Department of Health & Social Care

From Maria Caulfield
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House of Commons
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Dear Steve,

Many thanks for your letter in relation to Right Care, Right Person (RCRP) and for sharing the transcript from the evidence session that was held on 19 September. The Secretary of State for Health and Social Care has asked me to respond to your letter as the Minister for mental health.

I was interested to hear first-hand the experiences of police and health colleagues from Humberside and the West Midlands and was delighted to hear about the progress that has already been made with the implementation of RCRP.

Firstly, I'd like to take this opportunity to reassure you that I am committed to ensuring that those in need of mental health support or experiencing a mental health crisis receive timely care from an appropriately trained professional who can provide them with the right support. I fully agree that partnership working is crucial to the successful implementation of RCRP and that is why this is a key element of the National Partnership Agreement (NPA).

Thank you for setting out your concerns in relation to RCRP implementation, which we have responded to in detail below.

Recommendation 1 - We would be grateful for an update on the timescales that NHS England are working to and emphasise the need to complete this quickly.

The NPA does not set timescales for implementation – it states that police forces should determine the timeframe for implementing RCRP locally, and that this needs to be done following engagement with multi-agency partners, to ensure patient safety is maintained. NHSE and colleagues from the social care sector have been clear that safe implementation will require time and resource. As you are aware, the Humberside model took three years to implement during the pandemic, required reprioritisation of existing mental health funding, and is still being refined and improved. If RCRP implementation is rushed, it could impact on patient safety.

I am, however, pleased to hear you were reassured by the engagement that has already taken place with ICBs to determine challenges and any resource constraints. DHSC and HO recently issued a joint commission to ICBs and Local Authorities to

establish the readiness of local areas to implement RCRP. The results of the survey have been shared with NHSE, Home Office and policing colleagues to identify and work to address any implementation challenges. We are currently in the process of preparing a summary to share with ICBs and Local Authorities. If the committee would like to see this summary, we would be happy to share this with you.

To support safe implementation, we are developing guidance aimed at the health and social care sector and NHS England is developing guidance for health systems, which will be made available shortly. DHSC officials have been leading on the development of social care guidance, which is being co-produced with key stakeholders from the social care sector. These guidance documents, which have been informed by engagement with the police and key learnings from Humberside, will support local areas to implement RCRP safely and in partnership with local agencies.

Recommendation 2 - we recommend that the Government uses the upcoming Autumn Statement as an opportunity to provide the necessary certainty about funding for the rollout of RCRP, in particular around whether new funding will be provided, or if funding will need to be found in existing budgets.

Although there isn't currently any additional funding specifically allocated to deliver RCRP, NHS England will be working closely with the Department of Health and Social Care to refine existing national resource estimates, based on intelligence from local systems as they develop their plans for implementation. We will use this intelligence to potentially inform any fiscal events next year.

It's worth stating that this Government has already put record levels of investment into mental health. The NHS Long Term Plan commits an additional £2.3 billion a year for the expansion and transformation of mental health services in England by March 2024 so that an additional two million people can get the NHS-funded mental health support that they need. We are delivering £150 million capital funding for mental health urgent and emergency care. This includes funding for over 160 schemes which will provide new and improved spaces for people in mental health crisis, which in turn are expected to improve patient experience and outcomes, reduce the likelihood of inpatient admission being required and help reduce pressure on A&E departments and ambulance services. Many of these schemes will be completed by the end of 2023/24, and include new or improved crisis cafes, crisis houses and other alternatives to A&E for people nearing or experiencing mental health crisis, spaces in or adjacent to A&E for people who do need hospital admission, crisis assessment and liaison centres and health-based places of safety for people detained by the police.

At Autumn Statement, we successfully secured an additional £795 million to boost funding in two services; NHS Talking Therapies, an evidence-based psychological therapy programme for adults with common mental health conditions, and Individual Placement and Support (IPS), which provides intensive, individually tailored employment support for people who experience severe mental illness.

An additional 384,000 people over the next five years will benefit from a full course of Talking Therapies treatment, with a focus on improving outcomes by increasing the

average number of therapy sessions per person. Over 100,000 additional people will benefit from Individual Placement and Support (IPS), which supports people who experience severe mental health conditions or have complex mental health needs, people to gain and retain paid, competitive employment. This evidence-based model is integrated within community mental health teams.

There of course remain challenges in responding to mental health needs as demand for crisis mental health services has increased by one third since before the pandemic and doubled since 2017, but the measures above will help towards easing the pressure on mental health crisis services and contribute to a reduction in police time spent responding to mental health-related incidents.

