It may be appropriate that they can just go in on their own. That happens on many occasions, if, for example, it is a broken arm or leg or something like that, but where the



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situation is as you have described, every day of the week, be under no doubt that we would be there on blues and twos. Completely appropriate.

- Q23 **Tim Loughton:** In Sussex, we pioneered having community psychiatric nurses on patrol with police. Subsequently that has been rolled out across the country, and it is very effective. The question is whether we should have more of them to make it more effective in its capacity. I think everybody would agree that having two officers sitting in A&E for upwards of four hours is not the best use of police time. First, has that been used in your police forces? Secondly, if there was the capacity to have more of those CPNs working with the police, would it mitigate the need for the Right Care, Right Person approach? Thirdly, we used to have joint police and mental health facilities where police officers could deliver a patient/suspect to a medical facility that might be overseen by a custody sergeant equivalent. There would be a joint operation and those police officers could go back on patrol and the person would be looked after by specialists. Does that operate, and is it a better alternative to what is now being suggested?

Chief Constable Guildford: I was chief of Notts for six years before becoming chief of West Midlands. We had that model, with six cops and six mental health nurses. I thought it worked really well because good decisions were made, particularly in the example of the Humber bridge and the ability to talk to a professional with access to the NHS database, the police database and better collective decision making. I really like that. That does not happen in West Mids. In West Midlands police we have some mental health advisers and we have access to some of those professionals, but it is different in every health and police setting across the country. I really like that model, and that suggestion would certainly carry my support, if it was affordable for our partners to be able to deliver it. I would certainly support that as chief constable of West Midlands.

You went on to ask about detention facilities. For places of safety, it depends on which police force you are in. Most custody suites are the last resort as a place of safety, but they are often utilised because most NHS facilities have, over the years, been pared back and back. We can take people straight to an NHS facility, and all police forces do so regularly, but as a fallback the custody suite is there. The assessment is then made in the custody suite.

You referred to your colleagues in Sussex waiting for a period of four hours. We average about an 11-hour wait. Part of the bigger piece of work, which Paul has been leading on, is to look at how we can mitigate that to free up police officers to go back out on patrol, because the protocol suggests moving towards a one-hour handover. That is a very difficult ask for the NHS, and I am sure you will probe that in the second session.

- Q24 **Tim Loughton:** Chief Constable Anderson, did these things happen in your force? In which case, why did you also need this on top, or is this in



place of those things having happened in your force?

Chief Constable Anderson: It is important to realise that Right Care, Right Person covers a multitude of examples. We are focusing very much on a lot of the acute ones. We naturally focus on them because that is where all the risk is, but the bulk of the calls we get is at the bottom of the pyramid, as my colleague has articulated.

To go back to your question, mental health triaging is certainly a good way to do it. A better way to do it is to have a mental health nurse or practitioner in an ambulance, with police support if there is violence. When you look at the studies and speak to the patients afterwards, to have a police officer there increases levels of anxiety in that patient, so this is far better.

On the establishment of joint facilities, I echo my colleague. My personal view is that it is horrendous to take a sick person into custody. Sometimes it is the last resort, as Craig alluded to. In Humberside, through the work we have done with our partners, we take them directly to care facilities, and we have worked really hard to that one-hour handover. It is not perfect, but it is so much better. That works and it is the best model.

Q25 **Tim Loughton:** Are you still taking them to A&E as well? The biggest waste of time appears to be four, 10 or 11 hours, or whatever. Effectively, two whole officer shifts have been wasted there. Are you now taking them to a joint clinician-led facility where they can be handed over? If not, would you if there were more of those sorts of facilities available? Is the real issue the lack of those sorts of facilities as well as a lack of CPNs, be it in an ambulance or, like the model we have in Sussex, in a police car?

Chief Constable Anderson: In Humberside, we take them directly to a mental health facility, which is the appropriate way. I need to expand a little on A&E because there are sometimes misconceptions around that. A patient will need to go to A&E if there is a physical injury. Now, you are dead right that A&E is a real blocker. The reason for that is that at the moment, under legislation, A&E is not a designated place of safety.

In terms of health and how the health system works, if there was anything I would look to this Committee and ask for help over, this would be one of the examples. We could go to a call and take a patient. They are detained under section 136 of the Mental Health Act, but there is a physical injury. We have a duty of care under *R v. Sherratt, 1998*. First, it is around the actual, physical health element. We take them to A&E. You could wait for hours and hours. It is not possible at the moment, with the way the health system is set up, to undergo any of the assessment on the mental health side. We have to wait for them, and take them to the next place, still within health, which is the assessment centre. That can take absolutely hours.



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It is a really hard element, and it has been so hard in the negotiations. If you come to my police force—it will be the same for Craig—with any problem, you would come to us and talk to us, and we deal with you in our system. One of our frustrations has been that we would negotiate with ambulance; then we would negotiate with acute care, A&E; and then with the mental health triage centres. It would be so good if we could have a conversation where health, as a collective, dealt with their system so that we could talk from system to system rather than navigating it. That is so difficult for us.

Jonathan Evison: What we are talking about is dedicated, 24/7 section 136 suites where you can take people. That helps the police, but it also helps the fire service, because the fire service responds to some of these calls, and of course ambulance, because ambulance can be waiting for the same service through the NHS. By implementing these things, you are actually helping three blue-light services to do their job and release them. With ambulance and the police under pressure, it would be a really good move to release those people, officers and practitioners.

Chair: We will take that up. I neglected to bring in the good doctor. Dr Caroline Johnson has a quick follow-up to what James Morris was asking.

Q26 **Dr Johnson:** My question is about children and how you look after them in relation to the Children Act. James was talking about the Mental Health Act provisions, but there are provisions under the Children Act for you to keep children safe. If you have somebody in a public place, how do your call handlers make an assessment, which can be quite difficult, between whether it is a 17-year-old or an 18-year-old? You have different legal duties towards those people.

Chief Constable Anderson: We do. If a child is involved, we are more likely to attend and use our powers, as you have rightly highlighted, around the Children Act. Putting the Act to one side, we are dealing with more complex and different vulnerabilities. Absolutely, of course we do, because fundamentally we keep people safe.

