Police and Crime Committee

21 November 2013

Transcript of Item 8: Mental Health and Policing

Joanne McCartney (Chair): I am now going to move on to our main item today, which is our look at mental health and policing. This is really following up some work we have done previously. Last month, our Committee looked at access to health provision in custody in general terms and mental health was raised during that as one of the key issues as well, so we will have some questions on that later on.

Firstly, I really want to start with Lord Adebowale, if I can. Can you just briefly introduce yourself? Perhaps I should ask all the members to do that first of all.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): My name is Victor. Since I am amongst friends, you can call me Victor Adebowale. I am the Chief Executive of Turning Point and the Chair of the Independent Commission into Mental Health and Policing which looked into the Metropolitan Police Service's response to mental health in London. Victor will do.

Joanne McCartney (Chair): Thank you.

Christine Jones (Commander, Metropolitan Police Service): I am Chris Jones. I am a Commander in the Metropolitan Police Service in north London and I lead for the Metropolitan Police Service on mental health. I also now have the national lead for mental health for the Association of Chief Police Officers (ACPO).

Marie Snelling (Director of IOM and Neighbourhoods, MOPAC): Hello. I am Marie Snelling. Excuse my voice. I am sorry. I have lost my voice. I am the Director for Integrated Offender Management and Programmes in Neighbourhoods at the Mayor's Office for Police and Crime and health sits in my remit.

Joanne McCartney (Chair): Thank you.

Matilda MacAttram (Director, Black Mental Health UK): Hello. I am Matilda MacAttram and I am Director of Black Mental Health UK (BMHUK).

Joanne McCartney (Chair): Thank you all for coming here today. Victor, perhaps I could start with you because you were asked by the Metropolitan Police Service to look into this issue and you came up with a report which had a list of very important recommendations. Could I ask initially what response you have had to date from the Metropolitan Police Service?

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): The response from the Metropolitan Police Service is sitting next to

me to some degree and they can speak for themselves, but the response from the Metropolitan Police Service has been quite impactful in that Christine Jones has been given the responsibility of leading on the recommendations.

I should say that by way of background my agreement with the Metropolitan Commissioner [Sir Bernard Hogan-Howe] was that the work of the Commission would be entirely independent of the Metropolitan Police Service. It would have full access to files and he would respond publicly, accepting all the recommendations and explaining publicly those recommendations that he could not accept for whatever reason. That is still to happen for reasons that I kind of understand. It has been six months. I understand he will want to get all his ducks in a row. My personal view is that the families and the relatives and the people that we spoke to deserve at least a public statement about what the Metropolitan Police Service is doing specifically with the recommendations that we have provided for them.

I have had more than one meeting with Commander Jones and I have to say I am impressed with the directness and focus that she has brought to the recommendations that we made. If you want me to go through each of the responses that I have had so far from the Metropolitan Police Service, I am more than happy to do that.

Joanne McCartney (Chair): Perhaps in writing that would be great, but it is just in general terms at the moment and then we are going to look into some of the recommendations in a bit of detail.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): Yes. There are two types of responses to these things, level one and level two responses. Level two responses are fundamentally administrative: more committees are set up, more reports are written. They do not necessarily lead to the more important changes, which are level one changes, which are actual changes to things on the ground that people notice. There have been quite a few level two responses or, as Christine [Jones] would say, strategic responses that are necessary. I am not saying that that is a bad thing. I will continue to push for more urgency around the level one responses, the critical responses that mean change on the ground.

Joanne McCartney (Chair): OK. Can I move now to Christine? When we questioned the Metropolitan Police Service before in May of this year, we were told that all the recommendations had been accepted.

Christine Jones (Commander, Metropolitan Police Service): Absolutely.

Joanne McCartney (Chair): That is still the case?

Christine Jones (Commander, Metropolitan Police Service): That is still the case. I have spoken to the Deputy Commissioner and the Commissioner is intending to make a public statement, probably in mid-December. Part of the reason for the timing of that is, as you are probably aware, Norman Lamb [Minister of State for Care and Support] also commissioned a task and finish group to come up with a national concordat around mental health crisis services. What we want to do is make sure that all the work that the Metropolitan Police Service is doing reflects the action plan for the concordat as well. That is being announced fairly shortly, in the next couple of weeks, and the Commissioner intends to then make a statement following that.

Joanne McCartney (Chair): Yes, it has certainly got some press that there is an agreement imminent, but it is very sketchy on detail at the moment.

Christine Jones (Commander, Metropolitan Police Service): It is very exciting, actually.

Joanne McCartney (Chair): What will happen in that case if the recommendations from Victor's [Adebowale] independent report go a lot further than the national concordat?

Christine Jones (Commander, Metropolitan Police Service): I have been working alongside the concordat and part of it, so I know exactly where they fit against Victor's recommendations. In many cases, they actually take Victor's recommendations and develop them even further, which is exactly what I know Victor wanted. There is no tension between the two at all. In fact, I think the concordat will provide us all across the mental health landscape between the police, the public service and local community services a plan for the future, frankly. We are at point A and when we have implemented everything that is in Victor's report and the concordat, we will be in a far better place around the management of people with mental health crisis, so I see it as absolutely supportive of Victor's recommendations.

Joanne McCartney (Chair): What we have just heard from Victor is that it is a level of response which can be administrative, about putting an action plan in place or doing something. It is when the actions actually happen that things start to change. What response do you say to that and when can we see that? We were promised. Commander Rowley [Assistant Commissioner, Metropolitan Police Service] promised us back in May that a comprehensive action plan would be going to the Metropolitan Police Service's Policy Forum in July.

Christine Jones (Commander, Metropolitan Police Service): It did. We are going back again at the end of this month. There are a number of things that have been developed since Victor's report, the first of which is the vulnerability assessment framework training, which have been working on with an eminent academic to look at how we deal frontline with people who present with vulnerability. What this will lead to is that on every occasion, with every interaction with every member of the public at every stage, be it from calls received through to managing people in custody or those we encounter in the streets, our officers, frontline, will receive a level of training which enables them to recognise vulnerability and then to do something with it. As opposed to a risk assessment, which tends to be retrospective - so how we make sure we have done all the things we are supposed to have done - the vulnerability assessment framework actually will require officers to act there and then to address the vulnerability and garner support for that individual if they sit outside the criminal justice process.

Of course, that then links into liaison and diversion services and we are very heavily engaged with NHS England at the moment in the commission of service for our custody suites and that is progressing really well under Assistant Commissioner (AC) [Simon] Byrne [Metropolitan Police Service]. The Home Office is very interested in the vulnerability assessment framework and how they apply that to the health context within liaison and diversion, so this is really taking off as a national piece. We are also working with the College of Policing so that we get that standard of training across the country.

Joanne McCartney (Chair): That sounds hopeful, but it is still about the actions. One of the recommendations was that mental health is really a core business --

Christine Jones (Commander, Metropolitan Police Service): It absolutely is.

Joanne McCartney (Chair): -- and that it has to be reflected throughout every policy and every guidance that you have in the Metropolitan Police Service. Is that piece of work ongoing?

Christine Jones (Commander, Metropolitan Police Service): We have reviewed every single policy relating to mental health. We have also reviewed our human resources (HR) policies. We have reviewed our discipline processes. We have even reviewed how we go about dealing with repetitive calls from members of the public who may have a vulnerability which is why they call us. End to end; we have looked at where mental health impacts on all of those different approaches and activities.

The important thing, though, is that underlying mental health issues is the issue of vulnerability. There have been many recommendations in the past that have suggested that police officers need bespoke training in this element of mental ill-health or that element of mental ill-health. Actually, what it all comes down to is whether we recognise vulnerability. Do we deal with it effectively at the time? Are we are working in partnership to deal with people who are at their most vulnerable in terms of being victims of crime, subject to antisocial behaviour or victims of domestic violence and even those who come into the justice system? Are we making the most of triage opportunities? The answer that was, no, we were not, so the structures that come as a result of Victor's work and the structures that come as a result of the liaison and diversion work that is now embedded with NHS England will actually enable us to do that in a robust way and in a much more industrialised way across the whole of our service delivery in the Metropolitan Police Service.

Joanne McCartney (Chair): Can I ask about the comprehensive action plan? Is it possible that it can be disclosed to the Committee?

Christine Jones (Commander, Metropolitan Police Service): Yes, of course, absolutely.

Joanne McCartney (Chair): That would be very helpful. Thank you. Given that this is a very large area and it is going to have to seep through every piece of work, how are you prioritising the different streams of work?

Christine Jones (Commander, Metropolitan Police Service): Our training plan starts in January for all frontline officers and goes through to March. For the frontline uniformed response, so emergency response officers, all of those who work at borough level, they will receive vulnerability assessment training, as will our core staff. By the end of the year, every single member of the Metropolitan Police Service will have received that training, so that is how we will embed it at every stage. Regardless of what department you work in or at what point you engage with a member of the public, everybody was applied the same approach, so that is point number one.

The second issue is of course we are working very, very closely with and with the support of the London Mental Health Partnership Board led by Dave Mellish. The structures that we are looking at making consistent across London, for example, our exchange with health partners, how we deliver community-based multi-agency risk assessment conferences which will enable us to risk-assess people who are vulnerable, not as a result of crime necessarily but as a result of their mental ill-health or the conditions they are living in. All of those things will pass through the Mental Health Partnership Board so we get

consistency across London. We will have an opportunity to work in partnership and to engage third-sector opportunities as well. Again, that is something that Dave [Mellish] and the team within the Mental Health Partnership Board are very keen about.

We have also engaged very heavily with the London Ambulance Service and they have changed their approach now in terms of mental health crisis and their response to it, so that is focusing on the safety of the public. We have agreed with them that should mental ill-health crisis plus restraint occur, it is a medical health emergency and it is a London Ambulance eight-minute response, which is something that never existed when Victor took over doing the commission. I think that is a real step forward.

The concordat gives us the platform to stop transporting people who have mental ill-health in police vehicles and that is absolutely the bottom line. Clearly, there are other issues both nationally and locally around places of safety. I have to say, in London, we have good provision for places of safety, but people have traditionally been excluded as a result of alcohol, drugs, other intoxicants or violence. The mental health cconcordat makes it very, very clear that these must not be the reasons for excluding people from a health assessment, which again is a huge step forward.

Of course, we now have to work with health partners as to how we get from point A where we are now to meeting the needs of the concordat. All of this really focuses around the fact that there has to be parity of esteem, as Victor has said repeatedly. There has to be parity of esteem between those who are suffering physical ill-health and those who are unfortunate to suffer mental ill-health. The service provision that they get from the police must be sensitive enough to recognise that vulnerability. It cannot be the enforcement activity that we normally take against somebody who is a criminal. It has to be appropriate to the needs of the individual. Every single training programme that we have ever had around safe restraint is being reviewed. We are working alongside some of our mental health trusts to review the existing material that is out there to make sure it is fit for purpose. Some of it most definitely is not. Obviously, we will be coming to some really significant agreements with health trusts as to exactly what the police role is in terms of restraint within the mental health environment.

Jenny Jones (Deputy Chair): Bearing that in mind, Matilda, I am sure that Black Mental Health UK is very happy to have this report published and that the Metropolitan Police Service is taking it so seriously. Is that your feeling?

Matilda MacAttram (Director, Black Mental Health UK): This has been very, very overdue, but the commitment and the drive that I have seen the Metropolitan Police Service have on this issue has meant that a sector that has been stagnant and very resistant to change in this area is actually moving, so I welcome the fact that there is such a commitment from the Metropolitan Police Service. There are lots of things that we would still like to see, but we have not seen this kind of shift ever.

Jenny Jones (Deputy Chair): Have you been feeding into the concordat? Have you been engaged in that?

Matilda MacAttram (Director, Black Mental Health UK): Yes, we have been.

Jenny Jones (Deputy Chair): I am sure you do not want to criticise Victor's report, but do you feel there are any gaps, anything at all that could have been in there, that might have been in there, that you would have liked to have seen in there?

Matilda MacAttram (Director, Black Mental Health UK): Yes, we did. These are the concerns that have come to us from people who have used the service and people who are in the system. Even as a reference to Taser, for us, it is a big thing because you have produced a report this month and the use of Taser has gone up by 30%. We have been looking at this with the help of David [Dave Mellish, Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board] here. One of our concerns is the fact that police might use Taser when somebody is not complying with an order. If somebody is in crisis or they do not understand or, from the community that we serve, there are historic not-very-pleasant encounters, the reaction that an officer might expect might not be the one that they have.

We did some mapping with the concordat and we are speaking to frontline services. The service users are actually terrified of the police. If there is a van outside, they will not go out. They just will not go out. When they go into the services - this is what we have been told - they have been restrained, they have been handcuffed and they have been put in a cage. I do not know if we are going to address that, but that is a really live one. Actually, there are cases of people who have been Tasered while in a cage, which is not good.

Joanne McCartney (Chair): That is something we want to pick up in our Taser report and we will follow that up, so we can take that evidence as part of that. I am assuming that as part of a review of all policies, that is going to be included, Taser [inaudible] Taser.

