Freedom of Information Act 2000 (FOIA)

Decision notice

Date: 17 November 2020

Public Authority: Nottinghamshire Healthcare NHS Foundation Trust

Address: Duncan Macmillan House
Porchester Road
Nottingham
NG3 6AA

Decision (including any steps ordered)

1. The complainant has made a 110 part request for information relating to electroconvulsive therapy, serious incidents, restraints, seclusion and medication errors. The Trust refused to comply with the requests as it said it would exceed the cost limit under section 12 FOIA to do so.

2. The Commissioner's decision is that the Trust was correct to apply section 12 FOIA and that it was not therefore obliged to comply with the requests. However the Commissioner considers that the Trust failed to provide the complainant with advice and assistance in accordance with its obligations under section 16 FOIA.

3. The Commissioner requires the public authority to take the following steps to ensure compliance with the legislation.

    - Provide the complainant with advice and assistance in accordance with the requirements of section 16 FOIA.

4. The public authority must take these steps within 35 calendar days of the date of this decision notice. Failure to comply may result in the Commissioner making written certification of this fact to the High Court pursuant to section 54 of the Act and may be dealt with as a contempt of court.

Request and response

5. On 16 April 2020 the complainant made a request for information that contained 110 questions spread across five topics (electroconvulsive therapy, serious incidents, restraints, seclusion and medication errors). Please see Annex A attached.

6. On 16 April 2020 the Trust responded. It refused to comply with the request under section 12 FOIA as it said that it would exceed the cost limit to do so. The complainant requested an internal review on 16 April 2020. The Trust sent the outcome of its internal review on 12 May 2020. It upheld its original position.

Scope of the case

7. The complainant contacted the Commissioner to complain about the way the request for information had been handled.

8. The Commissioner has considered whether the Trust was correct to apply section 12 FOIA to the requests in this case and whether it complied with its obligations under section 16 FOIA.

Reasons for decision

Section 12 – cost exceeds appropriate limit

9. Section 12 of the FOIA allows a public authority to refuse to deal with a request where it estimates that it would exceed the appropriate cost limit to:

    - either comply with the request in its entirety, or
    - confirm or deny whether the requested information is held.

10. The estimate must be reasonable in the circumstances of the case. The appropriate limit is currently £600 for central government departments and £450 for all other public authorities. Public authorities can charge a maximum of £25 per hour to undertake work to comply with a request - 24 hours work for central government departments; 18 hours work for all other public authorities. If an authority estimates that complying with a request may cost more than the cost limit, it can consider the time taken to:

(a) determine whether it holds the information
(b) locate the information, or a document which may contain the information
(c) retrieve the information, or a document which may contain the information, and
(d) extract the information from a document containing it.

11. The appropriate limit for the Trust is £450 or the equivalent of 18 hours work.

12. The Trust has broken the request up into five parts, 22 questions relating to electroconvulsive therapy, 22 questions relating to serious incidents, 22 questions relating to restraints, 22 questions relating to seclusion and 22 questions relating to medication errors.

13. The Trust has taken three of the questions to explain the time and cost implications to demonstrate why complying with this request would exceed the cost limit:

Question 12
How many patients died during or soon after ECT and what was the cause (whether or not ECT was considered the cause)?

Summary

- The information required to provide a response to question 12 may not be held by the Trust.
- Multiple checks against numerous records, some of which may be held by other organisations, would be needed to determine whether any patients who received ECT had died and if so, when the death occurred and the cause of death.
- These checks would take in excess of **148 hours**

Additional information

- During 2019, 74 patients received ECT which was administered by the Trust). It should be noted that manual data collection was required to determine the number of patients who received ECT.
- The question posed refers to a date of death "soon after ECT" however, no information has been provided by the requester to stipulate what timeframe would apply. Therefore, an assumption would need to be made for example, that "soon after" means that the patient died on the day of the ECT procedure
- In order to establish whether a patient died during or soon after ECH, each of those 74 patients' records would need to be reviewed to establish:
  1. The dates and times of ECT procedures

2. If the patient has died and if so,
    - The date of death
    - The place of death
    - The cause of death
    - Whether the cause of death is considered to be ECT related