The call comes in and it goes to a call handler. The call handlers are trained. Mind is there with them in the control room. We look at the key elements. Is there a crime in action, either current or past? Is there a threat to life? In particular, under article 3, will it lead to significant suffering? Those vulnerability factors around children make it more likely, not less likely. However, I am very cognisant as an individual, looking at the studies that I have been involved in, that, when you look at the application of police powers, in particular under section 136, and long-term mental health in relation to those children—adverse childhood experiences—coming into contact with the police time and time again is not always a good thing. There is a fine balancing act. Where there is a child involved, of course we protect people.

Q27 **Dr Johnson:** It may not be police involvement that has caused children the problem. It is the fact that they have had to be called in the first



place that is the adverse factor, I would suggest. Does the training of your call handlers involve asking if there are children in the home or in the building? If you have someone having a crisis at home, do the call handlers check if there are children in the home?

Chief Constable Anderson: Yes.

- Q28 **Dr Johnson:** They do. My final question is about access to homes. Police have the ability to go into somebody's house under the law if they have reasonable cause to do so. If someone is doing a safe and well check and they are asked, "Is the person in this house safe?" and you get to the house and get no answer, you could potentially go into the house to check that the person is safe, could you not?

Chief Constable Anderson: Under section 17 of the Police and Criminal Evidence Act, the police have the power to enter premises. It exists under law, certainly common law. It also exists for other agencies as well. That is where there is a misconception. We are going in for an immediate risk and threat to life.

Under section 136, which has been misused by the system in the past, the power for a police officer to detain someone under the Mental Health Act is a power that can only be exercised in public. For it to be exercised in a private place, it effectively requires a warrant, and a doctor has to come and authorise and exercise it. That power sits there. It is there for health. For the police to go somewhere and try to coax someone out into public, in order for the police to use their powers, is probably not always the most appropriate. There are so many different variants that I would have to talk to specific cases.

- Q29 **Dr Johnson:** If you get a call that someone is sounding distressed within a private residence—perhaps from a neighbour—how would you respond to that under the original rules, and how would it change under these Right Care, Right Person rules?

Chief Constable Anderson: Under the original rules, we may, and we may still, knock on the door and, if they answer it, see if they are okay. The key question to ask under Right Care, Right Person is, "Are we the most appropriate agency?" For instance, if those calls have come from another agency and they are dealing with people predominantly for a health matter, and there is no crime committed and no threat to life, I would certainly suggest that we are not the agency to go there.

- Q30 **Paul Blomfield:** I want to explore a little more an issue we have touched on, which is the relationship between the public and the emergency services at the point of crisis. Chief Constable Anderson, you mentioned the three criteria for whether you feel a crisis falls with policing. At the point at which somebody calls 999 with a mental health crisis, how is that call handled now, and how is it different from the previous practice?

Chief Constable Anderson: Looking from 2019 onwards, all of our call handlers and, subsequently, our dispatchers have specific training in



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mental health. They understand how to deal with patients with sympathy and sensitivity. They also know the other services and what is available, working with our partners. We know that if we can get them the right care and the appropriate agency on the initial contact, that is far better. In effect, what I am talking about is effective signposting. Ultimately, this is about good decisions.

Q31 Paul Blomfield: How often is that signposting different from pre-2019? I am trying to get a picture of how this is working in practice, on the ground, if you are a member of the public and you are calling in. How often are calls going to be triaged in a different direction from previously? Can you give us a bit more texture on how it is working?

Chief Constable Anderson: A lot more calls go to other agencies or are going to them. What is different now is that call handlers are specifically trained. We have Mind, the mental health charity, working with us in our control rooms. Our supervisors, and our supervisors out on the ground, have received additional training. We have clear memorandums of understanding and a clear understanding with all our core health partners about signposting, about what is appropriate to signpost and what is not. On the exact figures for signposting, I don't have them off the top of my head. It would be somewhere in the region of about 20%.

Jonathan Evison: To give you a flavour, I invite you to come to the control room in Humberside. It is an outstanding control room. It looks a bit like the bridge of the Starship Enterprise. It is full of tech. As you are typing key words into the system, there is a drop-down of questions to ask. There are aide-mémoires within the system that aid the operator and direct them to whatever is required. It is not reliant on the human factor to be able to make those decisions. There are aids all the way through.

Q32 Paul Blomfield: I appreciate the huge contribution of the work that goes on in police call centres.

Chief Constable, I want to press a little further. You talked about the major difference being the training. Could you tell us a bit more about the training? You are asking staff to make some pretty life-critical decisions, aren't you?

Chief Constable Anderson: To be fair and frank, that is the job of our staff. That is what they do on a daily basis. They are wonderful people. They get additional training. We call it THRIVE. It is a risk assessment process. For your reassurance, we do not do it once. They get THRIVE'd and THRIVE'd again. As Craig has previously articulated, what can often happen is that a call comes in and sometimes it is obvious that we are going; it is immediate, we need to go on blues and twos and deal with it now. There are other calls that come in where it is clearly not appropriate for the police to attend. We are not the agency and we do not have the powers, the legal basis or the training to deal with them. Then there are a lot of calls that sit in the middle. We take them away, research them



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and speak to our partners, and check our intelligence systems. We can make a good, informed decision. It is about making good decisions.

One of the other differences now is that we are, once again, working very closely with our mental health partners. We have floor walkers who assist our officers and assist the call takers in making decisions. There are also clear flowcharts helping them and guiding them, informing them about the law and signposting them to where the most appropriate services are. It has been good, but I reiterate Jonathan's offer. Please come and have a look for yourselves. We would be proud to show you around.

- Q33 **Mrs Hamilton:** Good morning. My questions are geared at Chief Constable Guildford, because I am a West Midlands MP and I am passionate about mental health. I always say that.

This is my first question. Are MPs going to be classed as partners in the process that we carry out in the West Midlands? So far, as West Midlands MPs, no one has spoken to us about our views, what we think or anything pertaining to MPs.