Christine Jones (Commander, Metropolitan Police Service): Yes, absolutely. The whole point about this is that the police have been transporting people who are critically ill with a mental issue and it should not be the police who are doing that. That is point number one.

Access to 24-hour crisis care in London has not been accessible to the public. Consequently, friends, families and members of the public who come across somebody who appears to be going into crisis have had nowhere to go but the emergency services. Part of our development of all of this has to be the spectrum of services that support people who are ill, who actually should not be coming into contact with police and, when they do, they know that they are going to get the right support.

Matilda's views and the views of the people that Matilda represents have been hugely important for us. Obviously, the Vulnerability Independent Advisory Group, which has been set up again as a result of Victor's report, includes Matilda and a number of other people from our communities and groups that have an interest in how police manage mental health, deaths following police contact and that kind of thing. The only group that Victor is helping me at the moment to get better access to is inquests because I think they are extremely important as partners in this. Again, we will be showing them all of our training programmes. We will be going through those programmes. There is also an appetite to take people down to Grays End to show them the Taser training so that we can have the critical third eye from the lens of the community around when it is used and why it is used.

Again, my sense is that on many occasions police have been in that place because there is nothing else and that is the issue we are working through now. Actually, if you need to restrain in a mental health environment, why would that fall to police? If you woke up in hospital after a triple heart bypass and became violent with staff, there is no question that the police would be called. Of course they would not. In a mental health environment, if the right commissioned services do not exist, there has been a reliance on police attending to support staff. I can absolutely understand that, but we need to move on from that and that is the work we are doing.

Roger Evans (AM): I have some questions for Marie [Snelling], really, about the Mayor's Office for Policing and Crime's (MOPAC) response to this. What changes are you making to policy and your priorities as a result of Victor's report?

Marie Snelling (Director of IOM and Neighbourhoods, MOPAC): In response to Victor's report, Stephen Greenhalgh, Deputy Mayor [for Policing and Crime], has responded formally back. As you all know, mental health and the wider vulnerability agenda is absolutely a key MOPAC priority. It is referenced through the Police and Crime Plan, but ultimately we now want to take that a step further in terms of our work. We are now working through the Mental Health Partnership Board and through every element of this, both alongside the Metropolitan Police Service and indeed to challenge the Metropolitan Police Service on the activity that they are doing through all of those key networks and mechanisms.

I guess the other thing to say is that we are very, very keen to take a leadership role across London and Stephen [Greenhalgh] has been very clear on this in terms of integrating services, so not only just taking forward the recommendations and leading through those but actually to work through the work going on through the concordat and indeed take a leadership role across mental health in the justice system and more broadly. It is an absolute priority for us. We were at the table for all of those core meetings and in terms of the planning going forward and critically in terms of working and in terms of how we evaluate success. That is one of the things that you will be obviously looking for going forward. We are working with NHS England, the Metropolitan Police Service and wider partners to look at what an outcomes framework will look like across partners for this work going forward.

So, as Christine said, there has been some fantastic work. There is a lot more to be done and we will be taking a role at every level within that, including, critically, through the Mental Health Partnership Board.

Roger Evans (AM): OK. That is very encouraging. You reported the idea of having a specific target for mental health, which the commission suggested. Can you just tell us what your thinking was behind that decision?

Marie Snelling (Director of IOM and Neighbourhoods, MOPAC): As was set out in response to Victor's report, the reality for us throughout that is that identification and measurement underlie confidence and the contributory factors to that are actually complex and multifaceted. Actually, we did not think that that was an appropriate point at which to apply a target that may create preserve outcomes or indeed perverse incentives at that point in time. As I have just said, the critical thing for us is to be working through what an outcomes framework would look like going forward and from that understanding how we would measure success. The Deputy Mayor [for Policing and Crime] was quite clear on this in terms of not wanting to put in a target at this point in time.

Christine Jones (Commander, Metropolitan Police Service): If it gives you any comfort, I am working with the Vulnerability Independent Advisory Group to look at how we access service user groups and support groups to directly target them in a third-party way, if that is appropriate. It is work getting replicated within domestic violence, so that we can actually get fairly quickly into groups and find out if they sense a change and what their experience has been so that we can get that fairly fast feedback. Although we might not be at this stage sophisticated enough to say, "We can divide up a group of people who are by nature vulnerable and survey them", we can actually access them through their own support networks to make an assessment of just how our service is changing and whether or not it is meeting the need.

Roger Evans (AM): I am wary of adding further targets to the public service because, when everything becomes a priority, nothing is a priority, in effect. Victor, is there an easy way that we could measure success here so that we could tell pretty quickly that we were doing things better than we have done them in the past?

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): Yes. I am always struck by the idea that the excellent can get in the way of the good enough, so we found people with mental health challenges across all communities to consult with and talk to as we were constructing the recommendations in this report. We found those people. We used technology to do that, but we also met with people directly to do that.

Before I continue, I just want to put to bed the idea that we were not representative of any members of the black and minority ethnic (BME) community. I spent a considerable amount of time and the Commission's time talking with representatives of the BME community, above and beyond Black Mental Health UK just to be clear.

It is possible and, indeed, one of our recommendations, which I do feel I cannot really let go, is this idea that within the 20% improvement target, which is a general target set for the Metropolitan Police Service, the views of what potentially is a million Londoners - if it is 17% - ought to be addressed. Yes, you might start with a methodology that is not perfect, but you improve it. I agree with you that too many targets lead to a diffusion of resource, but targets are a tool, not a purpose in and of themselves. To not have a target which is about the most vulnerable in society is a mistake. It is these cases that impact on the wider public view of the effectiveness and the care that the police have for them. It is a mistake not to have that target and we have written to Stephen Greenhalgh about this. I was very grateful for his response, but a little disappointed.

Roger Evans (AM): Thank you.

Joanne McCartney (Chair): If you were able to give us a copy of that response, it would be very helpful.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): Yes, sure.

Joanne McCartney (Chair): Thank you. Matilda, you wanted to come in?

Matilda MacAttram (Director, Black Mental Health UK): Yes. In response to your question about targets, one of the things that can be counted quite easily and we are very, very keen to see change is the use of police custody. As Commander Jones says, London does have some of the best practice in the country and that is actually 100% accurate, apart from in certain trusts. The providers that cover the demographic where the largest group of people that Black Mental Health UK serves has the largest rate of using police custody. It is not because of the police. It is because the provider has failed to provide somewhere else or, even when there is a place of safety, it is not staffed. We have freedom of information (FOI) requests that have been sent to you all. If these numbers were to come down, because the Metropolitan Police Service has them, that would be an excellent start.

Also, Commander Jones has made reference to the use of police vehicles. We feel it is 100% inappropriate to have somebody who is in need of urgent healthcare to be put in a vehicle that has been commissioned for criminals. Even though that data is not public, we know for a fact that the Metropolitan Police Service has that data. If we could just look at the use of police vehicles in 12 months or 8 months or even 6 months and see that number come down and health providers pick up the slack because they actually have the budget to do this, we would see a change.

Another ask would be that when health providers do pick up people in crisis, they do not use caged vehicles because there are human rights concerns around that. If police are using that, then that is what their remit is as crime-fighters. However, if health providers are using caged vehicles, it is a whole other thing. I think that is a really easy ask and we could measure it in six months' time because we have measured it now.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): There are recommendations in the report about transport that are very clear and timed.

I would say - and this is an important point - that while we are very clear about mental health being core police business and the recommendations are focused on the police, the key point is interagency working. I have a concern that if the police deliver everything that we have recommended them to do but the National Health Service (NHS) does not, we will be back to square one. We have to ensure that the NHS delivers its part of the bargain. I have to say that while we might have, for instance, enough Section 136 suites, my view is that they are badly co-ordinated and inconsistently led and we require the same approach to crisis mental health in the NHS in London that we have for stroke, for which we are now one of the best providers in the world. It is and/and, I am afraid, not just either/or.

Joanne McCartney (Chair): We will have NHS England joining us shortly to take some of those points.

Tony Arbour (AM): Specifically on the point that you have made, Matilda, about budgets being made available, we have a note here which says that the reason the police are more frequently involved than they have been in the past is because the NHS, because of budget cuts, is depending on police to provide functions which they hitherto would have provided. In the case that you have mentioned of a health trust which is responsible for most of these cases, are you saying they are diverting money which is allocated for this to something else?

Matilda MacAttram (Director, Black Mental Health UK): There has been a conversation with the Minister [Rt Hon Damian Green MP] about this and where money is locked in the system. Sometimes it is about perverse incentives. Right now, the resources and the budget sit with secure settings rather than early intervention. It will require the NHS to be around the table with this one. It is a case of putting the money where the need is and where it is cheapest. Right now, the resources are where it is most expensive, so it is inpatient care - which is really, really expensive - rather than early intervention. I would ideally like to see community-based Section 136 suites so people do not even feel institutionalised. There might be an argument about money. The money is there. It is being smarter with what you have.

Caroline Pidgeon MBE (Deputy Chair): Yes. You partly already have answered the issue I wished to raise about whether you have fully looked at all of the BME issues that come out of mental health. Were there any areas that perhaps you were not able to look at due to time or resource constraints that perhaps you would have liked to have explored in more detail?

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): The answer to that is always "yes". Clearly, the issues that relate to black and minority ethnic people in London and the police are many and varied, but I made the point that there was some quite inaccurate reporting about the commission's work. Stuff got into the press before actually I had even said "yes" and before I had put the commission together or even decided what the terms of reference were, which was not particularly helpful, to be honest. This report was not about race. I know there are people that would like it to be, but it was not. It was about the Metropolitan Police Service response to mental health. In that, quite inaccurate press coverage was not helpful.

My view is that if we are going to do the piece of work, we have to do it properly. We found, in our engagement with the BME community - which was deep and disturbing, actually - that the overriding ambivalence towards the police that is in the black and minority ethnic communities became apparent in their response to mental health as well. We also found - and stated in the report, so it is there in black and white - that there is evidence of disproportionality, both in terms of the outcome for BME groups in relation to mental health and the police response.

I personally have been involved in at least two major reports with findings that have looked specifically at the BME community and mental health, so I could talk about the BME relationship to the police and policing and mental health in detail. As far as this report is concerned, we went into sufficient detail to tease out the key issues for that community. The Metropolitan Police Service's response will need to take into account a much wider view of its role in police with - and I use that word deliberately - with a black and minority community. That is a consistent challenge for the leadership of the Metropolitan Police Service.

Caroline Pidgeon MBE (Deputy Chair): In terms of your recommendations, there was this idea of a high-level group of stakeholders to provide the Metropolitan Police Service with ongoing advice and review and that was around race, faith and mental health.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): Yes.

Caroline Pidgeon MBE (Deputy Chair): Is the Vulnerability Independent Advisory Group (IAG) going to be that group and are you satisfied with how that is progressing?

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): My understanding is that that group has been established and, indeed, Matilda MacAttram is one of the members of that group. It is early days. I would hope that it is providing both the Metropolitan Police Service and the Commissioner and Christine with strategic and operational advice, nuancing the recommendations.

For example, on the issue of training, which I know Christine has made significant progress on, I would want to ensure that that training is on-going so it is part of the professional development of any police officer, that it links with the training that other professionals also have around mental health in the not-for-profit and indeed the health sectors and that it is evaluated with people with mental health challenges and their families. That would be my criteria for assessing the impact. I have not done that impact assessment and I probably will not, but that for me would be evidence that that work is having effect. I am pleased that it has been set up. It is an excellent level-two response that needed to happen.

Caroline Pidgeon MBE (Deputy Chair): Lovely. Matilda, can I bring you in here? Did you welcome overall the findings of the whole Commission? I think it sounded to me from your answer to Jenny that --

(The meeting was adjourned for 35 minutes, in response to a fire alarm).

Joanne McCartney (Chair): We are going to reconvene this meeting. Apologies to everyone. Some of us have managed to get a hot cup of coffee, so there was a bit of a bonus to that. I am aware it has put our time back a little bit. Caroline, you were in the middle of your questioning.

Caroline Pidgeon MBE (Deputy Chair): Matilda, do you welcome the high level group of stakeholders that has been set up with the Vulnerability IAG [Independent Advisory Group] and how is it working in practice?

Matilda MacAttram (Director, Black Mental Health UK): There has been one meeting so far and so we were informed about the reasons why it was set up and we were told that it is an advisory group and so we can advise, but the Metropolitan Police Service are the professionals and will take it or leave it as they see fit. We are advisory, which is --

Christine Jones (Commander, Metropolitan Police Service): Yes, as in they do not have statutory decision-making accountability.

Matilda MacAttram (Director, Black Mental Health UK): Yes, that was the phrase, sorry. We think it is really welcome. We just welcome this opportunity. It is an open door. From our perspective, this is how we see it. The Metropolitan Police Service has power and it is using the power in a way that is actually advantageous to the stakeholder group we serve, but we want to see the same sort of will across the whole remit in order to make the change that we need to see. It is a very, very good start.

