HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Please provide **ECT** information under the FOI act to the following questions: -

1 Please supply patient's information ECT leaflet.

This information is already in the public domain[1]. Please follow this link to FOI 3642 and the attachments previously supplied to you. I can confirm nothing has changed.

2 Please supply patient ECT consent form

This information is already in the public domain[1]. Please follow the link provided under question 1. I can confirm that the consent form has not changed since your last request.

3 Please supply any ECT reports/investigations

As previously explained and again after giving full consideration we feel that this data constitutes personal information. Therefore, we have applied S40 to this part of your request as the potential to identify individual(s) will would be a breach of the Data Protection Act (2018)[2].

4 How many ECT in 2021?

In 2021 we conducted 307 ECT treatments.

5 What proportion of patients were men/women?
6 How old were they?
7 What proportion of patients were classified people of the global majority or racialised communities ("POC / BAME")?
8 How many were receiving ECT for the first time?
9 How many patients consented to ECT?
11 How many patients died during or 1 month after ECT and what was the cause (whether or not ECT was considered the cause)?
12 How many patients died within 6 months after ECT and what was the cause (whether or not ECT was considered the cause)?
13 How many patients died by suicide within 6 months of receiving ECT (whether or not ECT was considered the cause)?
14 How many patients have suffered complications during and after ECT and what were those complications?
17 How many patients report memory loss/loss of cognitive function?

As explained in the past it is not possible to provide you with this level of breakdown of ECT information within the legal time limit[3] .

To provide you with this information would involve manually reviewing the 307 treatments recorded on our Electronic Patient Recording system (EPR). It is estimated that it would take 20 minutes (i.e. 2 minutes per question) to scrutinise each record i.e. 102.33 hours @ £25 = £2,558.33

[1] Section 21 – Information is available through other means
[2] Section 40(2) - Personal Data has been applied. This is because by releasing this information could identify individual(s) and constitute a breach of the Data Protection Act (2018).
[3] Section 12 - Cost of compliance exceeds the appropriate limit has been applied

10 How many ECT complaints were investigated outside the NHS and CCG?

Not applicable.

15 Have there been any formal complaints from patients/relatives about ECT?

There were no formal complaints mentioning ECT in 2021.

16 If so, what was their concerns?

Not applicable.

18 What tests are used to assess memory loss/loss of cognitive function?

This information is already in the public domain[1]. Please follow the link provided under question 1, alternatively please follow this link to a previously published response.

19 Have MRI or CT scans been used before and after ECT?

This is not a standard requirement for ECT.

20 If so, what was the conclusion?

Not applicable.

21 How does the Trust plan to prevent ECT in the future?

Please follow the link provided under question 1.

Please provide SERIOUS INCIDENT information under the FOI act to the following questions: -

22 Please supply any serious incident reports/investigations?

Please see the answer to question 3. We have applied S40 to this question[2].

23 How many SERIOUS INCIDENT REPORTS in 2021?

In 2021 there were a total of 134 Serious Incidents reported by the Trust.

24 What proportion of patients were men/women?

58 (43%) Female, 75 (56%) Male, 1 not stated

25 How old were they?

Age	Number of Serious Incidents Reported in 2021
< 18	8
18-24	16
25-34	22
35-44	20
45-54	27
55-64	14
> 65	25
N/A	2

26 What proportion of patients were classified people of the global majority or racialised communities ("POC / BAME")?

	Number of service Users/Percentage
POC	72 (54%)
BAME	10 (7%)
Not Stated	52 (39%)

26 How many SERIOUS INCIDENT REPORTS were investigated outside the NHS and CCG?

Not applicable. The Trust's Serious Incident process aligns to the NHS Serious Incident Framework (2015).

27 How many patients died during or 1 month after SERIOUS INCIDENT REPORTS and what was the cause (whether or not SERIOUS INCIDENT REPORTS was considered the cause)?

Not applicable. A Service User cannot die as a result of a Serious Incident report.

28 How many patients died within 6 months after SERIOUS INCIDENT REPORTS and what was the cause (whether or not SERIOUS INCIDENT REPORTS was considered the cause)?

Not applicable. A Service User cannot die as a result of a Serious Incident report.

29 How many patients died by suicide within 6 months of receiving SERIOUS INCIDENT REPORTS (whether or not SERIOUS INCIDENT REPORTS was considered the cause)?

Only the Coroner can make the determination of a suicide verdict. To provide you with this information would involve manually going through the deceased health record to determine whether a traumatic (non-fatal) event had occurred resulting in a serious incident report being written within 6 months of the death.

We do not believe reading through individuals medical records for the purpose of a FOI request would be in line with the GDPR Data Protection Principles or the Caldicott Principles.

Under Section 16 – Duty to provide advice and assistance we would again like to reiterate that a Service User cannot die as a result of a Serious Incident report, although it could be a contributing factor.

30 How many patients have suffered complications during and after SERIOUS INCIDENT REPORTS and what were those complications?

Not applicable. A Service User cannot suffer complications during or after a Serious Incident report.

31 Have there been any formal complaints from patients/relatives about SERIOUS INCIDENT REPORTS?

There were no formal complaints received arising from a Serious Incident Report during 2021.

32 If so, what was their concerns?

Not applicable.

33 How does the Trust plan to prevent SERIOUS INCIDENTS in the future?

To aim to prevent serious incidents and avoidable harm action plans are put in place and implemented for all serious incident investigations. Learning is shared though a suite of measures including SWARM post incident huddles, reflective learning sessions, seven-minute briefings, screensavers, learning events and learning notes.

Please provide restraints information under the FOI act to the following questions: -

34 Please supply any Restraints/investigations?

Please see the answer to question 3. We have applied S40 to this question[2].