- Extracting the information referred to above would require a thorough examination of the patient record, which would include the need to refer to several areas within the electronic patient record
- If a date of death is not recorded on any of the electronic records held by the Trust relating to the 74 patients who received ECT, the Clinical Spine would need to be reviewed for each of the patients without a date of death recorded to establish if the patient had died.
- If a deceased patient was an inpatient of the Trust at the time the ECT procedure was delivered, the information would be contained within the patient record. However, if the patient did not die at a Trust site for example, if they died in an acute hospital or at home, the Trust may not be informed of the death and/or the time of death and/or the place of death and/or the cause of death.
- If a patient who had received ECT at a Trust site and who had subsequently died had been transferred to an acute hospital (due to their presentation), the death may have occurred there. This means that records of the death would be held by the acute hospital, not the Trust. Therefore, enquiries would need to be made to the acute Trust as the Data Controller.
- Similarly, if the patient was receiving ECT on an outpatient basis and had subsequently died, it's likely that the death would have taken place outside of the Trust and again, enquiries would need to be made of other healthcare providers, including GP Practices, to compile the information required to provide a response to the requester.
- It is possible that in the case of a patient who received ECT and who died in a location other than a Trust site, enquiries would need to be made of more than one healthcare provider to compile all of the information required to provide a complete response to the requester.
- All data – whether compiled entirely from Trust records or from a combination of sources – would need to be presented to the lead healthcare professionals and Consultant Psychiatrists leading on the patients' care for an opinion in relation to whether the cause of death was related to the ECT treatment provided.
- A considerable amount of time, effort, resources and personnel would be required to investigate, collate, review and advise in order to facilitate provision of a response to this question.

Question 13
How many patients died a few months after ECT and what was the cause (whether or not ECT was considered the cause)?

Summary

- The information required to provide a response to question 13 may not be held by the Trust.
- Multiple checks against numerous records, some of which may be held by other organisations, would be needed to determine whether any patients who received ECT had died and if so, when the death occurred and the cause of death.
- These checks would take in excess of **148 hours.**

Additional information

- During 2019, 74 patients received ECT which was administered by Nottinghamshire Healthcare NHS Foundation Trust (the Trust). It should be noted that manual data collection was required to determine the number of patients who received ECT.
- The question posed refers to a date of death "a few months after ECT" however, no information has been provided by the requester to stipulate what timeframe would apply. Therefore, an assumption would need to be made for example, that "a few months" means that the patient died within three months of the ECT procedure.
- In order to establish whether a patient died within three months of the ECT procedure, each of those 74 patients' records would need to be reviewed to establish:
  1. The dates and times of ECT procedures
  2. If the patient has died and if so,
     - The date of death
     - The place of death
     - The cause of death
     - Whether the cause of death is considered to be ECT related
- Extracting the information referred to above would require a thorough examination of the patient record, which would include the need to refer to several areas within the electronic patient record.
- If a date of death is not recorded on any of the electronic records held by the Trust relating to the 74 patients who received ECT, the Clinical Spine would need to be reviewed for each of the patients without a date of death recorded to establish if the patient had died.
- If a deceased patient was an inpatient of the Trust at the time the ECT procedure was delivered, the information would be contained within the patient record. However, if the patient did not die at a Trust site for example, if they died in an acute hospital or at home, the Trust may not be informed of the death and/or the time of death and/or the place of death and/or the cause of death.

- If a patient who had received ECT at a Trust site and who had subsequently died had been transferred to an acute hospital (due to their presentation), the death may have occurred there. This means that records of the death would be held by the acute hospital, not the Trust. Therefore, enquiries would need to be made to the acute Trust as the Data Controller.
- Furthermore, within the three month period post-ECT, the patient could have been transferred to another healthcare provider elsewhere in the country (or even beyond). Enquiries would need to be made of each healthcare provider who treated the patient(s) after their transfer out of the Trust to compile the information requested.
- Similarly, if the patient was receiving ECT on an outpatient basis and had subsequently died within three months of the date of the ECT treatment, it's likely that the death would have taken place outside of the Trust and again, enquiries would need to be made of other healthcare providers, including GP Practices, to compile the information required to provide a response to the requester.
- It is possible that in the case of a patient who received ECT and who died within three months in a location other than a Trust site, enquiries would need to be made of more than one healthcare provider to compile all of the information required to provide a complete response to the requester.
- All data – whether compiled entirely from Trust records or from a combination of sources – would need to be presented to the lead healthcare professionals and Consultant Psychiatrists leading on the patients' care for an opinion in relation to whether the cause of death was related to the ECT treatment provided.
- A considerable amount of time, effort, resources and personnel would be required to investigate, collate, review and advise in order to facilitate provision of a response to this question.

