HEDDLU
GOGLEDD CYMRU
NORTH WALES
POLICE

Response Date:19/08/2025

2025/841 - Right Care, Right Person (RCRP)

In response to your recent request for information regarding;

1. The date (or timeframe) when the police force began implementing Right Care, Right Person (RCRP)

- RCRP Phase 1 – Welfare Checks – 15th Jan 2024
- RCRP Phase 2 – Walkout of health care and AWOL from mental health establishments – 7th October 2024

2. Any reports, assessments or data – internal or published – where the police force has monitored the implementation and impact of RCRP, including in relation to other services

As attached, external report completed at the end of year one.

THIS INFORMATION HAS BEEN PROVIDED IN RESPONSE TO A REQUEST UNDER THE FREEDOM OF INFORMATION ACT 2000, AND IS CORRECT AS AT 13/08/2025

Right Care, Right Person 2024 - 2025

A review of the first 12 months in North Wales

The Right Care, Right Person (RCRP) framework is a strategic approach designed to ensure that individuals in our community receive the most appropriate care from the right professionals.

The framework aims to reduce the inappropriate involvement of police in situations where other services, such as health or social care, would be more suitable.

Key points of the RCRP framework include:

- Timely Access to Support: Ensuring people in mental health crisis get compassionate and appropriate support quickly.
- Appropriate Agency Response: Police involvement is limited to situations where there is an immediate risk to life, or a crime is involved.
- Partnerships: Strong collaboration between police forces, health, and local authorities to implement the approach effectively.

This report will focus on the two phases of RCRP that are live in North Wales, namely :-

- **Phase 1** – Concern for welfare – implemented on the 15th January 2024
- **Phase 2** – Walk out of health care & AWOL mental health patients – implemented on the 7th October 2024

Understanding the demand

Consultation with partners in regard to both phases commenced mid-2023. A crucial part of this initial contact was setting partner expectation in relation to any additional demand that might be placed upon them when the framework was introduced.

It was apparent that most calls that would satisfy the definition of an RCRP incident were found in the "concern for safety" category of reports made to the police. A category that was surprisingly consistent when viewed over longer time frames. This gave a high level of confidence in relation to call volume and the nature of those calls, we were then able to use that data to gain an understanding of what demand would be retained (as our legal obligations were met) and what would be declined. It was therefore reassuring that when mapped over a typical non-covid year, the demand that would be declined was only equivalent to 7.9 incidents per day, or 2884 per year. It was anticipated that around 4 of these incidents would fall to the ambulance service, and the rest distributed to health and local authority partners. It was evident that when this information was presented to partner agencies there was relief, as it was apparent their expectations were far worse.

Its worthy of note at this point that it was decided early on that at no point would we simply decline service and terminate the call. Control room staff would always be in a position to advise the caller as to who the most appropriate agency would be and the reasons why, also providing the caller with phone numbers, email addresses and links to websites of organisations that could support them. This helping the caller to make more informed choices in the future and reduce repeat demand on control room staff. This was critical as it was evident that the default position for most callers was simply to call the police without really understanding what the police responsibilities were or any real appreciation of who should be dealing with medical, mental health and social care incidents in the community.

Monitoring

Throughout the initial 12 months of RCRP phase 1 NWP continued to engage with partners and report to both regional and national monitoring groups, it was apparent that NWP were the first force to implement the RCRP framework in Wales and so were under close scrutiny. At this point it would be right to congratulate partners in the way that they had engaged and prepared for any changes to internal processes, although there were some initial concerns from senior management and directors. The practitioners who would be affected by this change of process were entirely supportive, recognising that the ultimate priority here would be members of the community. Health colleagues (both WAST and Betsi) were exceptionally supportive at all levels understanding that this was an opportunity to make some meaningful changes in our community and introduce new ways of working. I can't thank them enough.

Reduction in demand

In the time since implementation, I have been monitoring demand closely. I was keen to ensure that the predictions made early on were accurate and I wanted to be able to identify any emerging issues before they became a crisis, no such concerns were raised, all partners continued to function as effectively as the pre-implantation position.