On the BME issue, I just wanted to raise a point because I think it is quite important. BME engagement is critically important on this, but all the data shows that it is not the BME community that is affected. The people who are ending up in custody - according to this Care Quality Commission, which counts who goes where into the system - are African-Caribbean. The people who die in custody, the data shows, are African-Caribbean. Looking at the BME focus, we had a five-year programme that did just that and Sean Rigg [Musician] sadly died during that watch and that is why [Sir Bernard] Hogan-Howe [Commissioner, Metropolitan Police Service] announced that there would be this Commission. If we see what we have seen before, we will get what we have always got. That is just something I think that is really important to raise.

Caroline Pidgeon MBE (Deputy Chair): Victor, you said before that you have talked to the wider BME community. Did you particularly do some work with the African-Caribbean community to address these issues?

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): Absolutely and, in the construct of the Commission, we did that. In fact, we made particular efforts to engage Black Mental Health UK. We tried multiple times - about 18, actually - to contact and engage, both about some of the press but also to engage Matilda's organisation in what we were doing and how we were going about it.

Caroline Pidgeon MBE (Deputy Chair): Christine, I wonder whether actually you could put in writing to us, given time, the list of the individuals and organisations that are on the Vulnerability IAG and perhaps the programme you have of meetings so we can get a feel for that.

Christine Jones (Commander, Metropolitan Police Service): I would be delighted to, yes, absolutely.

Caroline Pidgeon MBE (Deputy Chair): Thank you very much.

Jennette Arnold OBE (AM): Matilda, over the years, whenever we have had engagement with the Metropolitan Police Service at whatever level, the phrase coming from the Metropolitan Police Service is "we will draw a line". For the Metropolitan Police Service, there is always this drawing of a line for us to move on. I have lost track of the number of lines that the Metropolitan Police Service has drawn in my experience.

Let us be positive. There was a time before the commission and there is the commission. So much faith and expectation is there and it is great this morning to hear Victor commend the work and it is always great to hear a Commander who is positive and seems to be in charge of her piece.

Can you just put it on the record? Have there been any fatalities post the commission or in the last, say, two or three months?

Matilda MacAttram (Director, Black Mental Health UK): As far as I know, the Metropolitan Police Service's remit covers the capital, but we had a call from somebody about somebody called Leon Briggs, who sadly looks pretty much like Sean Rigg. That was in Luton. He was picked up by the police and the Independent Police Complaints Commission (IPCC) is now conducting a criminal investigation. Then there

is somebody called Terry Smith, who was picked up in Surrey. He was a mental health service user who came into contact with the police and now the IPCC is investigating.

On what the Metropolitan Police Service is doing, there needs to be a national focus because, when people hear these stories, they do not know about the geographical boundaries the different authorities have. They just see the police, so it sends a very powerful message. When you have in this case a very good visionary who is committed to bringing about change with an agency behind them that is putting the resources in to make it a reality, that is good, but Lord Victor said something about level two. What we are seeing is a lot of level one, but what we need to see is it transformed into the reality of those who actually use the services.

Joanne McCartney (Chair): We are now moving on to our second section, so we are going to welcome our guests from the health service. Alison, could you just briefly say who you are and what your position is?

Dr Alison Frater (Head of Public Health Commissioning, NHS England): Alison Frater. I am the Head of Public Health in NHS England in the London region. I am responsible for several areas of commissioning, including commissioning health in the justice system, so for commissioning all of the liaison and diversion schemes, commissioning the police custody suites, as well as in the prison and secure estate.

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): I am Claire Murdoch. I am the Chief Executive of Central and North West London Foundation Trust, which provides mental health services to a very considerable swathe of London, but I am here today primarily in my role as the Chief Executive Lead for the other mental health trusts in London around liaison with the police and development of joint working with the police. I also sat on the commission.

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): I am Dave Mellish. Good morning, everybody. I am Chairman of Oxleas NHS Foundation Trust, but I am here today because I chair the Mental Health Partnership Board.

Joanne McCartney (Chair): Thank you for joining us today.

Jenny Jones (Deputy Chair): Victor, I wanted to ask you about the role of mental health liaison officers and how you assess the role and also what you feel has been lost in the boroughs where they do not have them anymore.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): We took the view that it was an inconsistent approach to the liaison. Some were very good, but it was not consistent and that inconsistency was creating confusion, so, for officers on the beat, it was just unclear what their role was. Also, their support in the role was inconsistent.

We concluded that actually it would be a better use of police resource and would give a clearer focus if there were fewer of them, better resourced, better led and better trained. We recommended that the numbers were reduced to eight and that they were well resourced, well trained and embedded, so in a sense they ensured that there was a consistent approach everywhere. I would add a personal view, which is that in those boroughs where there were peaks, it was particularly important that the mental health liaison officers were well trained and focused, but it was to ensure there was a consistent approach throughout.

I understand from Christine that there have been moves. The idea of the eight was not accepted by the Metropolitan Police Service, but Christine can speak to that. My view is that it would be a mistake. The recommendation was made for very a specific reason and that is that there absolutely needs to be a go-to person in every area where there is a significant mental health challenge, which is everywhere. There needs to be a spread and those people need to be very well trained and they need to be given the status necessary for them to actually pull things together across policing and health. I would like to see that recommendation implemented, to be honest.

Jenny Jones (Deputy Chair): You are using the word "embedding", so your idea is that they would be embedded in areas, in a certain borough, and would cover two or three other boroughs?

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): There are 33 boroughs, so if you are saying that there were 8, clearly there would not be enough for each borough. What we were saying is that they would have an overview across a number of boroughs and what they would be able to do is ensure that the response protocol was adhered to, that advice was consistent both to the operational officers and to officers on the beat and that, crucially, the liaison with the mental health service providers in that area was consistent. That would include the approved mental health officers and the adult social care people who are part of this agenda as well. It is quite a complicated role, actually, that requires a high degree of skill to manage well.

Jenny Jones (Deputy Chair): Christine, how is the Metropolitan Police Service going to make sure that the day-to-day policing actually has good advice?

Christine Jones (Commander, Metropolitan Police Service): One of the biggest issues not just for the Metropolitan Police Service, frankly, but for every police service is to ensure that we have that consistency, that the protocols we have with mental health institutions are the same across London and that they meet the same standards, that the policing role is well defined and that the training packages are properly updated with new learning. All of those things mean that the more people you have involved in delivering that, the less consistent it becomes.

If we put that to one side for a moment and explain what is happening in the organisation more broadly, then I will come back to the question. You know that the Metropolitan Police Service is going through an enormous change programme. The local policing model has already been delivered and rolled out to boroughs --

Jenny Jones (Deputy Chair): But that does not include mental health liaison officers.

Christine Jones (Commander, Metropolitan Police Service): Bear with me for a minute. You are absolutely right. It does not. The reason it does not is because what I wanted to do was to draw mental health back into a very, very prescriptive role that is properly controlled at Association of Chief Police Officers (ACPO) level, ie my level, with delivery that is consistent north and south of London. What we have done for the time being is that I have two inspectors and chief inspectors who are working with me directly to engage with all nine mental health trusts across London to examine all the different information exchange protocols, all the different local practices that go on between the police and the local mental health trusts and so on and so forth.

Within the broader context is the protecting vulnerable people command under Martin Hewitt [Deputy Assistant Commissioner, Metropolitan Police Service] that is being developed at the moment and that will look at all the issues of child exploitation, domestic violence, rape, other sexual offending and all the elements that add up to vulnerability including missing people. Included within that is mental health, so we have now a structure that sits outside of territorial policing but that will come into territorial policing through named leads on every borough. They will be at superintendent level, so every borough will have a superintendent who has the responsibility for the protecting vulnerable people portfolio delivery on the borough.

Jenny Jones (Deputy Chair): They will have special training?

Christine Jones (Commander, Metropolitan Police Service): They will not only be trained, but they will be accountable to me, if you like, for mental health.

Jenny Jones (Deputy Chair): There is this phrase about implementing an organisational learning strategy. That could be anything. That could be an email that you send around and then you do not know if anybody is reading it.

Christine Jones (Commander, Metropolitan Police Service): Can I be frank? The way that the Metropolitan Police Service has dealt with learning, like most police forces, has been as a result of critical incidents and usually the borough that has experienced it is in the best learned in it for a period of time before it gets forgotten again. That is inevitable with big organisations.

What we have done in the Metropolitan Police Service is to go back and look again at how we manage critical incidents first of all and then how we manage the critical areas of risk. The Metropolitan Police Service has divided up now between the commanders the five critical areas of risk and they are mental health, domestic violence, missing people, sexual offending and deaths while in police contact. I have responsibility for mental health and domestic violence. The way that the process works now is that although an ACPO officer may be responsible for the immediate aftermath of a critical incident, any learning or recommendations, wherever they come from, be they internal, external, Her Majesty's Inspectorate of Constabulary (HMIC) – it does not matter where they come from – will go to the lead for that area of business. Anything around domestic violence or mental health comes to me. From me, it goes down to the borough in the form of what we are calling a health and safety sign-off for the borough. The borough commanders actually sign off that they have implemented these risk mitigation measures or this training or this new approach and then we go around every year and inspect every single one of those on every borough. That is how we are starting to embed in the new DNA, this idea of progress.

Jenny Jones (Deputy Chair): How do you test it, though? Do you question individual officers?

Christine Jones (Commander, Metropolitan Police Service): Yes. There is a collection of things. Let us say it is about standards of investigation. We will dip-sample those particular crime reports. We will hold focus groups with officers. We will look at sanction detection rates. We will look at court outcomes. We will speak to members of the public. That way, you get an idea as to whether or not the learning that you think has been embedded is actually meaning that activity and outcomes change for the public and change in terms of policing approach. That is the only way to do it. You need an end-to-end process.

Jenny Jones (Deputy Chair): I would love to ask you more about this, but we are under such time pressure now. Could we have an organisational chart? I was getting mixed up when you started talking about the different areas. It almost sounded as if you could have thrown anything into those areas and I was not really sure how they worked. It would be good to hear a bit more.

Christine Jones (Commander, Metropolitan Police Service): OK, yes.

Jenny Jones (Deputy Chair): Dave, you wanted to say something?

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): Only that the original recommendation in Victor's report was that there should be nine mental health, not eight. It was nine, coterminous with the nine geographic mental health trusts. It was a move away from the borough-focused mental health liaison officers. The move was to a mental health trust focus, so that it would improve the partnership arrangement between the police and the mental health trusts.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): Could I just say on that? I think, at the end of the day, the Commissioner and the Metropolitan Police Service will make the decisions that they need to make, but Dave is absolutely right. There were specific reasons for the recommendations that we made.

The key point is: does what the Metropolitan Police Service implements actually improve liaison? Does it actually improve it? What would be useful would be to pull some key tests for that that can be returned to in, say, six months' time. The sampling methodology is perfectly appropriate, but the advisory group has a role in testing this. Do police officers on the beat feel more informed? Is there clear evidence of better liaison with the mental health trusts? Is there a consistent protocol in place that happens everywhere at the same time? These are the key tests for the implementation of what Christine is --

Christine Jones (Commander, Metropolitan Police Service): The Mental Health Partnership Board will hold me to account and support me to do that. That is part of the reason why my role as lead in the Metropolitan Police Service and my statutory function within the Mental Health Partnership Board is so important because people like Claire [Murdoch] will hold me to account through Dave [Mellish] if our relationships are not (a) progressive and (b) supportive of what we have agreed within the partnership board as being our approach.

Jenny Jones (Deputy Chair): Victor, are you staying abreast of this? Are you actually going to keep an eye on it or is your job done?

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): To be honest, my job is done. I said to the Commissioner that I would do this. I have done it. His job is to respond to the report. Clearly, I will stay engaged, but I do have a day job. Quite a few, in fact.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): For me, the overarching glue that is holding this all together is the commissioning framework, our investment strategy. There are probably a few things that we need to say about that.

The first is that there has been a huge step forward in London in terms of us now taking forward a very solid approach to commissioning health services in police custody suites, which we are determined to link very firmly with our commissioning of liaison and diversion schemes.

Jenny Jones (Deputy Chair): We are going to ask some questions about that later on. There are people who know more about it than I do.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): Fine. It is just the sense that actually the kinds of issues that Victor is raising for me are our commissioning intentions. What is our service specification? How do we want this to work? Then, in six months' time, let us say, "Is it working?" Or let us say, actually, in three months' time, "Is it working?" Let us say, "What is the service specification that we are actually putting our money behind?" Then let us evaluate whether or not that is actually happening. That is the target I think we are looking for.

Joanne McCartney (Chair): Yes. Perhaps Dave [Mellish] and then one of the other two health experts might be able to help. Quite often, we are faced with big organisations like the Metropolitan Police Service or the NHS and one of the issues before us has been about not sharing information or about not knowing who to go to. We have some questions on the information sharing.

Is this recommendation for the nine mental health officers linked to each mental health trust something you actually welcomed in the commission's report?