Chief Constable Guildford: With respect, you are always our partners but, on this specific element of the work that we have been doing locally and nationally, the answer is no. But the door is firmly open.

- Q34 **Mrs Hamilton:** Okay, so it is open for us to push, not for you to invite us. I am not being awkward.

Chief Constable Guildford: Our door is always open, and we would always welcome views. Obviously, MPs feed in views to all our partners all the time.

- Q35 **Mrs Hamilton:** On Right Care, Right Person, my issue is with the confusion. MPs really have not had a clue about what has been happening at any stage of the process. I thought the West Midlands was further along than it is. That is not because I have been told that by the police or the PCC, but because of some of the conversations I have had with health. I admit I was wrong.

I will move to my main question, which is again for you. You are not as far down the road as Humberside and London. What do you think are the main challenges that the West Midlands will face when implementing Right Care, Right Person?

Chief Constable Guildford: We have already been doing the work, as I alluded to before. We have a meeting structure with our partners. I know you will be taking some briefings later. One of the main things is the perception that the police are not walking away. I have said that quite clearly and it has been very clearly communicated to all our partners. What we are trying to do is do this together. It is more of a marathon than a sprint. It took three years to do in different parts of the country. There will be sections of it that go quicker than others. There isn't a burning platform or cliff edge. We are doing it together. That is the first message. I think that is the biggest risk, if I am honest.



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Secondly, there is the impact on health partners in terms of cost. I have said that it is roughly an 11-hour wait. To get to a one-hour wait, the magic wand is not going to happen overnight. It is going to need resource in people and in money to be able to do that. I think that is the biggest strategic challenge for our partners, particularly—thinking about Tim’s question—with regard to the number of centres and how often they are open 24/7, fully staffed, for us to be able to take certain people at peak times.

The next challenge will be everything that we have heard in the news with regards to Birmingham. We have three ICBs across the West Mids, with a population of about 3.5 million: Coventry, Birmingham and Black Country. With all the things to do with Birmingham at the moment, speaking to a few colleagues outside, there is some nervousness about the impact on the wider system.

Q36 Mrs Hamilton: You talked about the 11-hour wait going down to one hour. I know that the West Midlands, and Birmingham especially, was actually leading the way a few years ago with some of our responses. We set up a centre called Oleaster to bypass A&E and ensure that we did some of the work that you are talking about. My final question to you is, is any of this still going on or has it all died a death?

Chief Constable Guildford: There is loads of activity and good practice that goes on in different pockets across the three big partnerships. Obviously, those partnerships start at different positions of funding but also of complexity of need and volume of need. Birmingham, in particular, has a high volume of need. We cannot get away from that. That makes it quite complex for the leaders locally, among colleagues, who are dealing with that situation.

From my perspective, I think there is loads of good practice going on. What the police are doing is gaining from some of the best practice that has happened elsewhere. As I said, we are doing it together. We are not doing it to partners; we are doing it together, and the police are not stepping away from the party.

Q37 Mrs Hamilton: As you said, it is a marathon and not a sprint. I am saying this to everybody: I think you need to think about your politicians, who would help you to sell some of the arguments. I know people think everybody hates politicians, but I don’t think that is actually correct. I think we are a vital link that has been missed out of some of the work you are implementing. I feel as if we have been on the back foot and not included. I would say to West Midlands, which is not as far ahead as Humberside and London, please try to put that right. That is my final point.

Chief Constable Guildford: I am going to send you an invite and make sure that you are included.

Chair: Having known Paulette for some time, my serious advice to you



would be to comply. To conclude, my opposite number, the Chair of HASC, Dame Diana Johnson.

- Q38 **Dame Diana Johnson:** I want to ask two quick questions. One is about the involvement of Home Office Ministers, particularly in 2019 when you were thinking of going down the road of Right Care, Right Person. What involvement was there with Ministers? We have heard there was not really involvement with Health Ministers, but did you have involvement with the Home Office?

Chief Constable Anderson: Initially, we started with our partners because it was coming straight into operational business. We already had really good, established partnerships in health boards. At the point when we looked to formalise the system via the police and crime commissioner, that is where the briefing started, via the PCC and then eventually to the Policing Minister, as we became more advanced. Certainly, looking at your colleague, once we were clear about the path we were taking and about what we were doing—everything is a negotiation; it was not just, “This is what we’re doing,” we did it with our partners—we subsequently talked to our MPs, yourself included.

- Q39 **Dame Diana Johnson:** Yes. I am not denying that at all, but I wondered about Ministers. Ministers only got involved once you had the system up and running. Is that right?

Jonathan Evison: I came to the game in 2020. I was elected in May 2020. I saw the benefits of this very early, and I approached Kit Malthouse and gave him a briefing on it. I have to say, to be fair to Kit and the Home Secretary at the time, Priti Patel, that there was not the evidence there. It was a new thing and it needed to bed in and complete its cycle.

When it was more fulfilled, I took it to the APCC—the Association of Police and Crime Commissioners—and Paul took it to the NPCC. From that point on, the Policing Minister and the Home Secretary, Suella, got involved. My concern had always been that it is two and a half years or three years to get it off the ground, but is it a realistic ask of police forces and health services to concentrate on it for that amount of time? Surely, there is a better way to do it. Of course, once you have ministerial consent and backing from the Home Secretary and the Prime Minister, as well as somebody I cannot get to—the Health Secretary—it makes it an awful lot easier to be implemented. I do not think it should take three years. I think you are on a nine-month to one-year programme.

- Q40 **Dame Diana Johnson:** We know the Metropolitan Police Commissioner wrote a letter to the NHS, saying that from the end of August he was going to implement the scheme in London. I understand it has now been put back to the end of October, but that is still a very quick time to implement it in London, with the Met facing all the issues it has at the moment. Do any of you wish to comment on that? How realistic is it for the Met to do this?