35 How many RESTRAINTS in 2021?

In 2021 there were 2,300 restraints reported.

36 What proportion of patients were men/women?
37 How old were they?
38 What proportion of patients were classified people of the global majority or racialised communities ("POC / BAME")?
39 How many RESTRAINTS were investigated outside the NHS and CCG?
40 How many patients died during or 1 month after RESTRAINTS and what was the cause (whether or not RESTRAINTS was considered the cause)?
41 How many patients died within 6 months after RESTRAINTS and what was the cause (whether or not RESTRAINTS was considered the cause)?
42 How many patients died by suicide within 6 months of receiving RESTRAINTS (whether or not RESTRAINTS was considered the cause)?
43 How many patients have suffered complications during and after RESTRAINTS and what were those complications?

It is not possible to provide you with the above requested breakdown of restraint information within the legal time limit [3].

To provide you with this information would involve manually reviewing the 2,300 incidents of restraints recorded on our Incident Reporting System and then it will then need to be cross referenced against the service user's Electronic Patient Record (EPR). It is estimated that it would take 80 minutes to scrutinise the Incident Reporting System and EPR record. (10 minutes per question per incident) i.e. 3,066.66 hours @ £25 = £76,666.66.

Under section 12 of the FOIA a public authority does not have to comply with a request for information if the cost of compliance exceeds the appropriate limit.

44 Have there been any formal complaints from patients/relatives about RESTRAINTS?

There were no formal complaints mentioning restraints in 2021.

45 If so, what was their concerns?

Not applicable.

46 Are counts of forced injections available?

This is not a reportable category on our Incident Reporting System.

47 How does the Trust plan to reduce restraints in the future?

This is covered in our MOSStogether (Making our Services Safer) Strategy.

Please provide SECLUSION information under the FOI act to the following questions: -

48 Please supply any SECLUSION reports/investigations

Please see the answer to question 3. We have applied S40 to this question[2]

49 How many SECLUSIONS in 2021?

In 2021 there were 362 seclusions reported.

50 What proportion of patients were men/women?
51 How old were they?
52 What proportion of patients were classified people of the global majority or racialised communities ("POC / BAME")?
53 How many SECLUSIONS were investigated outside the NHS and CCG?
54 How many patients died during or 1 month after SECLUSION and what was the cause (whether or not SECLUSION was considered the cause)?
55 How many patients died within 6 months after SECLUSION and what was the cause (whether or not SECLUSION was considered the cause)?
56 How many patients died by suicide within 6 months of receiving SECLUSION (whether or not SECLUSION was considered the cause)?
57 How many patients have suffered complications during and after SECLUSION and what were those complications?

It is not possible to provide you with the above requested breakdown of seclusion information within the legal time limit [3].

To provide you with this information would involve manually reviewing the 362 incidents of seclusions recorded on our Incident Reporting System and then it will then need to be cross referenced against the service user's Electronic Patient Record (EPR). It is estimated that it would take 80 minutes to scrutinise the Incident Reporting System and EPR record. (10 minutes per question) i.e. 482.66 hours @ £25 = £12,066.66.

Under section 12 of the FOIA a public authority does not have to comply with a request for information if the cost of compliance exceeds the appropriate limit.

58 Have there been any formal complaints from patients/relatives about SECLUSION?
59 If so, what was their concerns?

Due to the small number of complaints in 2021 regarding Seclusion we have applied Exemption Section 40(2)[2]. This is because entries of 5 or less are considered sufficiently small enough to be potentially identifiable data.

On this basis, this information is exempt from the duty to publish.

60 How does the Trust plan to reduce SECLUSIONS in the future?

This is covered in our MOSStogether Strategy.

Please provide MEDICATION ERRORS information under the FOI act to the following questions: -

61 Please supply any MEDICATION ERRORS reports/investigations

Please see the answer to question 3. We have applied S40 to this question[2].

62 How many MEDICATION ERRORS in 2021?

In 2021 there were 681 medication incidents reported.

63 What proportion of patients were men/women?
64 How old were they?
65 What proportion of patients were classified people of the global majority or racialised communities ("POC / BAME")?
66 How many MEDICATION ERRORS were investigated outside the NHS and CCG?
67 How many patients died during or 1 month after MEDICATION ERRORS and what was the cause (whether or not MEDICATION ERRORS was considered the cause)?
68 How many patients died within 6 months after MEDICATION ERRORS and what was the cause (whether or not MEDICATION ERRORS was considered the cause)?
69 How many patients died by suicide within 6 months of receiving MEDICATION ERRORS (whether or not MEDICATION ERRORS was considered the cause)?
68 How many patients have suffered complications during and after MEDICATION ERRORS and what were those complications?

It is not possible to provide you with the above requested breakdown of medication error information within the legal time limit[3].

To provide you with this information would involve manually reviewing the 681 medication incidents recorded on our Incident Reporting System and then it will then need to be cross referenced against the service user's Electronic Patient Record (EPR). It is estimated that it would take 80 minutes to scrutinise the Incident Reporting System and EPR record. (10 minutes per question) i.e. 908 hours @ £25 = £22,700.

Under section 12 of the FOIA a public authority does not have to comply with a request for information if the cost of compliance exceeds the appropriate limit.

70 Have there been any formal complaints from patients/relatives about MEDICATION ERRORS?
71 If so, what was their concerns?

Due to the small number of complaints in 2021 regarding medication errors we have applied Exemption Section 40(2)[2]. This is because entries of 5 or less are considered sufficiently small enough to be potentially identifiable data.

On this basis, this information is exempt from the duty to publish.

72 How does the Trust plan to prevent MEDICATION ERRORS in the future?

Please follow the link provided under question 1.