Recommendation 3 - we recommend that ICSs nominate one named individual to be the lead contact for any negotiations between health and social care partners and the police service, to allow the health and care system to speak with one voice and avoid the need for police forces to carry out parallel negotiations.

Right Care, Right Person can only be implemented through strong partnership working between local police forces, health and social care services, and other relevant services, including VCSE organisations. As set out in the NPA, areas will need to agree a joint multi-agency governance structure for developing, implementing, and monitoring the RCRP approach locally. This is also reflected in the College of Policing's Senior Responsible Officer (SRO) toolkit, which promotes the identification of key stakeholders and partners at an early stage of implementation.

We, along with NHS England, support initiatives that promote effective multi-agency working. This may include having a lead ICS contact for liaison between health and social care partners and the police service. However, police footprints do not match ICS footprints, so local agreement will need to be reached about whether there is a single lead ICB, or liaison is required with each ICB lead. As the implementation of RCRP is complex and encompasses mental health, ambulance, and acute hospital services, as well as social care and VCSE sector organisations, there will be some areas of implementation that require specific engagement with the leads for these areas.

I was reassured to see that responses to our LA and ICB commission indicate widespread support for RCRP and a shared commitment to roll it out. ICBs and LAs report that they are engaging with police forces to prepare implementation plans and local areas are making progress towards implementing the model. We will, however, continue to work closely with ICBs and Local Authorities to identify what support they may need to establish strong partnership arrangements and we will set out clear advice on this in health and social care guidance.

Recommendation 4 - we recommend that health evaluations are set up in all areas that implement RCRP, designed and implemented with national support. We believe that ICSs will have an important role here. We would also be grateful if you could send us further information about the national evaluation referred to in our evidence session and any health-based analysis or impact

assessments that were completed in advance of the decision to publish the RCRP National Partnership Agreement.

As discussed in the evidence session last month, the RCRP model was initially developed by Humberside Police and the first phase was implemented in 2020, before the NPA was published. Although a health evaluation has not yet been undertaken as most areas are in the planning phase or early stages of implementation, we have engaged extensively with health and social care partners, through one-to-one engagement, webinars and via the surveys to understand the implications of RCRP on the health and social care system.

DHSC analysts are collaborating with Home Office analysts on a shared process evaluation of the implementation of the NPA. This research will include quantitative monitoring data from the Home Office as well as qualitative research from the Home Office and DHSC, covering the police, health, and social care perspectives. This initial research will focus on how RCRP is being implemented in areas where RCRP implementation has been completed or is already underway and will conclude in Spring 2024. We intend to publish these findings next year. DHSC is also planning to undertake quantitative research to monitor roll out and further qualitative research to evaluate the outcomes and impacts of RCRP on health and social care patients, carers and staff beginning next year. This work aims to identify and spread best practice, encourage continuous improvements where possible and appropriate and to inform future decisions in this area.

As part of local governance arrangements, multi-agency partners will also need to establish mechanisms for reviewing impacts on police time, health and social care services and outcomes for patients and people with mental health needs. Advice on this will be set out in the health and social care guidance.

An Impact Assessment for RCRP has not been produced by this Department as police forces are operationally independent and, although the NPA sets out the strategic principles of RCRP and shows our support for this work at a national level, it will be for each Chief Constable to decide whether to implement RCRP and how much of the framework set out in the NPA and supporting guidance they wish to adopt. However, this should be done in partnership with local agencies, and we expect local areas to conduct an equalities impact assessment during the implementation planning phase. As part of our RCRP evaluation, we will monitor and evaluate the impacts of RCRP on health and social care patients, carers, and staff to encourage continuous improvements and to inform future rollout.

Recommendation 5 - we recommend that the Government and NHS England explore, through consultation, options to speed up the assessment process and ensure a timely handover of care from police officers to the healthcare service. These options might include steps to ensure that sufficient staff are available 24/7 to complete mental health assessments for patients in A&E, designating A&E as a place of safety, strengthening the Mental Health Act Code of Practice or funding to build dedicated areas in emergency departments to support those with mental health needs who also have a physical injury.

The NPA sets out that local areas should be working towards handovers taking place within one hour from arrival at an appropriate health setting, unless mutually agreed in relation to a particular incident on a case-by-case basis. As you identify, improving handovers is important to free up police time and to ensure people in need of mental health support get the appropriate care they need as quickly as possible. The implementation of RCRP requires local areas to work collaboratively to map local mental health provision and implement processes to ensure an appropriate response to mental health-related incidents based on local requirements. As part of this implementation planning, local partners should agree shared escalation processes to address any challenges or delays with handovers. Timescales for this will need to be agreed locally, however we know from the survey returns that most local areas are planning to implement RCRP in phases that align with the Humberside model, where timely handovers were addressed during the final phase of implementation. As highlighted in your letter, the Humber Teaching NHS Foundation Trust were successful in receiving part year Discharge Funding in 2021/22 which supported additional staffing and support through a third sector partner to staff the model of care. We will continue to work with NHSE to develop our understanding of the resource implications of RCRP, based on intelligence from local systems as they further develop their plans for implementation.