Chief Constable Anderson: I don't think this is going to surprise you, but I do not feel qualified to comment on behalf of the Metropolitan police. A point I made earlier is that a lot has changed since we started in 2019. I feel very comfortable with the work we are doing with national health partners. There is a national partnership agreement. I know there have been further suggestions, or a paper is being suggested, which is going to be looked at by the Health Committee, for amendments in law on where things could be made better and improved.

The landscape is so incredibly different. In fact, it is like night and day. People are now willing—just by the fact that we are here—to listen and engage with the conversation. I have to say this, but it was really difficult at the beginning. There were great people we were so close to, but it was obvious that we were dealing with a system in a tad of distress at the time. The real key to Right Care, Right Person—I would like to say this—is that if I had to say what the winning ingredient is, it is all of the partners from across the whole system, in particular the health system, coming together around one table. Before Right Care, Right Person, that had never been achieved. For us in Humberside, once we had set out the programme and what it looked like, that was the first time all the constituent parts came together. At that point, things started to move and happen. If you were to say, "Look, Paul, what's the winning ingredient?", to me, that is it.

Q41 **Dame Diana Johnson:** And not just being told by the police that they are going to do it.

Chief Constable Anderson: I don't want to comment on the Metropolitan police. The important aspect is to get the conversation going. That is what I would say.

Chair: Interesting. Caroline Johnson has a quick question.

Q42 **Dr Johnson:** I am impressed that you are thinking out of the box, working with other agencies and being very innovative in the best use of police resources. You have clearly saved huge amounts of police resource, which is great. There is obviously a cost to health of replacing that. How much money was transferred from policing to health? Was there any?

Chief Constable Anderson: No, there wasn't, but I would like to expand that point. As I alluded to, we were seeing transfer demand, which is demand from one part of the system to another, where policing was not able to do its job. We are not talking about policing demand. We are talking about demand that sat within health in the first place.

I think those things are above my pay grade. However, let's get down to the patient and what I have seen in the last two or three years. We have focused very much today on the acute cases, and concentrated on the section 136s. What I know with 100% certainty is that there were issues in the Humberside region where there were not enough beds available. Often, people were waiting because there was physically nowhere to put



them. That can be quite awful. When there were beds, there weren't staff facilities, as we talked about earlier. The staff were not available for those 24/7 facilities. They were pulled down from wards. If the doctors or the nurses were busy, as invariably they were, there was still no one, even though the bed was available.

Since Right Care, Right Person and since health has looked at it—you can talk to my colleagues in the next session—the money has been made available, and it is so much better. Generally, we are achieving the one hour. That is good for the patient.

Jonathan Evison: In Humberside, serious violent crime costs the police £45 million a year, the criminal justice system £60 million a year and the health service over £18 million a year. If we can have more resources available to do the day job, and if the police can stop and reduce violent crime, some of the resources you are talking about will come back to the NHS.

Chair: Very good. Thank you very much, Chief Constable Craig Guildford from the West Midlands and Chief Constable Paul Anderson and Jonathan Evison from Humberside. Thank you very much for giving evidence on Right Care, Right Person. We will now change panels very quickly and hear from representatives of the NHS. Thank you for your time.

Examination of witnesses

Witnesses: Dr Sarah Hughes, Adrian Elsworth and Roisin Fallon-Williams.

Chair: We have heard from the police. You are our second panel and have been listening, which is very helpful. We are grateful for your time. On our second panel we have, sitting in the middle, Dr Sarah Hughes, the chief executive of Mind; Adrian Elsworth, general manager of urgent and emergency mental health at Humber Teaching NHS Foundation Trust; and Roisin Fallon-Williams, chief executive of the Birmingham and Solihull Mental Health Foundation Trust.

Before I bring in Rachael Maskell, who is going to ask the first question, my colleague Paulette Hamilton wants to place a declaration on the record.

Mrs Hamilton: I have a declaration of interest. I am an independent lay manager with Birmingham and Solihull Mental Health Trust. I have been doing it for about 12 years.

Q43 **Rachael Maskell:** Right Care, Right Person has been introduced and rolled out nationally at a time when the NHS has very little resilience. We know that resources are really stretched both financially and with regard to staffing. What discussions have Health Ministers had with you regarding the roll-out of this policy?

Adrian Elsworth: Obviously, we rolled out Right Care, Right Person off the back of the crisis care concordat work that has been ongoing now for over 10 years. From a resource point of view, the money within the ICB



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was obtained to allow us to find additional staffing to support the roll-out and the freeing up of officers who previously sat waiting with individuals detained under section 136 of the Mental Health Act.

Roisin Fallon-Williams: I am not personally aware that those discussions have taken place. What I am aware of is that, last Friday, all the ICBs in the country received a letter asking them to consider what their priorities were going to be around Right Care, Right Person, what challenges they saw and what resources they thought they might need. There is a piece of work that has been kicked off very recently that I suspect has been supported by the DHSC around looking at what our perspective on all of that is, including what resources we might need.

Q44 **Rachael Maskell:** Is there any indication that there will be additional resourcing coming either to you as health providers or to the ICBs on the back of this policy?

Roisin Fallon-Williams: We believe that, as you have heard, in the West Midlands we are in the very foothills of the beginning of this, and logic and experience would tell us about how we develop different services. The fact is that we are generally not talking about people who are already within our services. We are talking about people who are socially vulnerable, who come from deprived areas and who are creating a need that is not being met at the moment in some way. For that reason, we believe it is going to require some resources. I understand that the national NHS team has done some initial scoping work. They thought that something in the region of about £260 million might be needed to enable all of England to be in a position to respond appropriately.

Q45 **Rachael Maskell:** Has there been any indication that that money will be coming from the Department, or will it have to be found from within budgets?

Roisin Fallon-Williams: There has been no indication that it will. That said, we know that we are in the fifth year of the long-term plan. The idea was always that it was going to create some level of parity of funding to mental health services. The idea of its being 10 years was that it was going to take that amount of time. We are about to go into the second half of that. One could expect that this could be thought about in the context of the second part of the long-term plan—the second five years.

Q46 **Rachael Maskell:** Dr Sarah Hughes, you lead a national charity working in this space. What discussions have you had with Ministers about the implications of the policy?