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): I think the theory is terrific. I worry that they will reduce the numbers from around 30 to responsibility at a very senior level at a borough base for vulnerable people, assisted by two individuals, one north of the river and one south of the river, to pull things together and to identify best practice and try to harmonise efforts and partnership arrangements across the piece, which is great. I worry that beneath that level, at the operational level between house working staff where all the difference is made and the local police, whether that is going to be tight enough. I am very happy. Let us suck it and see what happens. I am sure the Metropolitan Police Service and I am sure the NHS is big enough. If it does not work, we can amend it.

Joanne McCartney (Chair): I sit on my local crime and disorder boards and so forth. Traditionally, it has always been quite difficult to get health partners there, not because they do not want to but because of the pressures on time and other things. Do you think in future that you are going to be able to make those liaisons and have those? I suppose it is that continual contact that is needed.

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): From my point of view, the key to all our discussions here and the development of Victor's report is it is all very piecemeal. There are wonderful examples of best practice across different parts of London, but it is not uniform. One of the roles of the Mental Health Partnership Board and one of the roles of Christine's [Jones] department in the Metropolitan Police Service is to pull it together and identify best practice and make sure we are all singing from the best hymn sheet together, rather than having really good practice going on in one borough and two miles down the road they do not know anything about it.

Jenny Jones (Deputy Chair): I wanted to move on to training and guidance and restraint and so on. I did wonder if I could just ask Matilda because the commission calls for better training with an independent evaluation by the College of Policing. Are you aware of how much progress has been made?

Matilda MacAttram (Director, Black Mental Health UK): No, Black Mental Health UK has no input at all. We would welcome engagement on that level because we think it is really important. All the data shows that people from the African-Caribbean community who are detained under the Act will be restrained. That is just the experience. Could I mention a couple of other points now?

Jenny Jones (Deputy Chair): Yes.

Matilda MacAttram (Director, Black Mental Health UK): OK. Restraint is huge. We would be really keen to find out because what we would like to see -- and I do not know if this is possible. We do not believe that the police are the ones who should be restraining people anyway because the police are trained to deal with criminals. Restraint of somebody who is mentally disordered under the Convention Against Torture (CAT) is actually considered to be a violation of human rights, so what we would like to see - if it has to be done, which I do not believe it should, in an ideal world - is pain-free restraint of those who are vulnerable or de-escalation techniques. It has to be, from our perspective, the responsibility of health providers. Police when they go in just go in as officers. If mental health providers were to take responsibility for someone in crisis, what we would like to see is a completely different response. That is the point on restraint.

As far as the police go as well, you talked about joint protocols. We are aware of the Territorial Support Group (TSG) being called on to wards. There is a case that is quite live at the moment that occurred at River House. Even though the report was supposed to have been made public, it is so redacted that we do not even know how many officers were called to the scene. It is something that we would like some agency to shed light on. How the providers treat people inside the system has an impact on how the community sees the police and mental health services. What we would like to see is a commitment that no TSG officers are ever called on to wards because, we do not see that riot police, we do not see that that is their place at all. There are cases. We can email you the details, if you would like.

Also, where there are serious incidences, what we see with other statutory agencies is, if there is a fatality within police custody, it is automatically referred to an external body for investigation. If there is a fatality or a serious incident within the Prison Service or detention, it is automatically referred to an external agency. Every fatality and every serious incident that happens in a mental health setting is always investigated internally. More deaths occur of people detained under the Act than any other custodial

setting. For us, it is almost like there is not even a parity of esteem in death. Even the status of how they die is not seen as worthy of an external investigation.

I do not know how this Committee could look at that, but it is a really huge thing for us. We would like to see an independent inquiry with any serious incident involving the police and also a death of somebody detained under the Act when it is a preventable fatality.

Jenny Jones (Deputy Chair): It is a very good point and we will discuss how we can deal with it. Do you have any idea of how many times the TSG does get called?

Matilda MacAttram (Director, Black Mental Health UK): That is the thing. We have looked into this. Dave Mellish's trust does not even have a joint protocol that involves the TSG. There are some really good practices across the capital, but there are other trusts where they have an agreement and in their agreement they actually specify how long an officer should restrain a mental health service user when on their premises. It is something that we would like to have a spotlight shone on because we think that in fact it is a human rights issue.

Jenny Jones (Deputy Chair): Thank you.

Christine Jones (Commander, Metropolitan Police Service): As a bit of reassurance, Jenny, I thought Matilda was aware of this, but clearly not. I absolutely agree with her. I do not think police should be going into mental health institutions to restrain and I have put a stop to it. What I have said is --

Jenny Jones (Deputy Chair): You have stopped the TSG being sent?

Christine Jones (Commander, Metropolitan Police Service): I have stopped police responding to mental health institutions for the purposes of restraint unless there are very, very good reasons why. Claire [Murdoch] and I are busy working through a protocol for London because there are certain areas of London that we get very few calls to and other areas of London that we get lots of calls to. For me, the only time that police should ever go into that health setting, frankly, because you are talking about somebody who is ill, is if there is real danger to life. That is a different issue.

Jenny Jones (Deputy Chair): It is bad for the police as well, of course.

Christine Jones (Commander, Metropolitan Police Service): Of course it is bad for the police, but imagine what it is like for the person. I cannot think of anything more terrifying. We have an escalation process in place at the moment for the Metropolitan Police Service which basically means that if a mental health institution calls on police, it goes into my mental health team to assess the circumstances before we respond. It is as simple as that. We have that level of commitment that we are all on call virtually 24 hours a day to make sure that if we have to respond we have the right people doing it and for the right reason.

Jenny Jones (Deputy Chair): Do you know if this has actually reduced the number of times the police are going to --

Christine Jones (Commander, Metropolitan Police Service): Hugely. Absolutely massively.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): I think it is important that we understand a couple of things. The first is that Lord Harris [Chair, Independent Advisory Panel on Deaths in Custody] has done quite a comprehensive piece of work on deaths in custody, which it is important that we focus on because that is a separate piece of work.

In relation to my report, we were very clear - absolutely crystal clear - about the need for training around restraint and the use and misuse of the police in relation to mental health crisis. It runs throughout the report, virtually every recommendation references it, so it has been dealt with in the context of the report. I am just concerned that we pay due regard to the work that has been done more generally around deaths in custody, which is Lord Harris's work.

Matilda MacAttram (Director, Black Mental Health UK): Just for clarification, actually, I was aware of Commander Jones's commitment to not have police on wards and we really do welcome that because that is huge. One of the things that we would really like, if it is possible, to see is how that commitment is documented publicly, so that we know if another leader comes in, that the good work that has been done by one leader is part of how this system functions rather than an example of good leadership.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): It is not just a police issue.

Christine Jones (Commander, Metropolitan Police Service): No. This is where the Mental Health Partnership Board is so important because that sets the strategy for London. It sets the behaviours of each of the agencies and it will also support us in terms of joint improvement and joint training. That is absolutely where partner agencies are so important. It is not then reliant on one individual to drive it through. It is an organisational agreement.

Jenny Jones (Deputy Chair): Are you happy with what you are hearing?

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): That is absolutely right.

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): We meet as a partnership board every quarter. Victor's report was at the July meeting and Victor was there when we discussed across the piece with all the partners progress around their 28 recommendations and it is on the agenda for our next meeting in January where, again, it is an update of actions. There is going to be more movement then because there has been a frustration at the Mental Health Partnership Board and certainly frustration at the police waiting for the police model to gel itself because they can really implement it and show the green light for all aspects of the joint working. I am very hopeful that in January we will be much clearer as to the way forward, not least around joint training.

Jenny Jones (Deputy Chair): From what we hear, the more complex the situation becomes and the more time we need, obviously. Christine, can I just ask you, finally? What about learning from other organisations like the British Transport Police (BTP) and what they are doing on suicide, for example?

Christine Jones (Commander, Metropolitan Police Service): Absolutely. We have a member of staff now who is seconded to and works alongside BTP. Their suicide prevention strategy is now part of ours. I am reviewing not only the Metropolitan Police Service's strategy but the national strategy. We have already included elements of that in our internal procedures around staff and supporting staff. We have certainly embedded it in safe custody processes and it is a fundamental part of the vulnerability assessment framework. The suicide prevention piece is a really fantastic model and we have genuinely stolen it with pride from BTP. They are part of the London Partnership Board and they are also part of the south region and national ACPO working groups around mental health, so absolutely.

Jenny Jones (Deputy Chair): OK. That is brilliant.

John Biggs (AM): Do you feel that the basic training for police officers adequately addresses the need to be sensitive to this niche, if you like, in their workload? Do you think you fully cover that?

Christine Jones (Commander, Metropolitan Police Service): I am not sure it is a niche, to be honest, John. It affects so many people in London under so many different circumstances that, as Victor has made really clear, this is core business for us, hence the development of the vulnerability assessment framework.

John Biggs (AM): You have been very heavily criticised by the commission - I am surprised Victor is not going to hit you at this point, actually - for your lack of monitoring - that was the wrong language, I suppose - and the storage and monitoring and recording of information and the vigour with which they were unhappy with that. We have heard this morning unhappiness about data and its recording. What can you tell us about what you are doing to address that?

Christine Jones (Commander, Metropolitan Police Service): I absolutely reflect that unhappiness. When you have disperate systems, disperate information technology (IT) and technology that does not talk to itself, you are immediately into a difficult arena. Until I took over the lead for mental health back in September last year, we had no way of knowing by pressing a button how many people across London we had encountered with vulnerability leading to mental health issues. We had no way of looking up how many Section 136 interventions we had or Section 135.

We changed that in January this year and in April that rolled out across the Metropolitan Police Service, so we now use the Merlin system to highlight vulnerable adults coming to notice. We have 19,000-plus entries on that system now, which starts to give us an idea (1) about demand and (2) about managing people who within our communities are repeatedly vulnerable and actually bringing those to the attention of health partners or others who can support the reduction of that person's likelihood to be a victim of antisocial behaviour and crime or indeed become engaged in crime. It is actually a bigger issue, John.

One of the things I am looking at with HMIC now - and Olivia Pinkley [Assistant Inspector of Constabulary] has very kindly offered to help me from the HMIC - is what are the minimum dataset standards the Metropolitan Police Service and policing nationally need to produce in order to support both a joint strategic health needs assessment and our clinical commissioning groups to make sure that we are commissioning the right service. That will include things like the transportation, how we are transporting people because there is a lack of availability of ambulances or indeed the real decisions that are made by

police forces around ambulance provision, how often police stations are being used as places of safety and how often we are supporting emergency Section 135 assessment as opposed to upstream intervention from referral. All of those things are going to be really critical to a minimum dataset.

I have a national task and finish group that is up and running at the moment that has six weeks to come back with the national picture. We are doing the same in London. We are about to present to the partnership board the first suggested dataset that will come from the Metropolitan Police Service. My plan is that in future we will report at least once a year to the Mental Health Partnership Board and measure against those datasets that they have agreed to see whether or not the outcomes we are achieving actually meet the strategic direction of the partnership board.

John Biggs (AM): OK. I suppose I should apologise again for the clumsiness of my question, but what is the timeline on which you would be confident that, were there another investigation, there would be no criticism of your monitoring? You will be putting this stuff together. At what time will you be confident that you will have good metrics?

Christine Jones (Commander, Metropolitan Police Service): Good metrics now under Section 136. We have good metrics now.

John Biggs (AM): Yes, but you have had trouble providing information for this Committee meeting, I think.

Christine Jones (Commander, Metropolitan Police Service): Have we?

John Biggs (AM): Yes.

Janette Roker (Scrutiny Manger): We have not received any information. No one has seen any information yet.

Christine Jones (Commander, Metropolitan Police Service): It has been sent.

We have metrics that we have never had before and, as I say, we know that since April we have dealt with 19,000 people either as a result of a mental health vulnerability or Section 135 or Section 136.

I will tell you, though, that the metrics around Section 2, which is usually somebody who has been in custody as the result of a criminal offence and who later goes into a mental health setting, are still not right because our custody system is an extremely clunky and difficult system to pull information off, so we are working through the flagging system with that. That might be the issue that you are talking about.

John Biggs (AM): I am wondering whether this accords with the experience of others. You think you have it right at your end.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): I just wanted to add that the other side of monitoring is the development piece. We are putting the N3 NHS connection into police custody suites in a pilot sense so that we can actually link people immediately back into the summary care record. We are linking the information sharing protocols with the Metropolitan Police Service with our

providers. We have some very good practice in other areas of health and police liaison around information, for example, around knife crime in accident and emergency (A&E) departments which we can build on and around the work with the Haven, a sexual assault referral centre, where we have a very good track record of information sharing. There is quite a lot of work going on that will enable us to care for people better and get people back into mental health services rather than into a criminal justice setting or into a police custody setting, so a great deal of work on using information sharing protocols to actually achieve --

Christine Jones (Commander, Metropolitan Police Service): The structure for that was in the community multi-agency risk assessment conferences, which we are introducing specifically for vulnerable people. Where we have had that multiagency risk assessment process for people with, for example, a domestic violence history or something similar, we now have that for vulnerable adults. Of course, we have adult safeguarding legislation coming down the line for us next year, so we are actually now geared up in a way that we never were before to meet that challenge.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): It might be helpful just to be really specific about this, so recommendation 15 was very clear about establishing a system on Merlin, which Christine has done. The timeline for that was immediately, so that has actually happened.