In addition, under our Delivery Plan for recovering urgent and emergency care services, a range of actions are being taken to improve mental health crisis care, including 24/7 access to liaison mental health teams that are resourced to be able to meet urgent and emergency mental health needs in both A&E and wards, the provision of specialist mental health ambulance vehicles, and universal access to urgent mental health support through NHS 111.

On a technical point, to confirm there is nothing in legislation which prevents an A&E department from being used as a place of safety and the Mental Health Code of Practice also envisages that a place of safety can be within an A&E department. The Mental Health Code of Practice will be updated when the Mental Health Bill is taken forward and it remains our intention to bring forward the Mental Health Bill when parliamentary time allows.

We would appreciate, in the response to this letter, an update on ongoing work and options under consideration to improve the situation described.

We recognise that there is still a long way to go to ensure that all mental health patients have access to the best quality of care. Ahead of this winter, NHSE is working hard to deliver improvements in the UEC mental health pathway, including:

- Focusing on avoiding hospital attendances by continuing to invest in crisis alternatives in the community and rolling out the 111 ‘select mental health’ option which we are aiming to soft launch from December 2023.
- Continuing to improve the crisis resolution and home treatment services by encouraging local investment in intensive home treatment, including by improving the quality of local services, to reduce out of area placements and reliance on inpatient care.

- Ensuring every ambulance control room has access to multi-disciplinary mental health professionals to support 999 mental health demand across all ages (either co-located or delivered remotely).
- Working with systems to ensure that they have an effective psychiatric liaison service, including for children and young people, and working to develop tailored solutions to improve in-patient flow.
- Moving at pace to measure, report and improve data quality on UEC MH waiting time standards across all age pathways with plans in place to formally introduce standards in the future.

You reference the rollout of mental health liaison services in your letter and I am pleased to confirm that 100% of hospitals with a type 1 Emergency Department have a 24/7 liaison service (on site or via in-reach), which is a specialist service providing mental health care in a physical health setting, and 61% have a 'core 24' or an approved equivalent model in place as of March 23. Core 24 is a liaison mental health service model provided 24 hours, 7 days a week; it is commonly provided across urgent and emergency care pathways.

We are also investing at least £179.7 million to deliver 3 new mental health hospitals in Surrey, Derbyshire, and Mersey as part of wider plans to eradicate mental health dormitories and improve care for mental health inpatients. This is on top of the two mental health hospitals being funded as part of the New Hospitals Programme: an updated secure facility at Northgate Hospital in Morpeth, Northumberland, which has received £43.09 million and a specialist facility in the new hospital scheme at St Ann's Hospital in Dorset which has received £2.37 million to date. This is alongside £5.9 billion of funding for elective recovery, diagnostics, and technology, and £1.7 billion for over 70 significant hospital upgrades.

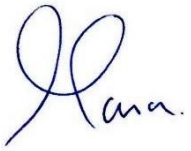
In order to address any issues with RCRP implementation, NPCC have agreed to work with DHSC, NHSE and HO on an oversight process to ensure we have a more systematic approach and timely access to information about any issues that are occurring. This process will not replace the need to have robust local escalation processes in place and the information will be used to inform guidance and communications.

I recognise the disappointment about the absence of a Mental Health Bill in the King's Speech, but it remains our intention to bring forward a Mental Health Bill when parliamentary time allows. Lots of people have fed into reforming the Mental Health Act – from making the case for reform as part of the Independent Review right through to the recent Pre-Legislative Scrutiny Committee – and we are grateful for all these important contributions. We have carefully considered the Joint Committee's pre-legislative scrutiny report on the draft Bill, and we will respond in due course. In the meantime, we continue to take forward non-legislative commitments to improve the care and treatment of people detained under the Mental Health Act, including continuing to pilot models of Culturally Appropriate Advocacy, providing tailored support to hundreds of people from ethnic minorities to better understand their rights when they are detained under the Mental Health Act.

Finally, I'd like to take this opportunity to thank the committee for your interest in this important area of work. It is crucial that people in a mental health crisis are

supported by mental health specialists with the relevant training, skills and expertise and we will continue to work with cross-government colleagues, the police, and health and social care partners to support local areas to implement RCRP.

Kind regards,



MARIA CAULFIELD MP