Dr Hughes: It is fair to say that it has been pioneered by the police. The conversations with the entire system and various stakeholders have been tricky to pin down. I do not think that conversations with NHS partners, with Ministers or with the Department of Health and Social Care have got to a place where we would be satisfied that the investment demand is



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really considered or carefully thought out, or that there is a system-wide response that the ICBs could implement, should Right Care, Right Person be rolled out in every part of the country.

- Q47 **Rachael Maskell:** There are certainly longer-term objectives behind it. We have been hearing in the first session that there are immediate changes in the way that policing operates when Right Care, Right Person is rolled out. It is really important that policy is developed from data and evidence. What have you seen about the risk to service users of policing not necessarily being present? Has that been backfilled by mental health staff, particularly with regards to where police would have come out to a section 135 or 136?

Adrian Elsworth: We have not seen any significant issues because the police still remain involved. My colleague Paul, from Humberside police, touched on the fact that there is almost a tier system in regard to care requirements. Mental health services are involved at every step of that. However, when we get higher up and when there are more concerns around risk to an individual, there is still a role for the police to play. It is very much around understanding whose role it is at what juncture and, more importantly, having routes of escalation to allow those conversations so that nobody falls through the net in regard to care needs.

- Q48 **Rachael Maskell:** Have you talked to the acute trust and the ambulance service to see if there has been increased demand on those services as a result of instituting Right Care, Right Person? You may not see it in the mental health trust, but there may be fallout elsewhere.

Adrian Elsworth: There have not been any significant increases in the acute trust. There has been a lot of work undertaken regarding how we support mental health presentations in our acute trusts. I almost need to park that because we have not seen a shift there. I cannot comment on the national footprint, but the local ambulance service is currently looking at their data with regard to concerns for welfare. They would be in a better place to be able to respond to that question.

- Q49 **Rachael Maskell:** That might be something we need to follow up. Thank you. Roisin Fallon-Williams, looking at the implementation, obviously you are further down the line, so to speak. You have longer to go to implement this system. It sounded very much from the first panel that it is being introduced in a piecemeal approach, so it is what is right for the force. What evidence are you drawing on to ensure that patient safety and patient need is being addressed? It does not seem that there is national policy behind that, more local determination. One of the comments that really stood out was that the way there was an intervention between health and policing services was based on resource.

Roisin Fallon-Williams: What we would always use, in the absence of that national policy, is our data, although I have to say that the long-term plan has been really helpful in helping us understand what best



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practice needs to look like in mental health services. We will call on our data. It is really important for the Committee to understand that this highlights that there is a group of people who are not mentally unwell. They do not necessarily require health services, but they are vulnerable and we may not yet have a regime of mental health wellbeing services that are available to them.

To use my own data as an example of that, there was a lot of discussion in the earlier panel about section 136. In the last 12 months, we have had nearly 2,000 people come through on a 136 in Birmingham. Only between 16% and 25% of those have converted into a Mental Health Act need, so every month that means between 218 and 220-odd people are coming through the place of safety suite, coming through a section 136 and do not require what it was originally thought they needed.

That is a group of people that I think Right Care, Right Place could really focus on. At this moment in time, we do not have an assessment place where we could take those people. We have a place of safety. We have a psychiatric decision unit, which is where they are taken. As I said, Mind is not a mental health service; it is a partner that supports people around their mental health wellbeing. What we heard from Humber mental health service is that it was providing those kinds of services to them at that particular point. There is a range of services that may not currently be available, but which we may need to put in place in order for the right care and the right people to respond to things.

Dr Hughes: I urge colleagues around the Committee table to visit Humberside, the dream team of this initiative. They have a special set of ingredients there. They have the collaboration, the data and some resources and good partnerships. The concern that we have, which is why we are calling for a national crisis concordat, is that the roll-out, or the announcement, has meant that there are forces around the country already implementing the Right Care, Right Person way of working without all of that in place. We know of local Mind and local trust partners who are already experiencing people having no response because the police will say, "We no longer respond to mental health calls."

The national roll-out is what we are concerned about. The roll-out in Humberside and in other areas like Birmingham where those services and those relationships are strong is one thing, but that does not exist everywhere. The issue of oversight and evaluation for Right Care, Right Person is the thing that we are primarily concerned about. We are already seeing the roll-out without the four phases that you heard from Chief Constable Anderson earlier.

Chair: The dream team.

Dr Hughes: You must visit them.

Q50 **Mrs Hamilton:** My question follows on from the first question I asked on the West Midlands. It is a quick one for Roisin. Rachael talked about



services, and you talked about the additional services that you feel may be needed if we are really going to address the problem. How far down the road are you with discussions regarding costings, how that could happen and how you are going to work with other partners to develop it all?

Roisin Fallon-Williams: We have not developed that piece yet. As I said, all ICBs were issued a survey last week which will enact a piece of work in all systems, looking at this. What we have done locally, though, is to take a lead as an organisation on bringing together everybody across the Coventry, Warwickshire, Black Country and Birmingham and Solihull areas. We had our first workshop only 10 days ago. That included some of our voluntary partners, but it also included the police, and it is going to include the coroner, going forward. There is something about the learning around some of the situations that have led to people being in a situation where they have not been supported as well. We are at the very early stages of developing that kind of support network.

In terms of the relationships, the police are partners with organisations like Mind and us. We have some of the most enjoyable work to do supporting the most vulnerable people in society. It can sometimes be a real challenge, and that can put challenges on relationships. What we try to do, whenever that happens, is to learn from it and how we can do better. That is exactly the approach we are taking with this. That first workshop was not around, "We can't possibly do this; this is all going to be really difficult." We got into the space of, "We need to understand each other's position better on this. We need to understand what Humber has been doing, but we also want to work to a set of principles around developing the trust and doing so in a collaborative way." That first workshop set the scene around the kind of principles and behaviours that we want to see from each other when we are doing this work.

Q51 **Mrs Hamilton:** Dame Diana Johnson highlighted the letter that came out in London saying that things would change in August. It was then put back to October. That is not happening in the West Midlands.