The other key recommendation was recommendation 21 in which we make it clear that:

> *"The MPS [Metropolitan Police Service] should transfer commissioning and budgetary responsibility for healthcare services in police custody suites to the NHS."*

I think that is a significant move. That is a game-changer and, as Dr Frater has pointed out, that makes a significant shift.

Joanne McCartney (Chair): Has that already been done now?

Christine Jones (Commander, Metropolitan Police Service): It is underway. AC [Simon] Byrne is leading it and we are fully engaged. Yes, it is underway.

Joanne McCartney (Chair): We asked MOPAC and they said you were going to consider the options.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): It is probably important to say that we have had our first meeting of our board. That is jointly chaired with the Director of Operations and Delivery in NHS England (London region) with Assistant Commissioner Simon Byrne and we had very good representation at that meeting. We have set up our project plan. We have a project group in place and so that is moving forward.

Joanne McCartney (Chair): MOPAC has made the formal decision to transfer it to the NHS?

Dr Alison Frater (Head of Public Health Commissioning, NHS England): Yes, absolutely.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): That is a significant shift.

Marie Snelling (Director of IOM and Neighbourhoods, MOPAC): Stephen Greenhalgh [Deputy Mayor for Policing and Crime] committed to that and also that partnership that was referred to happened after the last Police and Crime Committee meeting and MOPAC sits on that ---

Joanne McCartney (Chair): That would have been one of our recommendations, I think.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): That is a significant shift. Can I make one other point which is quite important to this? Recommendation 16 refers particularly to technology and a central command centre, which clearly has an impact on people with mental health in crisis. It also has an impact on the whole police operation across the Metropolitan Police Service. What we have found is that, in the cases that we have looked at, there was an indication just that it was not fit for purpose in terms of giving the police appropriate information on the way to incidents and linking repeat incidents so that the police arrived with all the information they required. That is a more significant challenge because it will require, in my view, investment in that technology to make it state-of-the-art.

John Biggs (AM): You started talking about this and about the clunkiness of the technology. I know in my other capacity on the Budget Committee we have been looking at police technology and there is a lot of very clever stuff happening.

Christine Jones (Commander, Metropolitan Police Service): You will be aware of Command and Control (C&C) Futures. It is steaming down the track now. We are, obviously, as you will know, John, well engaged with the user requirement for it. That is the brand new C&C technology system that is coming to the Metropolitan Police Service, which I think frankly will revolutionise the way that we manage information.

John Biggs (AM): We can look very closely at that because the world is full of examples which have not quite worked as intended, but the intention is very clear, so that is all right. Have you adequately addressed the question about joined data sharing with the NHS?

Joanne McCartney (Chair): I think you said you have some terminals in custody centres as a pilot, but is there any other scope for data sharing?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): I suppose, from the point of view of trusts operationally - and we have talked about this with both Christine and Alison - actually, we ought to be agreeing now what data we look at jointly and validate it jointly. In my perfect world, maybe even in my imperfect world, I would put some joint resource in. Modest. It is probably half a post or something that we could jointly fund that would own the datasets that we want to look at. The partnership board will at any one time have a work programme of very practical, on-the-ground changes that we are trying to drive. That has to start with the right information so that we do not spend the first three to four months of any change we want to drive trying to find out what it is we are talking about and that we have systems in place that give us that information so we can act more quickly. To be honest, one of my tests as to whether joint data is being actively jointly collated and understood would be a joint resource that does that, even if it is existing people who come together as a little virtual team for half a day a week or a month. I do not think this is a big resource. It is about a

mindset that says, "This data is not helpful until or unless we can both validate it or agree that we cannot and then understand why". We can push this just a bit further in ways that will help us on the ground drive quick change, which is what we have begun doing.

John Biggs (AM): For the record, then, the Holy Grail is to collect data in passing as part our natural process of looking after people, rather than wrapping ourselves in bureaucracy?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): Yes, absolutely.

John Biggs (AM): We can justify everything we have done afterwards, yes?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): Absolutely.

Joanne McCartney (Chair): You have set up this joint project board looking at the transfer of health provision for people in custody. What is the timescale for that to actually take place? That is to the health here. What do you hope? Then, to Christine, I suppose, what has been happening with your existing bank of police nurses?

Christine Jones (Commander, Metropolitan Police Service): I will be perfectly frank with you, Joanne. I am not entirely sure of all the details. As I say, AC Byrne is leading this and, although I support him from the mental health side of the business, it is something I have no knowledge of that.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): To answer both of your questions, firstly, we are very keen to roll forward NHS commissioning of police custody suites as soon as possible. At the first meeting, we agreed how we are going to take this forward. We have set up an operational group. We are looking at commissioning intentions for 2014/15. We have looked at the map and the way the Metropolitan Police Service actually subdivides its police custody suites and we are very keen that we get some commissioning going in some areas and we do the learning as we take it forward. We are looking at 2014/15 for really beginning to make that transition and certainly by the 2015/16 commissioning we should be pretty much covering London.

In terms of addressing your question about the existing staff, clearly, that is part of the project plan. The Human Resources issues, communicating with those people, making sure that they come into employment through one of our trusts as a transition piece, making sure that the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) arrangements are all in place for securing their futures and that, actually, we do begin to bring them into the NHS family so there is much more skills training available to them and they are not free-floating privately-employed nurses who perhaps do not generally have a proper annual appraisal. We are trying to raise the standards and make sure that we do look after those people and bring them with us and that they link in more firmly.

Joanne McCartney (Chair): Have you given any thought as to what the --

Dr Alison Frater (Head of Public Health Commissioning, NHS England): Indeed, we did. In fact, I think the Prison Service, as Claire says, is a very good example. There is absolutely no doubt in my mind -

and I lived through all of the transition of NHS commissioning in the prisons - that we have raised the standards of care massively, the provision of care, the way it is linked in with the rest of the NHS, the care through the gate. Clearly, there are still some things we need to work on, but nevertheless it is all in there and the training and support for people in prisons and the skills and workplace development.

Joanne McCartney (Chair): Have you given any thought as to what the governance structure will be yet?

Dr Alison Frater (Head of Public Health Commissioning, NHS England): Absolutely, yes. The governance for the joint board that they referred to obviously will go up through AC Simon Byrne through the Metropolitan Police Service and have the governance through that element and then also through the NHS England senior management team. We also have a joint commissioning board for health in the justice investment strategy generally and when I took up post I was absolutely determined that we put that strategy into the Police and Crime Plan for London, so we are currently producing with Marie's [Snelling] team and with Diane Newton [MOPAC] a mental health in the police and crime strategy, but we have our joint commissioning board, which has all the partners on it, and in fact we have drawn the Mental Health Partnership Board into that governance structure and so we feel that we have developed hopefully clarity around governance, but also a governance approach that engages with all of the key stakeholders, and there are increasing numbers in our new NHS architecture.

Joanne McCartney (Chair): One of the criticisms that came out of custody and health last time was actually that inspection regime that takes place, because although now the Care Quality Commission (CQC) does some inspections with HMIC, the Force Medical Examiners (FME) we have heard from say there is really a lack of medical inspection at the same time. I am just wondering, given that this is now National Health Service, will that inspection framework have that medical inspection at the same time that custody in particular is being inspected, or is that something down the line that we need to think of?

Dr Alison Frater (Head of Public Health Commissioning, NHS England): It certainly would come under the rubric of medical inspection. I do not know whether David [Mellish] wants to say something about this, but the only other comment I wanted to make about that issue I think is another piece of the jigsaw here is the strategic clinical networks and the increasing focus in the NHS, particularly in commissioning, on clinical commissioning. We have set up two strategic clinical networks to support this work, one is around the strategic mental health clinical network, which sets standards, looks at workforce skills, development and training, and so on; that is their job. There is also a strategic clinical network that we have just appointed a clinical director to for vulnerable people, so including people in custodial settings. They are also extending that to other vulnerable people. I think we have really tried very hard to make sure that we have that professional standard and clinical underpinning for that work.

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): I hope that the really good illustration will be the concordat that has been referred to, it is signed by everybody, from Ministers downwards, including the CQC, the HMIC, the IPCC, they have all signed up to it. Unless there is regulation and oversight to my view it is not going to be worth the paper it is printed on and I think if there is that oversight by the CQC as far as health is concerned, by HMIC as far as the police are concerned, the similar bodies for social services and local authorities, it will happen if there is regulation, because if you are regulated and expected to something these things tend to happen. If you are not regulated and, yes, we all sign up to it fully with great intentions, over time it

somehow disappears into the ether, so I think there will be a lot more regulation holding people to account.

Caroline Pidgeon (Deputy Chair): I think we have touched on some of these that I was going to raise, but, Victor, since your report has come out, have you felt there has been any change in terms of interagency working and co-operation?

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): The level two, which is what I would expect, at the level two, a lot of the responses that you have heard have been at the level two, the strategic responses, administrative terms, which are necessary to prepare the ground for the critical level one responses, which, in the response by Dr Frater, clearly the pulling together of the team that is going to oversee the transfer and the commissioning of NHS services for the police, that is a key role. What you would expect as a result is key indication data, which says actually there are fewer people dying or being mistreated or whatever in police custody, but the improvement of care, which is measurable, has happened, and all that should be happening within a timeline, so you are moving to level one measurements as opposed to level two debate.

Yes, I am pleased that we are making the right movements, but I am a pragmatist, I want to see the level one indicators because actually one of the things that we found in doing this work is that there are an awful lot of meetings; what I am interested in is the output, the outcome, and the shift.

Caroline Pidgeon (Deputy Chair): So there are lots of good words and it feels like it is moving in the right way, it is the actual --

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): I think it is more than just words to be fair, I think to be fair to both Christine and Dr Frater it is more than just words, I am actually chairing the NHS England Parity of Esteem Board, so I have a responsibility to ensure that this happens, because it is a key parity of esteem issue, and I also think that [Dame] Barbara Hakin [Chief Operating Officer and Deputy Chief Executive at NHS England] who sits on the NHS England Board is also taking a keen interest in level one outcomes, so to be fair it is more than just talk, I think the work that is being done needs to be done, but you need to be thinking about level one.

Caroline Pidgeon (Deputy Chair): Yes, in 6-12 months seeing how we measure that, absolutely. Dave, we will come to in any case about the Mental Health Partnership Board, do you feel that is working? Are there other things? I think there was a recommendation that it should be given more strength in some ways in the report. How do you feel that it is working and are all the partners fully engaged in this and moving forward as Victor has indicated?

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): Can I answer that in a minute, just coming back to sort of agreeing with Victor on the level one side. It is a mix and match at the moment. There has been a lot of activity if you include policies around Section 136, agreed policies around that with the police and the health service, if you agree policies around absence without leave and if you agree policies that are being worked upon around

police attendance on acute wards, all that work is going on ahead, but there are other bigger issues, including in Victor's report that are still to be put in place, as we mentioned earlier on.

As far as the Mental Health Partnership Board is concerned, it arose originally from work conducted under NHS London around joint concerns by the police and the health service around the application of the Mental Health Act, not least section 136, not least the lack of data around that we have already referred to. From that concern, the Mental Health Partnership Board came into being around about 18 months ago and it was purely provider-led, so it was the police and the mental health services, social services, working together to try and resolve joint issues like 136 I have already referred to.

As soon as one lifts one's head and starts thinking about what does it mean in the future, what do we look like, you must involve commissioners and you must involve the Mayor's Office, so I am really delighted that over the last six months or so since Victor's report was published we are now heavily involved, NHS England, with Alison's department kind of oversees now the work of the Mental Health Partnership Board, the new commissioning board, the role of the partnership board is to feed into that new commissioning board what the priorities and actions are in relation to the policing and mental health across London. So we have that level and are now working on the level below the partnership board at a borough-based level or local level where the work of the partnership can be mirrored by the people who actually do the work and local issues can be resolved and local practices can be refined and reformed as necessary, and it only comes up to the partnership board if there are problems and individual agencies need to be held up to account.

The Mayor's Office is now involved, Diane Newton from MOPAC sits on the Mental Health Partnership Board, Victor and I have had a couple of meetings with the Deputy Mayor [for Policing and Crime], Stephen Greenhalgh, and Helen Bailey, the Chief Operating Officer [MOPAC], around this, and as a result of that Diane now sits on the board and in fact we are working with the Mayor's Office and NHS England around triage pilots, we are working with the police and the health service where nurses go out with the police and try and prevent 136 occasions happening in the first place, so it is kind of preventing, and I think that is a hugely positive way forward. I am very reassured, as far as the partners are concerned, certainly every meeting we get more and more people around the table if that is an indication, but the proof of the pudding is what has changed, what the outputs are, and what we are committed to doing starting in March is produce an annual report each year in March and the major recipients will be the Mayor's Office, the Scotland Yard, the NHS England, the Mental Health Service, to show what the partnership board has done in the last 12 months and what it hopes to do in the future 12 months.

Caroline Pidgeon (Deputy Chair): It does sound like everyone is engaging more.

