NHS
South East Coast
Ambulance Service
NHS Foundation Trust

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Internal Ref: 250718
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Dear

The trust acknowledges receipt of your Freedom of Information Act 2000 (FOIA) request, referenced above. Please ensure you quote this number in any future correspondence.

FOI Request

You asked us:

1. Please tell me how many patient safety incidents linked to the Right Care, Right Person policy (adopted by police forces in partnership with health services towards mental health incidents) have been reported by the trust in each of the following years:
a) 2025/26 to date b) 2024/25 c) 2023/24

2. Please tell me how many deaths linked to the Right Care, Right Person policy (adopted by police forces in partnership with health services towards mental health incidents) have been reported by the trust in each of the following years:
a) 2025/26 to date b) 2024/25 c) 2023/24

3. Please tell me how many patient safety incidents have been reported by the trust related to calls not being given a face-to-face response for each of the following years:
a) 2025/26 to date b) 2024/25 c) 2023/24

4. Please tell me how many deaths have been reported by the trust related to calls not being given a face-to-face response for each of the following years:
a) 2025/26 to date b) 2024/25 c) 2023/24

5. Please tell me if the trust has a policy for times of high demand in which ambulances are only sent to the highest priority incidents eg a no-send policy? If yes, please provide a link or short description of the policy.

6. If yes to question 5, please tell me how many times this policy has been used in each of the following years:
a) 2025/26 to date b) 2024/25 c) 2023/24

Formal Response

The Trust confirms it holds part of the information you have requested.

* Data blurring at less-than-5: The Trust can confirm that this information exists. However, where an output represents fewer than 5 individuals or incidents in the period requested, we have not provided exact figures. This practice is known as data blurring, which serves to mitigate against the risk of possible re-identification of individual data subjects via data recombination (sometimes referred to as jigsawing). This risk is assessed in accordance with the Information Commissioner's Office (ICO) *Anonymisation Code of Practice*.

1. Please tell me how many patient safety incidents linked to the Right Care, Right Person policy (adopted by police forces in partnership with health services towards mental health incidents) have been reported by the trust in each of the following years: a) 2025/26 to date b) 2024/25 c) 2023/24

A retrospective search of our incident reporting system (DCIQ) was conducted, to identify patient safety incidents associated with the Right Care, Right Person (RCRP) policy. Staff ordinarily reference this policy in incident reports using either the phrase "Right Care Right Person" or the acronym "RCRP" within the free-text fields.

To ensure comprehensive identification, the search included both RCRP and Right Care Right Person keywords. Additionally, where incidents are reviewed through our incident review groups, we may retrospectively apply tracking keywords – one of which is "Right Care, Right Person."

Duplicates across these data sources were removed to ensure accuracy. The following numbers of patient-related incident reports were identified by calendar year:

2023:	0 incidents
2024:	27 incidents
2025 (to date):	20 incidents

Please note this output reflects only those incidents explicitly referencing the RCRP policy and do not capture cases where the terminology was not used in the report.

2. Please tell me how many deaths linked to the Right Care, Right Person policy (adopted by police forces in partnership with health services towards mental health incidents) have been reported by the trust in each of the following years: a) 2025/26 to date b) 2024/25 c) 2023/24

Where harm is suspected to have occurred to a patient, incidents are reviewed by our incident review groups to assess the nature of the harm and determine whether a learning response should be commissioned under the National Patient Safety Incident Response Framework (PSIRF).

Incidents taken through this process are tracked using specific keywords, one of which is "Right Care, Right Person." A review of PSIRF incidents categorised as

potentially resulting in fatal harm (previously referred to as “death”) was conducted, focusing on those explicitly linked to the RCRP policy.

The following numbers of fatal harm incidents relating to RCRP were identified for each calendar year:

2023:	0 incidents
2024:	0 incidents
2025 (to date):	0 incidents

Please note this output reflects only incidents where the RCRP policy was explicitly referenced, and following review the level of harm was categorised as fatal harm (previously death). Incidents not using this terminology are not captured in this count.