Roisin Fallon-Williams: No. There was probably a bit of anxiety at the beginning when West Midlands police started to talk about it, but what we have now managed to do is what I have just said. What we are concerned about is that West Midlands police are talking about a 12 to 18-month programme to do this. As we have already discussed, we are very unclear. The response could potentially be different in different places because every system has different things already on the ground.

We heard our colleague from the police in Humber talk about the situation in 2019. In Birmingham, for example, we have a psychiatric decision unit. We have a place of safety that, as I said, takes nearly 2,000 people a year. We have psychiatric liaison services that see over 2,000 people a year in the emergency department. They assess them within an hour.



Dr Hughes: The liaison diversion services.

Roisin Fallon-Williams: Yes. We all have very different starting points. We are not even at the stage of saying, "This is our map of what we've got; these are what we think the gaps are, given what we know the situation with Humber was; and this is what our data is telling us." We think it is ambitious and I am all for ambition, because at the end of this we will be better meeting the mental health wellbeing needs of people, but we have to be realistic.

Q52 **Mrs Hamilton:** My final point is around consistency. Parts of Birmingham, as people know, are very deprived, but so are other parts of the country. Do you foresee any risk of a postcode lottery developing in terms of how individuals experience crisis, and how it is responded to?

Dr Hughes: Absolutely. One of the things I want to say, which is in slight disagreement with the first panel, is that the issues around police time for handovers and problems in accessing help in emergency is not new news. It is an issue that we have all been grappling with to various degrees for at least 15 years. Ten years ago the crisis concordat came about and enabled a whole-system response to these very issues. Of course, over a period of time further challenges came into the system, and we started to see an increase again in some of the challenges.

All of the plans around crisis response around the country are different. There are some baseline expectations that there are alternatives to crisis. For instance, in Peterborough there are sanctuaries that I was part of developing in 2013 as part of the crisis care concordat. Without those alternatives, Right Care, Right Person is compromised. We really need to understand what it is about Right Care, Right Person that will enable it to achieve its ambition, which is to increase the capacity in the police force and get people the right care. That is why Humberside is quite important to think about, because they are principle-led and they are clear that it is not about a demand priority. That is not the case everywhere.

There are some parts of the country where we already know that funding for alternatives to crisis is being withdrawn. We need to understand the conditions in which Right Care, Right Person can exist out there. We need oversight. We need evaluation. We need a nominated person in local authorities and systems to make sure that it is on track. We absolutely need investment in local systems, whether through the long-term plan or through a way of thinking about the policy particularly. The risk of inconsistency around the country is very high, as we stand.

Q53 **Amy Callaghan:** Chief Constable Paul Anderson alluded earlier in his evidence to specific strains in individual areas. Are there particular workforce challenges in mental health services in each of your areas? Will you comment on whether you anticipate that workforce challenges could be a particular stumbling block in rolling out Right Care, Right Person across England and Wales?



Adrian Elsworth: I can only speak locally. There was a delay in rolling out phase 3, which saw more of an impact from a workforce point of view. In relation to concerns from welfare, which was phase 1, and the AWOL position, it was more about rearranging and communicating with teams about how they work differently to ensure that no one fell through the net. They were the first point of contact rather than the last point of contact. Therefore, when we came to the understanding of releasing officers within an hour from point of detention of a 136, it was a challenge.

The data has clearly been shared by the police that, in our area, we saw waits in excess of three and a half hours per detention, normally for two officers. For us to be able to address that, we had to replace the police bodies, almost like for like, with an appropriate healthcare assistant, which is what we looked at. We drafted a business case with our ICB colleagues to clearly identify what resource was actually required. As I say, there was a delay between phase 2 and phase 3 until we were able to identify the workforce requirements to ensure that the kind of handover from police to health was safe for the service user.

Q54 **Amy Callaghan:** That is helpful. Is work ongoing to recruit and retain staff to fill those deficits?

Adrian Elsworth: Yes. We truly believe in partnerships, beyond what has already been touched on regarding Right Care, Right Person and the essence of what was originally in the crisis care concordat. We have gone into partnership with a number of VCS colleagues in our region, and are addressing some of our workforce challenges by sharing the delivery of care with our VCS colleagues from the money that we received to be able to deliver Right Care, Right Person safely. It was very much a contract with the VCSE to support staffing 24 hours a day, seven days a week, in the health-based place of safety. We ourselves were able to recruit healthcare assistants alongside that. It was very much a partnership approach to ensure that we have sufficient workforce.

Q55 **Amy Callaghan:** Do you agree, Roisin?

Roisin Fallon-Williams: We are facing workforce challenges across health and care generally. It is one of the reasons why the long-term plan is partly as long as it is. We need time to be able to train different types of workers, and for them to work differently with our voluntary sector colleagues as well.

We rely quite heavily, particularly at the Mental Health Act end, on our social care colleagues to have enough approved Mental Health Act practitioners. In Birmingham in particular, we have some real challenges around that. I think the commitment that Adrian has just talked about to doing things differently with our colleagues, working with Mind and with other voluntary bodies, means that we can support some of the challenges around the workforce. If we are talking about only needing a CPN or only needing a consultant, that is much more challenging.



Q56 Tim Loughton: You sat in on the earlier session and heard my points about two other approaches, with CPNs going on patrol along with the police, and a place of safety which was clinician-led but with a police element, where police could take somebody—I don't think the chief constable fully appreciated this—not just with mental health problems but with low-level physical injuries rather than to a mainstream A&E department. Do you think those are viable alternatives which would make this new scheme less necessary and save a lot of police time? Have they not been rolled out more because of lack of resources and available professionals to do it? What is the restraint on them? It is generally agreed that they have been successful pilots, certainly the CPNs in Sussex.

Dr Hughes: You are quite right. There is a lot of evidence to support all of these models around the country. In Cambridge and Peterborough, we have CPNs in the control room. It is similar in other parts of the country, as you have described. All of these models contribute to a really important crisis care pathway.