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): I hope the difference will be is that we will be able to literally hold each other to account. We have all been here before where we have agreed everything and for all sorts of reasons it does not kind of happen and I think without a body like the partnership board or something similar where we can all sit around and work out what the common problems are and what the solutions are and then make sure that those solutions are implemented, we will kind of go round and round in circles. I think the Mental Health Partnership Board is seen as a good model and certainly in the concordat it said it was a good model so hopefully we will --

Caroline Pidgeon (Deputy Chair): OK, thank you.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): That is recommendation 22 and recommendation 20 done.

Christine Jones (Commander, Metropolitan Police Service): Just briefly in respect of triage, I just want to be clear, we are looking for the most effective and efficient and sustainable approach to triage in London, which may or may not reflect models that have been tried elsewhere in the country. We are trying to find something that works for London with London's demands and the spread of demand across London that is sustainable and we are working very closely with MOPAC to do that.

Caroline Pidgeon (Deputy Chair): Thank you. Claire, do you want to come in and maybe talk a little bit about how you see the relationship between the Metropolitan Police Service and mental health trusts in your sort of wider role?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): Just a few things on that, I suppose I come at this very much from a worm's eye view; I am looking at the thousands of practitioners, whether they are the police, the London Ambulance Service [LAS], social work or health staff, and obviously I mainly look at health staff, but those vital partnerships, and whether things are changing on the ground or not and what the big issues of the day are. They sit then under the partnership board as our work programme.

I guess I would say that relationships with the Metropolitan Police Service are actually very good I believe at a strategic level, so Christine and I have each other's mobiles, we were texting each other I think late Friday night and Saturday morning; I am acting on behalf of all of the mental health trusts so I can make quick contact with colleagues if there is something we need to move on quickly. I am absolutely cited on behalf of the trusts, Frankie [colleague], who is sitting here, Chris Borlay and [Chief Inspector] Dan Thorpe [Metroploitan Police Service] who I have not seen here, but I know who your [Commander Christine Jones] key team are and how to get things done; that is just a fact now; that is really good.

Each of the mental health trusts has, I believe the police call them SPOCs, but basically special points of contact, so there might be things that are not chief executive level issues that need to be picked up and acted on pretty quickly, but they might be our leads, so each of us now has a named lead who really has responsibility for driving both change in the trust but also being a day-to-day contact with the Metropolitan Police Service. I think that is a big step forward.

I think that on the first two pieces of work that we agreed to undertake through the programme board and in partnership with the Metropolitan Police Service, which was 136 and Absent Without Leave (AWOL), we are making real progress and that is progress we can count and evidence. I think, as ever, perhaps it is slower than we would have liked, but there are some really simple changes that we targeted as a priority that benefit patients primarily and use all of our time and expertise better. For example that would be, I think Victor's commission found this as well, that would be police picking up somebody on a Section 136, bringing them to a place of safety and being turned away because it is full. We have named this a practice that will simply stop; that places the onus in this instance on the NHS to ensure that never happens and to treat each occasion when that does happen as an incident that needs to be looked at, reviewed,

understood and changed. That is changing. We know that the incidence of that is decreasing but it needs to become a never-event.

One of the ways that we are achieving that is frankly through the protocol we have agreed, which is the police should phone ahead to the 136 Co-ordinator and say, "I have somebody here, can I bring them to you now, and, if not to you, where?" so that there is one journey. Obviously we hope in the future that it will not necessarily be the police bringing that person in, but the LAS, but there are some simpler things we are doing that are changing on the ground practically here and now, similarly with AWOL, people who go absent without leave.

I am really pleased at the progress we are making. My criticisms of us and the relationship thus far is that I think we do need to be absolutely clear about the key people, both on the police side and in health, who are going to be the operational team that both drive the changes, evaluate the changes, and troubleshoot if things go wrong. I think we are just about getting clear on that. We learned about Dan [Borlay] last week. I feel that we are almost at that point. I also feel that, because of huge changes in health commissioning in the last year that you are somewhat sighted on, it was difficult for a while for trusts to be able to find the route through to specialised commissioning to say, "How do we solve some of these bigger problems such as transportation or adult social workers?" or there are going to be a range of things, and that is also clarified now. We are much clearer about the knitting together, the oversight of what we do, but my main interest is what happens to patient services on the ground, frontline police officers who are doing their best to deal with them well, and health staff.

I do just want to say it is not all bad as well, if I might. If you listen to the media and everything you would be forgiven for thinking that all Section 136 patients are not in health but in the police cells, and that is true in some parts of the country, in London we have approximately 25 places of safety and health and of the 4,000 or 5,000 136s last year something like 50 were in police custody, so I feel that there is a lot that happens and works really well that we can build on, so I am feeling, being a chronic optimist, I am feeling very optimistic about this.

Can I just say one last thing, I am also a registered mental health nurse, and it is to pick up on a point made earlier. I am still a registered nurse, and I am in my 30th year of being one of those, and I used to work on acute wards and I want to pick up on this acute ward issue. There are lots of things that have grown up as custom and practice actually over decades; I think it is not that there have been sudden changes in health and now we are looking to the police to do our job for us. I think that there are practices that when I was a ward sister were in place even then, so this is decades of practices and issues that we are trying to tackle and change. The attendance of police on acute wards, for example, did happen 25 years ago when I was a ward sister and if you felt you had lost control of a patient and things were becoming very difficult the police would be very helpful.

Christine [Jones] and I have talked about this a great deal that we do want to move to a very clear point across London where the police are never called to attend in a ward, and it picks up on your point as well, unless there is real life and limb examples and there are - I can think during my very long career of where the police absolutely would still need to be called today we have had hostage situations of staff held at knifepoint of patients being threatened at knifepoint - situations that health staff sometimes need police backup for. I have talked to Christine at length about this, who assures me that her staff will continue to attend when we call. But we do need to do a piece of work over the next six months or so, which we have

agreed, that really understands why trusts call, when they call appropriately, when it is inappropriate, and if it means changes for how we behave in the NHS, maybe trust by trust, because I think Christine has pointed to variation, then we need to look to resource, training, culture, in whichever unit it is that is calling the police inappropriately. I think we have to be pretty challenging back to the police though if we call them and they do not come and there is an issue of safety, I am going to be speaking with Christine and saying, "What was this about?" but we will understand that together.

I think that there is a lot of real progress; my worry is about sustainability, Christine goes, I go, Dave goes, and you do not hear from a set of people in five years' time about all this great work we have been doing. I am running a busy trust, I have not put myself forward to lead on behalf of the trust not to make a difference in this arena that lives on beyond me and Christine, I think we have to have all that. Sorry, that was a very long answer, but there is a lot going on that has stimulated discussion among police on the ground, my staff on the ground, and that is a good sign, we are stimulating something.

Joanne McCartney (Chair): I think that continuity is vital.

I am just going to bring Victor in because I know you need to go and you have already stayed nearly half an hour past your time, so thank you for that, but I think you wanted to say a few words before you go.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): This is important, so I appreciate you giving me the time.

Only to repeat what I have said really, but I just feel so clearly about this and so passionately about it. There are certain key issues that must change, so the LAS must be commissioned to provide a crisis and emergency response to all Londoners including those with mental health crises, it is simply not acceptable to have anything else. We must have Section 136 suites, which are acceptable for human habitation. We might have enough but they are in poor quality, clearly. If you want to know what good looks like, have a look at what Goodmayes [Hospital, North East London Foundation Trust] are doing in terms of their suites.

I think we must have proper training of police officers and proper backup and support and leadership, which you can point at, which makes a difference, ie people with mental health problems are saying that they are getting an excellent service and they are not saying that at the moment.

While I agree that there is lots of good practice out there, when you have talked to well over a dozen families and people who have lost relatives in the most horrific circumstances, when you know that those people did not have to die, I think you must start there; that it is totally unacceptable that 55 deaths have occurred, 11 have been black African and African-Caribbean individuals; that is where we need to start. I make no apology at focusing on the bad news because I think it is the only way the good news gets any better. My view is it would be really helpful if your committee was able to focus on the level one responses.

Joanne McCartney (Chair): Thank you. Can I just give you assurance that we will follow this up and we will look at it after six months, after 12 months, and we will make sure it is on our radar in the forthcoming years as well.

Lord Victor Adebowale (Chair, Independent Commission into Mental Health and Policing and Chief Executive, Turning Point): If I can be of any assistance to you as you go forward. Thank you very much.

Joanne McCartney (Chair): Thank you. Actually we are coming on shortly to deal with two of those issues you raised, which is Section 136 and the London Ambulance Service, so we are going to bring those up in a minute, but just on the last section, I know Matilda wants to come in.

Matilda MacAttram (Director, Black Mental Health UK): Yes, I do welcome Claire Murdoch's points, I think they are really important, about the providers partnershipping and holding each other to account, and it is really good to see that at a national level and also at a local level, we do that at local authorities, mental health providers and the local police providers also have joint protocols and they hold each other to account, but what we see consistently. This also goes for MOPAC, I really appreciate the fact that they are partnershipping with this engagement with both NHS England and the Metropolitan Police Service, so it is consistent, but it also consistently excludes one voice, the voice of those who are over-represented in the system. It is good that you are holding each other to account but what we find is in the past when that happens is you can have conversations and you can smooth things over while sometimes it is important to maybe have another perspective, another focus. I just wanted to raise that point because there is a lot happening at a certain level and, unless the community are informed about it, it is going to be more of the same for them unless they see something more. That is just my point.

Joanne McCartney (Chair): It is about engaging throughout the process and Claire [Murdoch] is nodding her head, is that the intention?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): It is. I think Victor made the point earlier, because I think that is such a true point, we do need to challenge each other and you cannot have cosy relationships and it will not be a comfortable journey and that is important. We do need to work with communities and patient groups and the public on this as well. As foundation trusts, we have thousands of members and quite an elaborate user group, and we also have user governors and so on and so forth, so there is a big machinery there that we do try and mobilise as individual trusts around quality of service, what is it like for you. We all have huge mechanisms for getting regular feedback about urgent care, for example, and care in a crisis. I think the challenge for the [London Mental Health] Partnership Board that maybe we need to take back as an agenda item when we next meet in January is in addition to the mechanisms we all have, and that we have as well at specialised commissioning level, how does the partnership board itself perhaps have an accountability to and a challenge back from a stakeholder group that represents the people on the receiving end of those services really. Maybe that is something we could discuss because I think there is a lot of it that goes on in this context --

Matilda MacAttram (Director, Black Mental Health UK): The Metropolitan Police Service have their forum and it would just be good to see consistency because it is just very live in certain instances.

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): I think it really is a case of work in progress, I was trying to allude before, I think you have copies of the existing terms of reference for the [London] Mental Health Partnership Board; that is being changed and worked on as we talk because of the involvement there with NHS England and the Mayor's Office, so we are changing the terms of reference of that. Then also, as I mentioned before, we

are trying to put in a structure at kind of the local borough-based level. I think once we have finally determined the terms of reference, it is then what is absent around the table at the moment is stakeholder groups, and I think that is our big gap, and they need to have a voice and have an input into the work we are doing.

Jennette Arnold OBE (AM): Can I just say what I have just heard is one of the best bits I have heard so far because I was just getting a little bit concerned about the relationship between all the top-end thinking and strategising and meetings and the feedback from the user, from the relatives, whatever you call that stakeholder group, so thanks for putting that piece on the table there.

About the relationship with the LAS, Christine, when you started you gave us some good news about - can I use the word 'target' - about the LAS now agreeing to respond to a call within eight minutes. Can you just elaborate on that, so how would it work?

Christine Jones (Commander, Metropolitan Police Service): The issue around mental health and restraints, and I think it plays into the point Victor was making earlier on, which is there is a reason why people are dying as a result of this, and in my view there are two reasons, one is the failure to recognise the implications of restraining somebody who is in a mental health crisis, so failure to recognise the signs and symptoms of somebody who is going into physical crisis, and secondly then failing to access emergency medical care. In that simple framework, if you do not recognise that you have a critical clinical issue in front of you and service providers do not recognise that it is a clinical critical incident, then you are never going to get the right service and you are going to end up with unnecessary death.

What we have done is we have gone back to the LAS and said, "Look, when people are in mental health crisis, all of our research, all the work that Victor has done, our history, all the things that Matilda [MacAttram] talks about, tell us that somebody who is in mental health crisis who is restrained by police is in immediate risk of health crisis". Up until about February this year, we had no agreement with the LAS that they would recognise those conditions as therefore indicative of critical health issue. They now do, so the emergency response that they provide is their emergency eight-minute response.

The bigger issue of course is, do the LAS have the capacity and capability to deal with the demand across London more broadly? That is not an answer that I can provide for you, but what I will say is that as part of the work that we are doing through the clinical commissioning issues with Alison [Frater], through the Mental Health Partnership Board, we are looking at the capacity and capability of the London Ambulance Service to cope with the demands that mental health, the demands that normal clinical ill health, places upon them in London, and where is the role for police in all of that. Because I think until there is a sufficiently varied capability provided to the LAS to provide the different types of transport that people in different health crises or different health environments will need, and reasonably the LAS will say to you, if we have somebody in our care and control who is very aggressive, who is difficult to control, do they want to put that person in the back of a £300,000 ambulance for it then to be completely demolished? They have a point, but that does not mean to say that a police van is appropriate. That is the conversation that we are now having, so we have to look at what they are commissioned to do, how far that reaches into the diversity of transport provision that they can provide, and indeed what the mental health trusts want from them. I know that is something that Claire [Murdoch] is looking at.