Furthermore, a review of the referenced data sets by our Quality Team was able to identify any cases where patients were reported to have died, where RCRP was referenced as a potential issue in the incident report:

2023:	0 deaths
2024:	*Number less than 5.
2025 (to date):	*Number less than 5.

Please note the 2024 and 2025 cases remain under investigation.

3. Please tell me how many patient safety incidents have been reported by the trust related to calls not being given a face-to-face response for each of the following years: a) 2025/26 to date b) 2024/25 c) 2023/24

Following a review of reported patient safety incidents associated with the Right Care, Right Person (RCRP) policy, we identified a subset of incidents where concerns were raised regarding the absence of a face-to-face response for the patient.

The following numbers of such incidents were identified for each calendar year:

2023:	0 incidents
2024:	5 incidents
2025 (to date):	*Number less than 5.

Please note this output reflects only those incidents explicitly referencing the RCRP policy and specifically noting concerns about the lack of a face-to-face response. Incidents where this concern was not documented are not captured in this count.

4. Please tell me how many deaths have been reported by the trust related to calls not being given a face-to-face response for each of the following years: a) 2025/26 to date b) 2024/25 c) 2023/24

Where CQC notifiable levels of harm (Fatal/Death) are suspected to have occurred to a patient, incidents are reviewed by our incident review groups to assess the nature of the harm and determine whether a learning response should be commissioned under the National Patient Safety Incident Response Framework (PSIRF).

Incidents taken through this process are tracked using specific keywords, one of which is “Right Care, Right Person.” A review of PSIRF incidents categorised as potentially resulting in fatal harm (previously death) was conducted, focusing on those explicitly linked to the RCRP policy.

The following numbers of fatal harm incidents relating to RCRP were identified for each calendar year:

2023:	0 incidents
2024:	0 incidents
2025 (to date):	0 incidents

Please note this output reflects only incidents where the RCRP policy was explicitly referenced, and following review the level of harm was categorised as fatal harm (previously death). Incidents not using this terminology are not captured in this count.

Furthermore, a review of the referenced data sets by our Quality Team was able to identify any cases where patients were reported to have died, where RCRP was referenced as a potential issue in the incident report:

2023:	0 deaths
2024:	*Number less than 5.
2025 (to date):	0 deaths

Please note the 2024 cases remain under investigation.

5. Please tell me if the trust has a policy for times of high demand in which ambulances are only sent to the highest priority incidents eg a no-send policy? If yes, please provide a link or short description of the policy.

The Trust does not have a distinct ‘No Send Policy’. However, ‘No Send’ is a defined action within its Clinical Safety Plan (CSP).

“IMPLEMENT CSP 3 NO SEND: "No send' to all C3 & C4 calls excluding CSP exemptions. All 'No send' incidents to be reviewed within 60mins. Review to be undertaken by appropriately trained staff.”

The No Send action can only be invoked when the Trust is at CSP3 or higher, and at the direction of the Strategic Commander.

6. If yes to question 5, please tell me how many times this policy has been used in each of the following years: a) 2025/26 to date b) 2024/25 c) 2023/24

The Trust used to audit when it deployed No Send but, because of its very infrequent use, it has not undertaken these audits in 2025.

The Trust does not hold a record of the precise dates, or number of occasions when the CSP action of No Send has been used historically.

Next steps

We publish a variety of information which may assist future enquiries relating to our service on our website – www.secamb.nhs.uk.

Should you be dissatisfied with our response then in the first instance please contact Richard Banks, Head of Corporate Governance, via the following email address: FOI@secamb.nhs.uk

You can ask us to review our original response. If you would like us to carry out an internal review, please let us know within 40 working days of you receiving our original response. This review will be conducted by an individual who was not directly involved in reviewing the original response, ordinarily, the Trust Data Protection Officer. We will endeavour to complete this request within 20 working days.

Should you remain dissatisfied then you can contact the Information Commissioner's Office (ICO). Complaints to the ICO should be made within six weeks of receiving the outcome of an internal review. The easiest way to lodge a complaint is through their website: www.ico.org.uk/foicomplaints.

Alternatively, the ICO's postal address is:
Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, SK9 5AF.

Yours sincerely,

Freedom of Information Coordinator
South East Coast Ambulance Service NHS Foundation Trust