The truth, though, is that resources in the system are still such that the police are used as a way of backfilling some of the care needs. When I say "backfilling", I do not mean to insinuate that it is not core police business. It often is, but we agree that they are not appropriate all the time. That is exactly the point that we need to make about the entire system around the crisis care pathway. There have to be alternatives. Currently, that is not the case around the country. Right Care, Right Person has great risk of operating in a silo without that kind of back-up. If you do not have places of safety or therapeutic environments to take people to, the police will inevitably still be landed with an individual they feel helpless to support.

In a way, it is a vicious circle. Ultimately, those people still need to be supported. While we can see in Humberside, and were reassured, that there were no significant adverse events related to Right Care, Right Person, I would suggest that is because of the relationships they have in some of the services that they have available to them. That is not the case everywhere. Clinical staff in the control room are a huge investment. Some police and crime commissioners have funded that. Some has come from local trusts. There is a whole range of ways that it is being funded. The crisis care concordat was a way of consolidating that. That is not what Right Care, Right Person will do.

Q57 Tim Loughton: Is that not part of the problem, though? You used the term "backfilling". I think the police would say that they are used for an awful lot of front filling as well, and that they are the first port of call for things that are clearly clinical leads, but they are the ones who go there first.

Do you want to comment on that, Mr Elsworth? There are lots of different examples around the country, but the one example on which everybody agrees is that an awful lot of police time is being wasted and it is entirely



counterproductive. Greater team working with the various agencies to find a common solution is probably the way ahead, and yet the Humberside experiment is one of the few areas where that is happening. Part of the problem is that there are different approaches in different parts of the country. Clearly, in much of the country it is just not working.

Mr Elsworth, why was Humberside not rolled out more widely earlier? Are there lots of people clamouring at the door of Humberside—both health authorities and the police—to say, “That looks great. How can we do it here?”, rather than the Government and the Met having to say, “We’re bringing these in regardless of how ready they are for it in certain parts of the country”?

Adrian Elsworth: Every health economy up and down the country is very different. What can be delivered in one area may not necessarily be the right thing for another area.

Q58 **Tim Loughton:** I just don’t buy that. This is a national health service. Somebody with a mental illness in one part of the country, whether it is rural or urban, has a mental illness. The emergency services are the same—police, ambulance and fire brigade—in every part of the country. There may be different nuances on certain services that are available or not. The problem is the same and the available personnel are the same; it is the way they are structured. Simply saying that it is different for different parts of the country doesn’t cut the mustard really, does it?

Adrian Elsworth: The principles we are talking about around Right Care, Right Person, in terms of who is the right individual to engage at the earliest opportunity, is where this originated. The work that was undertaken locally has been in the making for over eight years in that relationship, not just with the police and acute trusts but with the local authority and drug and alcohol services. We have been able to build the appropriate pathways required to meet the needs of our population. Nationally, that is something that would need to be looked at within an area to address its population needs.

Q59 **Tim Loughton:** Do you think that is true in the West Midlands? Are you very different from other parts of the country?

Roisin Fallon-Williams: If I think about our epidemiology and our demographic, we are different from many places but the same as others. Paulette has already alluded to the fact that 40% of people in Birmingham live in the most deprived areas in England. That 40% have a very different presentation, and very different issues that we need to deal with, from the other 60%, just in our own patch. We need to think quite locally with our communities. We also have a very diverse population. Of our 1.3 million people, over 40% of them come from ethnic minority groups. Therefore, how we respond particularly to someone’s wellbeing from a mental health point of view has to be nuanced.

Q60 **Tim Loughton:** In the West Midlands do you have specialist BME-focused



mental health responders, for example?

Roisin Fallon-Williams: No. We use our health inequalities data to help us understand how we might need to work differently with different communities. For example, in one particular patch we have south Asian individuals who very rarely access particular services. We have done a very particular piece of work with that community on how we can support them to access services better. It is the lens through which we look at how we are supporting people in our communities and how we are providing services.

Q61 **Tim Loughton:** You have said that you need to handle different populations differently. You have said that you have put resource into researching what the demands of those different BME groups may be, but you are not dealing with them differently.

Roisin Fallon-Williams: I have just given you an example of how we are dealing with them differently.

Q62 **Tim Loughton:** But you do not have specialist teams to do that. Surely, if you are saying, "We've got to have different ways of dealing with different people around the country," you have different teams to do that. But you have not actually done that in the West Midlands. You have identified the problem, but you do not have a team that can specifically pick up the specialist problems which that community may have.

Roisin Fallon-Williams: The example I have given you was about adapting the service, not through enabling it to be provided through people who were of the same ethnicity but through the team that was available responding differently to a particular community.

Dr Hughes: That is part of why it is different around the country. Some of the relationships with third sector organisations provide that speciality. The NHS trust does not have to provide everything. As our previous colleagues said, much that goes on in the crisis care pathway is not clinical need. It is need that could be met by a third sector provider or a non-therapeutic service. Having clinical staff in all aspects of mental health delivery is not always appropriate. Certainly, for people from racialised communities or with other special needs, working in partnership is the thing. That is why that footprint is very different all around the country in the 42 ICB areas.

Roisin Fallon-Williams: I think we would all agree with the point you made at the beginning. All the evidence is there that we get better outcomes by everybody working together in a true partnership way. We have not necessarily always been in the position of doing that. That is why for us, in Birmingham and Solihull, that first workshop was about developing those principles and everybody signing up to that being the way we were going to do it. All of the evidence is there around that.

We piloted street triage in Birmingham. That was a partnership between the West Midlands ambulance service, us and the police. We had a



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vehicle and all three of those partners were in that vehicle. They went round the streets and responded. We had a very good impact. Some of the outcomes from that were really good. That partnership working is imperative, as you have just described. There are good examples, not just around Right Care, Right Person, which is a new strapline or concept to describe how we need to meet the needs of our vulnerable communities.

Q63 Paul Bristow: To follow on from what Tim said, you have talked a lot about the caveats around what would make this policy work. Dr Sarah Hughes, I cannot decide whether you support the policy or not. Is it the right thing to do?