We are not there yet but what I would say is that the issue around recognising that emergency condition that exists from mental health crisis plus restraint is absolutely firm, signed up to, and agreed, it is a medical emergency.

Jennette Arnold OBE (AM): OK, thank you for that. Can I just feed back to you, Christine, quickly, that I was up at London Bridge going home and the station was brought to a stop because there was a lady there who it was said was in a mental health crisis, but she was also under the influence of drink, and she was being very aggressive. But what stunned and pleased us all was that she was being talked to by the police officers and they were clearly waiting for something, and we did not know, and then they came over and said to us they could not take her away, they were waiting for the ambulance, so I do not know if that is part of the protocol?

Christine Jones (Commander, Metropolitan Police Service): It absolutely is, because my view is, just because you are mentally ill does not mean to say that you deserve less of a service from health partners than you do if you had broken your arm. Wherever possible, unless it is an absolute emergency, and this would apply across the board in terms of people who are physically ill, unless it is an absolute emergency and there is no other option then we will not take people with mental ill health in police vehicles, and nor should we. It is not right for the patient and it is not right for the public and it is certainly not right for the police officers, but there may be occasions when we have to and in which case under those circumstances we already have an agreement with LAS that if we have to transport in a police vehicle we will have a paramedic accompany us and that paramedic will continue to have oversight and responsibility for the ongoing health needs of that individual during their journey.

Jennette Arnold OBE (AM): Thank you very much. I have another question for you because a constituent emailed me and he said to me that he is a black gay man and he has mental health problems and he is concerned about the police officers that he meets. Unless they are his regular team, they absolutely have no regard for his mental health illnesses, they see him as a black man who is being aggressive and he is regularly arrested in the back of the police van, so in your training we have to be mindful of all the complexities that come with us as humans.

Christine Jones (Commander, Metropolitan Police Service): Absolutely, and that is the point, I do not think we have invested enough in teaching our officers to understand vulnerability. What we have said is, "You need to be trained in this, you need to be trained in this, you need to understand this risk assessment, you need to know …" No, actually, our officers need to know this, that is the primary issue for us, we need to understand the legal framework in which we operate and then the issue is how we understand the vulnerabilities and diverse needs of our communities and that is my issue. I do not think we have trained our officers effectively in recognising vulnerability. We have done lots and lots around race, we have done lots and lots around professionalising investigation, but actually the human piece around this is how we deal with people on a daily basis, how we recognise their different needs by understanding where they may be vulnerable, and to be perfectly honest the feedback that we have had from the communities in London around satisfaction has regularly told us, "The officer failed to recognise my vulnerability". We have the evidence there; we are now using it to fundamentally change that frontline training and, as I say, every single officer in London will have had that training by the end of next year and every single encounter we have with a member of the public they must apply that framework.

Jennette Arnold OBE (AM): That is great, and I do not wish that you do not become a commissioner, but I do hope you stay in your post for a while to get this done, because we get command fatigue and so there will be a petition, "Keep Christine Jones in her post".

Christine Jones (Commander, Metropolitan Police Service): Jennette, rest assured, I am absolutely committed to London and I am going nowhere.

Jennette Arnold OBE (AM): That is very good. Claire, we have heard this morning about the variable services on offer. Is it not the case that whenever you bring in new ways of working, new strategies, it tends to be the best that get better and the areas that really need change very little happens. How do you then focus on the areas that we know about? For instance you know that there are trusts or foundations that regularly call the police, and you know, like in the practice that we have heard of, that they do not. How do you focus these changes on the areas where the change needs to happen, rather than just the best practice getting to be even better? That is a key issue, is it not?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): Yes, it is, and there are high degrees of collaboration between the NHS mental health providers in London, but we are a competitive bunch as well, and I think that is a good thing because I do not know any of the trusts that do not want to be the best, and certainly I want mine to be. I think that it comes back to the data and information issue, because what happens too often, particularly around crisis, is that sometimes there is more heat than light and you put your attention where there is the most noise and that might not be where there is the biggest problem. Some of what we are absolutely trying to do in sharing that information is understand which trusts are inappropriately calling the Metropolitan Police Service the most? Let us then understand, is it certain wards or teams within that trust, or is it endemic. Actually you do not start to really solve and address problems unless you have good information, you know where the problem areas are, and you tackle them. I think there has been an absence of that.

Jennette Arnold OBE (AM): Is that part of the plan?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): It is absolutely part of the plan, is to share much more information around these basic things. The 136 work, for example, every quarter the LAS, the Metropolitan Police Service and the nine trusts have to give a very detailed update on the implementation of the plan. So, for example, we will know how many times - next time we get a report - did a trust send patients away who turned up on a 136, which trusts, is it all of us, is it some of us. My own trust has several places of safety across multiple London boroughs, so it might not be a trust issue, it might be a [London Borough of] Brent issue. I think information; well-informed information will help us act. We are a limited resource, all of us, we cannot just be scattergun, we have to go to where the issues are, the problems are, tackle those. The competition to be the best will run quite naturally anyway. I agree with you, it is tackle the problem areas, and help each other, do not just tackle, if there is an issue, I have been talking to Christine about one trust in particular that is an issue of concern right now, and I think that is my job as a fellow chief executive from a fellow trust to say, "Can I help?". I disagree slightly with Victor; I think you learn in two ways, from the problems and best practice, I think if you do both you can share the best practice and take that to the areas where there are problems, so I think we have to collaborate and help each other as well.

Jennette Arnold OBE (AM): Yes. The other issue that Victor raised was the quality of the standards of service provided. You talked about the quantity in terms of saying that the service is there, but he then made the point about the quality of the suites. Do you take that onboard?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): We have looked at the Section 136 work two ways as a partnership board, one is what can we do immediately here and now, what are the practices here and now that need to change, need to stop, and that is what we focused on, but the second piece of work that we have agreed, and we very much now hope the Commissioners will - we know they will - work alongside us, is thinking about do we have the right number of places of safety, are they in the right places, should we have fewer, which will have advantages and disadvantages, but should we have fewer, better-staffed, purpose-designed, more 24-hour, kind of a real body of resource and critical mass of resource. We do not know the answers to those questions because actually we should be talking to our communities, user groups, commissioners and others, about how we do it. That piece of work is on the agenda.

I would not say that it is my experience that current 136 resources are inhumane or quite as awful, but I think there is a spectrum and we should all be aiming at the kind of top end of quality of environment and so on and so forth. There is definitely work to be done. I think it is that --

Jennette Arnold OBE (AM): I suppose the test is the feedback from the users and people who go in there.

Alison, what evidence is there to suggest that the recent pilot scheme that aimed to keep people out of custodial settings and reduce demands on police time are working, eg street triage? What discussions are taking place regarding the London pilot? Can you answer that?

Dr Alison Frater (Head of Public Health Commissioning, NHS England): There is probably a sort of background piece around liaison and diversion schemes, which are about keeping people out of police custody suites and actually out of that mentally ill people in crisis grouping, and we are at the moment running I think 25 liaison and diversion schemes in 19 boroughs at the moment, but we are about to roll those forward into all boroughs across London. There were those schemes.

Just moving into the areas we were just talking about and actually I think it is about building capacity and resilience so that we are not just relying on ambulances to respond to people in crisis, but then we are looking at other kinds of schemes, I think the expression used was street triage, which I think we slightly think differently about it in London, do we not, and we are just about to launch our London pilot of thinking about how we will do that differently. I think at the moment it is slightly premature for us to announce exactly what we are going to do in London because my understanding is that we are just about to have a sort of formal announcement of that.

The notion really is about saying, shall we have alternative conveyancing, had there ought to be a set of taxis that take people home or take them back to the institution they have escaped from - thinking about the AWOL - or actually sort of involving nurses that will come out and actually support people and get them back into a place of safety working along with social workers and counsellors.

Jennette Arnold OBE (AM): Perhaps that prior to that you could send us embargoed information that would be worthwhile so that we can see that and understand it when it arrives.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): Absolutely, I mean I think the embargo is fairly sort of pending really.

Marie Snelling (Director of IOM and Neighbourhoods, MOPAC): I think it is just that the work is in development across a set of partners and the potential options and model will be coming forward in due course once that has happened, absolutely that can be shared.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): It is probably also important to observe that we are all working on jointly --- sort of MOPAC, NHS, provider.

Jennette Arnold OBE (AM): It is reasonable to say then that everybody is working to meet the recommendation that no person is transferred in a police van to a hospital and certainly not accompanied by the TSG.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): I think we are all very committed ---

Jennette Arnold OBE (AM): Love them as I do.
Jennette Arnold OBE (AM): There is an outstanding question here about MOPAC's bringing agencies together, but, Chair, can I suggest that it seems to me that is a whole big piece because there is so much that we have heard this morning, I am not sure that I could accept just a sort of couple of statements about how MOPAC is going to do that, and can I also suggest that it may well be something that we should be taking up with MOPAC directly?

Joanne McCartney (Chair): I think, Marie, you have, in those few sentences at the start, spelled out a little bit what you thought your role is, but perhaps if you would expand on that in writing to us that would be very helpful indeed.

Marie Snelling (Director of IOM and Neighbourhoods, MOPAC): Can I just add one further things, which I think Alison [Frater] referred to earlier, is that the whole of this work sits in a bigger piece that we are looking at in terms of health in the justice system much more broadly, which is not then just about mental health and it is not just about mental health and policing. It is actually looking at the whole of the criminal justice system and the way that health plays through I think in terms of our relationship with NHS England on that has been developing and I think there has been a really positive step forward in terms of looking at co-commissioning and actually where should investment be placed to drive best possible outcomes. There is something for us to think about, thinking about this piece of work and all of the things we have talked about this morning in a much broader piece around the role of health within criminal justice more broadly.

Joanne McCartney (Chair): Thank you.

I want to now ask some questions about section 136 and there have obviously been some high-profile cases not too long ago with regards to the use of this, and it is when people that have a mental health

issue that require immediate care or control can be detained under the Mental Health Act and in the past quite often the police have had to pick up the pieces and often people have been transferred into custody and therefore have entered the criminal justice world if you like when perhaps they shouldn't have done. We have heard a little bit about some of the work we are now looking at and some of the scoping, but what is the timescale you have for looking at your places of safety and do you have a plan with regards to it? Are you doing a London mapping exercise for example?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): Trusts are individually, all of us, looking at our places of safety and the quality of them as they stand, the 25 or 26 places of safety that exist now. It is also true to say the CQC are going to do a themed inspection of places of safety across the country at some point this year. I do not think, and if we have I am not aware of it, that we have set an absolute timetable on when does that bigger review take place, because what we will not do, I suspect, is look at the numbers of places of safety in isolation from almost hubs that are really well staffed that might not just be for 136 patients, but I am loathe to use the word 'crisis centres', but resource centres where we can do the 136 assessment work for individuals that require that, but actually something bigger, because emergencies and urgent referrals come into mental health services by a number of routes and I think if we are looking to do something bigger, 24-hour, maybe with more community involvement and so on and so forth, that is a major piece of work and I do not know whether Alison has, and I think we have to involve commissioners in that; that goes way beyond something that individual providers can just do unilaterally, I think it has to be about what model of crisis and urgent response work would we like.

It would also be fair to say that a number of the places of safety currently in London are in A&E [Accident and Emergency] departments. You do want some places of safety in A&E departments because it is often apparent that the person has a physical health as well as a mental health problem, they may have taken an overdose, you might need bloods, pathology, other screening, and you do not want to disadvantage the mentally ill person by not taking them to a hospital, but an awful lot of people probably do not need A&E departments as places of safety, so I think it needs a major rethink. I believe it is a hospital pass, but it is one of those, "We must do this", but it needs to get into a work programme.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): I think that is right and a very high proportion of people, vulnerable, ill, people in crisis, and the group we are talking about, are known to mental health services, and so I guess my instinct would be not to create a whole other treatment, therapeutic sort of hub for them, but to get them back into the services that ought to be looking after them. There is something about really understanding that piece better.

When we think about these issues, we have focused very much on this issue of Section 136 and ambulances, and actually what we do need is a bigger picture that actually talks about vulnerable people and begins to think about how we prevent them getting into the situation in the first place by making sure the services that are supporting them are actually doing it appropriately; prevention in its broadest context, so actually working with our public health teams and local authorities to think about those issues. Also, making sure that the services, when we actually doing crisis intervention, are very responsive in getting people back to where they need to be. There is more work.

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): We are looking across London at the urgent care pathway in mental health. There has been an

awful lot of work on the urgent care pathway London-wide in physical health. Maybe not here, but the stroke pathway work and all of that, there has been fantastic work that has changed the lives of Londoners and has saved lives in London because we have thought differently about that urgent care pathway. That urgent care pathway work does need to happen in London because, although I take Alison's point that the vast majority of patients are known to us who go into crisis, at any one point it could be up to 30% to 40% who are new to us as well.

