ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Association of Ambulance Chief Executives

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Steve Brine MP
Chair, Health and Social Care Committee
House of Commons
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Dear Mr Brine

Re: Right care, right person national partnership agreement

Thank you for your letter of 28 December 2023 inviting comment about the implications for ambulance services of the roll out by the police of right care, right person (RCRP) under the national partnership agreement (NPA).

The Association of Ambulance Chief Executives (AACE) has a well-established, strong working relationship with the National Police Chiefs' Association (NPCC) and has over recent months remained in close, regular contact with senior police officers leading the national co-ordination of RCRP. We are broadly supportive of the fundamental principles of RCRP and - as part of national level meetings involving a range of bodies including the NPCC, Department of Health and Social Care (DHSC), NHS England (NHSE) and others - we helped shape the NPA prior to its publication in July 2023. Subsequently we have had the opportunity to influence guidance drafted separately by NHSE and the College of Policing (CoP) designed to underpin the NPA.

Throughout our engagement we have found national partners to be receptive to our feedback and concerns and they have readily amended the NPA and guidance to address those issues we have raised. We feel that the NPA navigates the difficult and complex issues raised by the RCRP with appropriate sensitivity and with due regard for the attendant risks. Were all police forces to implement the RCRP in line with the principles of the NPA, whilst the roll out would no doubt be challenging, we would be assured that the risks were likely to be well managed. Unfortunately, the feedback we have received from ambulance services suggests that the spirit of the NPA is often not being adhered to by police forces in terms of pace of implementation which raises significant safety concerns.

Key concerns that we would wish to highlight to the committee are:

1. **Timescales for implementation:** The NPA states that: 'It is crucial that at the heart of planning and implementing RCRP for people with mental health needs, there is a focus on ensuring patient safety is maintained and people in mental health crisis are not left without support…' and goes on to state that: 'While police forces will ultimately determine the timeframe for implementing the RCRP approach locally, it should be established following engagement with health, social care and other relevant partners…'

   Feedback we have received from ambulance trusts indicates that timescales for implementation of RCRP are often 'set' by the police rather than 'agreed' following meaningful engagement with partners. We understand the need for police forces to feel assured that RCRP is being progressed by health partners with drive and momentum, but the findings from the Humberside model were very clear about the central importance of partnership working and taking time to agree local responses.

   What we have seen in other parts of the country is that RCRP has been implemented (or RCRP type behaviours have emerged ahead of formal implementation) before health systems have managed to build capacity to manage the demand transferred from the Police. In most areas where RCRP roll out has commenced the initial impact has related to 'concern for welfare calls' and patients who have left healthcare facilities (often referred to as patients absent without leave). Most areas have not yet experienced the more significant impact of police reducing their attendance to mental health incidents.

2. **Consistency of application:** We understand the clear position from colleagues in the NPCC and HO in respect of Chief Constables retaining operational independence and that police forces may therefore choose to roll out RCRP in different ways. The challenge for ambulance services is that they typically have four or more police forces within their own operational footprint all of whom may settle on differing RCRP models. Whilst it is understood that there will always be a degree of local variation to suit genuinely differing local systems, there is a risk of unwarranted variation between police force practices that could lead to operational inefficiency. We would welcome any steps that the police can take to improve consistency between police forces' application of RCRP which we think would improve the effectiveness of the model.

3. **Concern for welfare:** Whilst most discussion of RCRP tends to focus on the mental health component, under RCRP police forces have also reduced their attendance to calls from the public relating to a general concern for the welfare of friends, relatives or neighbours unless those calls meet the RCRP threshold (to investigate crime or where there is an immediate risk to life/risk of serious harm). In some instances, there appears to have been an assumption made by police forces that ambulance services would fill the capacity gap left by their reduced attendance to these incidents.

   Calls are judged on a case-by-case basis and of course some welfare calls would merit an ambulance response. But there are calls relating to a general concern for welfare that would meet neither the police threshold for attendance or ambulance threshold for attendance – calls where there is no known medical emergency or evidence of a patient being present at all. We are clear that it would be in nobody's interest if inappropriate police demand becomes inappropriate ambulance demand (and we are grateful to the NPCC for their support of this position). It would not be appropriate use of resources to send a front-line ambulance to respond to a general concern for welfare in the context of ambulance services managing queues of confirmed medical emergencies (that definitely do require an ambulance) and while experiencing extended response times delays to confirmed Category 2 emergencies (including conditions such as strokes and chest pains.)

This is a gap in provision that will need to be resolved locally and may require the commissioning of new solutions. We feel this is a significant 'grey area' that has hitherto been overlooked and – returning to our comments about timescales – it is a grey area that should be addressed by local partners before – not after – the police stop responding to these incidents. To date this is the single biggest feedback theme we have heard from ambulance services with some control room staff describing feeling like they're in a 'high-stakes game of chicken' where the police have refused to attend and told the caller to hang up, redial 999 and ask for an ambulance.

4. **Failure by the police to attend when required:** We are concerned by reports from ambulance services of occasions where the police have not attended incidents when requested to provide support that have subsequently resulted in patient harm or ambulance clinicians being assaulted. These are incidents that would appear to meet the RCRP threshold for police attendance. Our national level partners in the police have been absolutely clear that under RCRP police forces should still attend incidents under these circumstances; we welcome Humberside Chief Constable Paul Anderson's unequivocal evidence to your committee on this issue.