Dr Hughes: Yes. We absolutely support the principles around Right Care, Right Person. No doubt. We agree that for many people in crisis experiencing a police officer turning up is the worst thing. That is absolutely without question.

What we are saying, though, is that for it to have the best chance of thriving across the country there is much more work to be done. The work that is being done in Humberside gives us a template for that, but we cannot ignore the fact that there are matters of collaboration that need to be dealt with. There are matters of oversight and matters of resourcing. Until all of those factors are dealt with, I am afraid that we are going to hold some ambivalence about whether there will be a consistent way of doing this, around England certainly. Humberside is good, but that is not what is happening everywhere else.

Q64 Paul Bristow: You support the policy, but only if everything is in place to make it work. Is that right?

Dr Hughes: Pretty much.

Q65 Paul Bristow: A minute ago we were talking about horses for courses. To answer Tim's question, it is different. What we cannot do is grab Humberside and implement that across the rest of the country.

Dr Hughes: No.

Q66 Paul Bristow: In your mind, we would have to set up hundreds of different solutions across the country. We would have to have a bespoke solution and spend all that time. Is that what you are saying?

Dr Hughes: I think best practice is to work in local areas with partners to develop the best service for people who are living in that locality.

Q67 Paul Bristow: That is what has happened in Humberside.

Dr Hughes: Yes, absolutely.

Q68 Paul Bristow: We can take that template.

Dr Hughes: Yes.



Paul Bristow: We can take that template so it is not different in every area, in the sense that—

Dr Hughes: We can talk semantics, but what we are talking about is that the principles of Right Care, Right Person are spot on. We absolutely concur. The delivery will look different around the country, bearing in mind the resources and the relationships that they have available to them. We are quite happy to support the principles being rolled out across the country, but there are caveats. If it is going to work, these things are going to be necessary. How that looks in each area is relevant to the ICB. The ICBs can co-ordinate.

The fact is that we have a long-term plan that sets out the mental health expectations and investments that are going to be provided in each locality. Of course, ICB areas also make choices about where they deploy funds. We are never going to be in a situation where we can prescribe. The health policy landscape has made that impossible.

Q69 **Paul Bristow:** What worries me is that I think the NHS, on the whole, is quite poor at learning from itself. Innovations happen and they are wonderful, but to get that on pace and scale across the rest of the system is often poor. What we are asking is, what role do you think the Government have nationally in making ICBs do this? I am not sure the police can sit back and just wait.

Roisin Fallon-Williams: As somebody from the NHS, I think we always need to be in a position where we are learning from what other people do. I do not think anyone is sitting here and saying that what is happening in Humber should not be happening elsewhere in the country. It might be ice cream, but it might be slightly different flavours, depending on the localised aspects of things. What we are saying is that it needs proper time to implement. Actually, we cannot just—

Q70 **Paul Bristow:** How long, do you think?

Roisin Fallon-Williams: I think that 12 months to 18 months, without having an understanding right now of what kind of resources we could expect to support it, is ambitious. If we were sitting here now saying, “It is something that the long-term plan says we need to implement, and there will be funding coming alongside it,” we could realistically be talking about doing something.

Q71 **Paul Bristow:** The police cannot wait. That is the issue a lot of the time.

Dr Hughes: Can I remind you that this has been going on for a long time? It is not new news.

Q72 **Paul Bristow:** They are going to do it anyway.

Dr Hughes: Yes.

Q73 **Paul Bristow:** I want your opinion. The challenge will be that ICBs have to move at pace and scale, and learn from Humberside. What they cannot



do is just wait for the police to do this, because it is going to happen.

Roisin Fallon-Williams: We are not waiting. Certainly, in Birmingham and Solihull we are not waiting. I hope you have heard that from us.

Q74 **Paul Bristow:** You two are doing it. I am saying that the rest of the country cannot just sit back and wait. You have a real role in the work you are doing, Dr Sarah Hughes, to make this happen. I think it is going to happen anyway, with or without—

Dr Hughes: Absolutely, and we want it to happen. We want people across the country to get the best care at the right time. There is no doubt about that.

Q75 **Dame Diana Johnson:** I have a very small question. Why do you think the Commissioner of the Metropolitan Police decided to take the action he did? Was it because he was frustrated with health just not engaging and with the police needing to deal with the fact that so many police hours are being used in this way? Is that what it was about?

Dr Hughes: I cannot speak for him, but obviously we have had contact with them since. I think it is born of deep frustration. There is no doubt that the current situation impacts not only the public—they don't get the service they need—but the mental health of the police force itself, which as a result can often be compromised.

For all sorts of very good reasons, I can understand the frustration. We were disappointed that it felt like everybody was being done to, notwithstanding our compassion for them, and now we are urging them, saying, "Look, with all of that said, we are asking you to come round the table with some real commitment to partnerships and collaboration." Together, we are committed. We are not walking away at any point, but it was an unhelpful intervention at that point. We have had good and robust conversations since. I think they are shifting, but of course the worries around their own demand capacity continue.

Q76 **Dame Diana Johnson:** Why did Humberside not agree, when they set up Right Care, Right Person, to have a proper evaluation, not just from the police side but from the health side? Why was that not thought about? It seems fairly basic to have an evaluation of something like this.

Adrian Elsworth: We had VCS colleagues as part of the original stakeholder group, and there were conversations with service users about their experience. Obviously, the national evaluation is commencing. There is a local one that has commenced, but I absolutely accept the point you are making. We could have done things slightly differently. We could have engaged more service users on their experiences.

Q77 **Dame Diana Johnson:** I am amazed that you didn't. It seems basic stuff, doesn't it, to evaluate—if you are setting out on a major change, to evaluate whether it works.

Adrian Elsworth: Yes.



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Dame Diana Johnson: Thank you.

Chair: I hope it has been useful to put some of your views on the record. It has certainly been useful for us to hear how this is working in location from both panels. Thank you very much, Dr Sarah Hughes from Mind, Roisin Fallon-Williams from the Solihull Mental Health Trust, and, of course, Adrian Elsworth from Humber Teaching Trust. Thank you very much for your time today.