Dr Alison Frater (Head of Public Health Commissioning, NHS England): There is a need, you know, we have talked about dual diagnosis and the issue of substance misuse and alcohol problems and so on, so we need to make sure we are providing a more integrated approach really.

Joanne McCartney (Chair): I think, Claire, that the central northwest undertook a review of Section 136 in January last year, so about two years ago now. Can I ask you, what was the findings of that, in particular in response to the barriers for change I suppose?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): We found that our own places of safety in five key London boroughs from Hillingdon down to Kensington and Chelsea, and other boroughs in between, we found that our own places of safety were all operating at very different standards, operating procedures, not a common standard to how even we as one trust were working with the Metropolitan Police Service and community around that, so I think one thing was - and a big lesson for us and it has definitely changed a year and a half on - was we should at least know what best practice looks like and have that commonly in place. I am not saying we are there uniformly, but that was one. The big issues are availability of Adult Mental Health Services (AMHS) social workers and that has not come up much today but that can be a block because in many boroughs, people may not know, but once you are on a Section 136 you can hold somebody for up to 72 hours. It would usually be really poor practice to hold them for 72 hours and the thrust is to get them assessed and on the right pathway within hours. One of the major blocks can be the availability of social workers out of hours who are key to that assessment, because often at night, out of hours, the emergency duty team for social work is covering children and adults, and that is a block.

Joanne McCartney (Chair): Are the local authorities represented on that partnership board?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): Yes, we have the local authority input there. I think in terms of Victor's list of things we just have to sort out, that has been a problem for years, we just have to sort it. I think LAS and conveyance and things like that is a problem, and we have talked about that and I do not see why it has to be ambulances always, I really do not, and I have some sympathy with an LAS that has to choose between someone having a heart attack and that £300,000 ambulance and somebody who at least has got, in this case, maybe the police with them. Who do you choose? I think we have to think creatively about a different way of transport that is better for the patient. I think that has been a problem really.

There is another point that I have of course forgotten, but will come back to me. There are blocks. Finally, community alternatives, being able to take people away from A&E, prevent them getting into places of safety in the first place, maybe doing more work that goes to the community centre or looking really creatively at prevention, as Alison said.

Joanne McCartney (Chair): OK. Jennette, do you want to come in quickly?

Jennette Arnold OBE (AM): Yes. I wanted just to reflect on what you have just said or what I have just heard. The issue is not an "or" it is an "and and and" surely, as Victor was saying, if we are going to be talking about parity of esteem.

A person experiencing a mental health crisis has a right and there should be every regard to their needs in the same way that there is an issue about somebody having a heart attack. I want to feel, if I have a sort of mental moment or go into crisis, that you are not going to be able to say through your criteria, "Oh, but there is somebody, John Biggs, is having a heart attack so he has parity over you". He surely shouldn't get that anyway.

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): Can I just be quite clear about what I mean there --

Jennette Arnold OBE (AM): Can you, because you re-frame that. It is "and and and".

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): It sort of is, so I suppose what I think is, over the years --

Jennette Arnold OBE (AM): Or are you speaking for the LAS maybe?

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): No, I am not, I am speaking for the patient, but it is my view that there is a systemic problem with thinking that fully kitted out ambulances designed for physical health are the right vehicles to send to mental health crises, and I suppose actually what I want is more ring-fenced, more bespoke, more tailored to the needs of the mentally ill or people who are vulnerable or in crisis, transport. I think that we will keep banging our heads against a wall that will leave people with mental health problems disadvantaged unless we actually look at a structurally different solution, because I think there is an inherent problem with the structural solution we have all been surprised does not work regularly, it is because the ambulance kitted out for a heart attack will go and look after someone with a heart attack who will die within 8 minutes or 30 minutes if they do not get there. I think we have simply failed to be creative and look at the needs of our patients and service users and send them the transport in a ring-fenced way, similar response times, but in appropriate transport, appropriate to the crisis they are facing, and so I am glad you have tackled me on that because if I leave any impression that it is not about parity of esteem, similar response times, then I would be very sad about that. I am saying we bang our heads against the wall, we have to be more creative, I have really come to that conclusion in recent years.

Matilda MacAttram (Director, Black Mental Health UK): I really appreciate the reference to inappropriate transport because it is a huge issue and I know I have mentioned it before but I just wanted to really have it on the record because we do know, and it is not the chief executives who are in the room, but we do know that there are providers who are commissioning caged vehicles. The CQC [Care Quality Commission] will tell you more about it.

Joanne McCartney (Chair): In London? Perhaps the [London Mental Health] Partnership Board could look at that.

Christine Jones (Commander, Metropolitan Police Service): I think this is a private ambulance contract, this is nothing to do with NHS England, it is nothing to do with the mental health trust, this is a private ambulance contract that is being offered and it has not been accepted.

Matilda MacAttram (Director, Black Mental Health UK): No, it is actually being used.

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): Which [NHS] trust, can I ask, because I will look into it?.

Matilda MacAttram (Director, Black Mental Health UK): I will email you, yes. Maybe I am incorrect, but my understanding is that it is being used at the moment; that is my understanding.

Joanne McCartney (Chair): If you can check that and let us know if that is the case. Perhaps, Marie, if you could take that up as well, because that would be a concern.

It has been suggested that Section 136 really does not work and that if, in the sense of taking things to police custody, and actually that if things do not change very quickly that one method of ensuring that people do not get taken into police custody is to actually remove police cells from the definition of a place of custody.

Claire Murdoch (Chief Executive Officer, Central and North West London NHS Foundation Trust): But there have been 50 cases out of 4,000 to 5,000 in the past year in London, to just give a sense of it.

Christine Jones (Commander, Metropolitan Police Service): I think it was 143,000 detainees between November 2011 and October 2012, 55 were Section 136 patients. I think the important point is that I think we should work to the presumption that a police station is never a place of safety unless there are such exceptional circumstances where somebody for example has committed an extremely violent crime, or some other reason why the criminal justice process must take over. I do think that the fact that we are commissioning the custody healthcare programme from NHS England will actually enable us to ensure that it will not matter if that person is in a police station because they will still receive the level of clinical care that they need. But in so far as 136 is concerned, you will find that, within the Metropolitan Police Service, we have a rigorous process already of looking at every single Section 136 submission because sometimes we do get difficulties between trusts and this is the whole point of the importance of the relationship and data sharing. But as far as the habitual use, it does not happen, and would not happen, and I would not allow it to happen, and I know that the Commissioner would absolutely be furious if he thought that there was any suggestion that we would start to change our views towards police cells being used as places of safety.

I think the other important thing to mention though here is that the concordat has made it really clear that simply because somebody has a comorbidity of either drugs or alcohol or that they are violent does not mean that they should go to a police station and I know that has happened in other areas of the country where there has been a kind of test agreement that if somebody is drunk or drugged or violent that the police will hang on to them until such time as they are safe to be deposited at places. That does not exist in London. Clearly there are issues around how we, the Metropolitan Police Service, interact with acute

trusts, how we make sure that the right circumstances are available to keep staff and the individual safe if they are violent or they are drugged or drunk, but the agreement nationally is that will not exclude people from places of safety for assessment under the Mental Health Act. Again, I think for the kind of last few cases outside of those extreme cases, but I think that will mean that our numbers drop to virtually nothing, but we will be monitoring that and, as I say, part of my daily activity is to see when and where and under what circumstances 136s are brought to custody, and I am not aware of any for, I can't remember how many months now, that have come into police stations at all.

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): My own view is the Committee should have some reassurance about the debate has now, in London, moved on to appropriateness of transport, not whether a police station should be used as a place of safety in the first place. That in itself is an advance and a huge improvement over the last 20 years I would suggest, and I think the whole process, I do not think there is a problem about what the police do and what the NHS response is, it is sort of local practices and habits that have grown up, like it is wrong, for instance, for the Metropolitan Police Service to take someone to a place of safety who has a serious physical injury - they should go to the A&E. It is wrong for NHS to say, "You cannot come in until we have the two approved doctors and the AMHS [Adult Mental Health Service Social Worker] and you sit in the van in the car park for five hours while we organise that". That is appalling. It is wrong for the NHS to turn around and say, "You cannot come in here because there is no beds", totally wrong. That is kind of what we are working on; it has moved up a notch since saying, "Dump everyone at the police station and work it out after that".

Tony Arbour (AM): For you, Christine, about the relationship between the Metropolitan Police Service and the LAS. You have said that ideally, if you were using a police vehicle, there will be a paramedic.

Christine Jones (Commander, Metropolitan Police Service): We have an agreement with LAS that, under the circumstances where we have to transport, then that person should be accompanied by a paramedic, yes.

Tony Arbour (AM): Tell me, how does the paramedic get there?

Christine Jones (Commander, Metropolitan Police Service): On a bike, motorbike, we have paramedic motorcycles across London, there are also double-crewed ambulances, so if the ambulance will not transport because it is unsuitable transportation then the person that would normally be in the back with the patient will be in the back of the police van. It still takes an ambulance off the road, so I am not describing to you anything that is perfect, Tony, but what I am describing is that at the moment during our transition between, this is where we have been for god knows how many years, this is where we are going to get to. We have some measures in place along the way that make the vulnerable, and frightened probably, member of the public who is having to receive this service at least physically safe between the point that they encounter police and the point at which they access either emergency --

Tony Arbour (AM): Sure, sure, sure, I understand all of that. Is it happening? You say you have this agreement with them; does it now happen? Because we have stuff here in these reports, which says that the ambulance service is not willing to respond if the police are there and that the police very reluctantly, and I have read all this stuff, they have to make a separate 999 call, I would have thought they would do it

through their own communicators, to get through to the ambulance service to get an ambulance there. Is that happening?

Christine Jones (Commander, Metropolitan Police Service): It was earlier on in the year but Maxine de Brunner [Commander, Metropolitan Police Service] has been leading an awful lot of work between Central Communications Command and LAS and we are kind of moving away from that. I think the bigger issue though, Tony, to be perfectly honest with you, is the demands on the LAS and how they are met and much as we want to move to the world where under no circumstances will police transport ever be used for anybody who needed physical or mental health treatment, the fact is that we still take people to hospital who have been stabbed because if they are in urgent need of help and there is no ambulance available we will get them to hospital in any way we can. That practice around physical ill health has happened in the Metropolitan Police Service for many years, you probably recall there used to be instructions that even in extremes we would not take people with head injuries in police vehicles because of the propensity for those to be so significant, but we have always had fall-back plans in case we have had to transport people.

I think with the Mental Health Act that has no longer been a fall-back plan; that has been the role of the police. We are on a journey and all I can tell you is that the agreements are in place and the understanding is in place. The practical and tactical application of that is never going to be perfect, but we have a recording mechanism so that every day I will find out from my staff through the central mental health team if and when we have had to transport somebody in mental health crisis, most particularly somebody who has been restrained, because that is the highest risk to them, to the member of the public, and obviously to the confidence of people in London with the Metropolitan Police Service. Those are the bits that I am really focused on.

As I say, we have a journey that we are on, and we are on it with partners, and this is not as if it is the Metropolitan Police Service standing alone again saying, "We do not feel we should be doing this", actually all the partners across the whole spectrum, as is evidenced by the concordat, absolutely agree that there needs to be parity of esteem in mental health and we are on a journey to get there. The LAS are part of the Mental Health Partnership Board and, as I say, they have already responded very quickly to a recognition that mental health plus restraint equals a clinical emergency and will respond to it as a clinical emergency, but the fact is LAS have a tremendously difficult job to do in London and I think we would still have to recognise that there are going to be times when we have to step in and we have to do that safely.

Joanne McCartney (Chair): I think it would be useful if you could, after the meeting, give us some indication of how many were happening before and what has happened since the concordat?

Christine Jones (Commander, Metropolitan Police Service): We can get that from our central command.

Joanne McCartney (Chair): That would be very helpful. Do you keep records of whether a paramedic has actually accompanied?

Christine Jones (Commander, Metropolitan Police Service): I am not sure we go to that degree to be honest. What I can tell you is that we have had no unsafe transport in the meantime, so there has been no serious injury following police contact, there has been no clinical emergency following police contact

and so there is nothing at the moment that says that our processes are not working. However, you know as well as I do, we are only as good as the job that we do today.

Joanne McCartney (Chair): Can I thank you all for coming? Could I say, we perhaps have not asked all the questions you wanted us to ask, so if there is anything you are dying to tell us please do contact us after this meeting.

Before you leave, Dave, can I ask, are your partnership board minutes going to be made public?

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): Yes, is the answer to that.

Joanne McCartney (Chair): It would be great if you could add us to your stakeholder list as well I think so we can get regularly updated; that would be very good.

Dave Mellish (Chairman, Oxleas NHS Foundation Trust and Chair of London Mental Health Partnership Board): Thank you, yes.

Joanne McCartney (Chair): OK, so can I thank you all for coming today. Thank you.