   But feedback from other areas suggests that there may be excessive over-application of RCRP in some police forces. Feedback from one ambulance service indicates that since March 2023 staff have raised concern in relation to 160 incidents citing RCRP as a factor with 33 incidents involving some degree of harm. The same ambulance service has been involved in eight Coroner's inquests concerning incidents where RCRP has been applied (and the Coroner has raised significant concerns about gaps in service provision relating to welfare calls).

5. **Scale of transferred mental health related demand:** Due to the absence of a full multi-agency evaluation and impact assessment of RCRP prior to initiating a national roll out, it is very difficult to anticipate what additional demand ambulance services should expect. In most cases police forces have not been able to quantify reliably the demand that they expect to transfer to ambulance services. We expect the impact to be significant and not at a level that can be absorbed.

   Whilst ambulance services were invited by NHSE to bid some time ago for specialist mental health response vehicles (MHRV), those vehicles have yet to arrive and in many cases, commissioners have not committed to the additional revenue costs to pay for the additional staff to necessary to crew them. In addition, bids by ambulance services for MHRV capacity pre-dated general awareness of the existence of RCRP in Humberside, and pre-dates any indication that the scheme would be picked up for national roll out. The net effect is that - while the inbound MHRVs offer part of the solution to improving the ambulance response to mental health incidents - additional resources will be required to address the transferred demand expected when the police reduce their attendance under phase four of RCRP.

   Early data from London Ambulance Service (LAS) suggests that since the introduction of RCRP by the Metropolitan Police Service (MPS) they are receiving each day an additional 200-250 transferred incidents after the police call handlers have screened out people who have neither a police or a healthcare need using a set of questions they agreed with LAS. These are triaged by LAS 999 call handlers and either responded to through their 999 resources or redirected to 111 where appropriate (a situation made possible only because LAS are also 111 service providers). Nearly all of these people do legitimately have a healthcare need and the NHS is better placed to meet this than the police were, but most of the patients did not need an emergency ambulance.

In addition, since the roll out of RCRP, the LAS believe that they are receiving circa 400 incidents per month relating to concerns for welfare originating from healthcare professionals (often referred to as patients absent without leave). These incidents aren't easily triaged and are often calls that do not require a frontline ambulance response. The LAS are working closely with NHSE regional team, hospital trusts and mental health trusts to agree the actions they should take prior to calling on another agency to respond. But nationally it is of concern to us at AACE that ambulance services are seen as the new 'default' response which speaks to our message that it serves nobody if what was undoubtedly inappropriate police demand becomes inappropriate ambulance demand.

The MPS have not yet stopped transportation of all S136 patients – something that is programmed after the LAS receive their MHRVs in April. LAS anticipate that half of the MHRVs will be required to complete their existing mental health related workload with the other half being allocated to the anticipated transferred demand from the MPS.

LAS anticipate that the additional revenue cost of all these elements will be £4.7 million for 2024/25 with a full year effect of £6.8 million in 2025/26. As yet, this new activity is unfunded by ICBs and to be fair to them they have received no additional funding to reflect the transfer of work from the police.

We are not able to extrapolate from the LAS estimates full national cost implications for ambulance services arising from the roll out of RCRP, but the LAS data indicates that the investment needed to maintain public safety for this vulnerable group of patients will be significant.

As the evidence your committee has already heard makes clear, RCRP was conceived as a local intervention in Humberside which is broadly coterminous with one of the five operational areas within Yorkshire Ambulance Service (YAS). For the ambulance service, management engagement would have principally been conducted at this local level. There was no early indication that RCRP might in the future form the basis of a national strategy that would be promoted by the NPCC, the Home Office (HO) and the DHSC.

For the removal of doubt, we imply no criticism of the multi-agency partners in Humberside who worked together on what they designed as an intervention for local implementation, within their own boundaries, and under their own shared governance arrangements. But at the point that it was identified and promoted as the basis for a national roll out programme, the absence of any apparent multi-agency evaluation and impact assessment was a significant omission meaning that many agencies – ambulance services included – are now 'flying blind' in terms of new demand arising from RCRP.

We are surprised that such a significant system change - with such clear risks for some of the most vulnerable people in society – has gained so much momentum in the absence of a full understanding of the impact. But in this context, it becomes even more important for police forces to implement RCRP in line with the principles of the NPA, in a true spirit of partnership, in a way that enables health systems to build the capacity needed to ensure the continuity of public safety.

It is crucial that ICBs take a proactive lead role in co-ordinating and mapping the response of the local health system to the arrival of RCRP and there must be an honest, clear-eyed assessment of the additional investment required for ambulance services and other health partners.

For our part, we will continue to work closely with the NPCC, CoP, DHSC, HO, NHSE and other health and social care partners to support the safe and effective roll out of RCRP. It's the right thing to do for patients and the police have for too long plugged a gap in care. As this letter hopefully makes clear, our concerns are about how RCRP is rolled out – and how it's funded - not if it should be rolled out.

Yours sincerely

DAREN MOCHRIE QAM, MBA, Hon.DHC, Dip IMC RCSEd, MCPara
Chair