In the first twelve months demand from all partners combined reduced by 9.6%. A positive indication in itself, and would suggest that calls for service had reduced, likely in the knowledge that the RCRP threshold was not met and that organisations were empowering their staff to manage their own risk and duties of care. In the same period Ambulance demand relevant to RCRP fell by 11%.

Local authority demand is in itself harder to isolate given that numerous individuals could potentially contact the police and from various departments and numbers, however I am able to count contact as "other agency demand" and so I remain confident that this demand also fell in line with the overall partners demands (9.6%)

Specifically looking now at Hospital demand, this captured in the phase 2 work. Monitoring started in July 2024 at the same time changes were made to the health boards missing patient protocols. This allowed for more closer alignment to the RCRP framework. Education and engagement with staff also commenced in earnest, this included a weekly monitoring group with senior health colleagues.

Thereafter we soon began to see reductions across the region and this put us in a good position to introduce the RCRP threshold in October 2024. To date combined demand from absconded patients is down by 45%, also of note in the week 15th – 22nd January 2024 NWP had a 100% deployment rate to calls from hospital sites. This implying that all call for service were appropriately made, the first time this has been achieved since we began to monitor demand. Further demonstration if needed of the way that the health board have supported these principles.

Looking now at the total calls for service made. The number of RCRP relevant incidents identified by police staff in the 12 months since implementation was 5422. Of that 1709 decisions were made to attend the incident, a 31.5% deployment rate. This would suggest that 68.5% of all calls for service were declined, a total of 3713 incidents in12 months, equivalent to 10 incidents a day.

You will note that this figure is then higher than predicted (7.9 incidents). So, were partners expectations misled? No… this is not the case. A crucial part of the preimplantation demand review also focused on the calls that were already being declined prior to the RCRP framework. This indicated that already 1 in 4 calls made to the police were not physically attended, these calls were generally outlandish incidents made in the main by members of the public, and occasionally partners… when it was obvious even without the defined framework that it was not a police matter.

Therefore, before providing a figure to partners this demand was removed as it was demand they already experienced. Therefore, only new demand was factored in.

When this figure is taken into account the declined demand is 2358 incidents, equivalent to 6.4 incidents a day, less than that was anticipated, but still comfortably close to the initial estimate.

I feel that there is one stand out reason for this minor discrepancy. The autonomy awarded to control room staff to be able to accept an incident when a call is received from a member of the public and it is apparent that they have no realistic alternatives for help.

In such cases discretion could still be applied and officers may respond. I see this most often with elderly fallers who are conscious and breathing and simply need help, officers have responded to a number of these request, I concede that this is not a sustainable position and a permanent solution needs to be sought, but I'm comfortable that discretion is exercised to support the public at times, even if there is no legal obligation and it's just the right thing to do.

Organisational benefits

Focusing briefly on what this means for North Wales Police. 2358 non-deployed incidents are equivalent to 10 thousand hours of officer time saved, and this from only the first twelve months of implementation.

This is time that can be reinvested protecting our communities and supporting victims. As a partner agency you have assisted us in achieving this and I thank you.

In conclusion, the landscape in North Wales has changed in the past year, I feel organisations who manage risk and own a duty of care to the public are far more comfortable managing that risk themselves than they have been in the past.

I see significant changes to local process, organisations becoming self-sufficient but with clear plans to escalate when a genuine situation arises. This in stark contrast to the previous culture of "organisational anxiety" and often that impulsive need to inform the police "just in case", the police also guilty of accepting that risk... "just in case".... However, this was an unsustainable approach and put organisations and the public at risk.

A person in mental health crisis needs the support of a mental health professional and appropriately trained health colleagues, and rarely, if at all, a police officer in body armour carrying a taser. I think we now recognise this for the good of our community and I hope we continue to work together in this positive direction.

North Wales Police have health staff embedded in the force control room, demonstrating a clear partnership approach to delivering the best quality of service in our communities.