Question 14
How many patients died by suicide within a few months of receiving ECT (whether or not ECT was considered the cause)?

Summary

- The information required to provide a response to question 14 may not be held by the Trust.
- Multiple checks against numerous records, some of which may be held by other organisations, would be needed to determine whether any patients who received ECT had died and if so, when the death occurred and the cause of death.
- These checks would take in excess of **148 hours.**

Additional information

- During 2019, 74 patients received ECT which was administered by Nottinghamshire Healthcare NHS Foundation Trust (the Trust). It should be noted that manual data collection was required to determine the number of patients who received ECT.
- The question posed refers to patients who died by suicide within "a few months of receiving ECT" however, no information has been provided by the requester to stipulate what timeframe would apply. Therefore, an assumption would need to be made for example, that "a few months" means that the patient died by suicide within three months of the ECT procedure.
- In order to establish whether a patient died by suicide within three months of the ECT procedure, each of those 74 patients' records would need to be reviewed to establish:
  1. The dates and times of ECT procedures
  2. If the patient has died and if so,
     - The date of death
     - The place of death
     - The cause of death
- Extracting the information referred to above would require a thorough examination of the patient record, which would include the need to refer to several areas within the electronic patient record.
- If a date of death is not recorded on any of the electronic records held by the Trust relating to the 74 patients who received ECT, the Clinical Spine would need to be reviewed for each of the patients without a date of death recorded to establish if the patient had died.
- If a deceased patient was an inpatient of the Trust at the time the ECT procedure was delivered, the information would be contained within the patient record. However, if the patient did not die at a Trust site for example, if they died in an acute hospital or at home, the Trust may not be informed of the death and/or the time of death and/or the place of death and/or the cause of death.
- If a patient who had received ECT at a Trust site and who had subsequently died had been transferred to an acute hospital (due to their presentation), the death may have occurred there. This means that records of the death would be held by the acute hospital, not the Trust. Therefore, enquiries would need to be made to the acute Trust as the Data Controller.
- Furthermore, within the three month period post-ECT, the patient could have been transferred to another healthcare provider elsewhere in the country (or even beyond). Enquiries would need to be made of each healthcare provider who treated the patient(s) after their transfer out of the Trust to compile the information requested.

- Similarly, if the patient was receiving ECT on an outpatient basis and had subsequently died by suicide within three months of the date of the ECT treatment, it's likely that the death would have taken place outside of the Trust and again, enquiries would need to be made of other healthcare providers, including GP Practices, to compile the information required to provide a response to the requester.
- It is possible that in the case of a patient who received ECT and who died by suicide within three months in a location other than a Trust site, enquiries would need to be made of more than one healthcare provider to compile all of the information required to provide a complete response to the requester.
- Contact may need to be made with the Coroner's Office to obtain additional information and in particular, whether any reference was made in the findings of the inquest(s) to indicate whether the deceased suicide was related to ECT treatment.
- All data – whether compiled entirely from Trust records or from a combination of sources – would need to be presented to the lead healthcare professionals and Consultant Psychiatrists leading on the patients' care for an opinion in relation to whether the cause of death was related to the ECT treatment provided.
- A considerable amount of time, effort, resources and personnel would be required to investigate, collate, review and advise in order to facilitate provision of a response to this question.

Costs

The NHS personnel involved in this particular request would be costed as following –

FOI request processing	7.5 hours	£92.62
Research of records and information collation £1290.57	104.5 hours	
Clinician review of data £951.12 minimum	36 hours	
TOTAL minimum		**£2334.31**

14. The Trust emphasised that there are a further 19 questions within the section relating to ECT, with an additional four sections each of which

contain 22 questions. The total cost of meeting this request would considerably exceed the time limit.

15. In this case, the Trust has included time within its estimate to contact other public authorities who may hold relevant information if not held by the Trust e.g. Acute Hospitals or GPs. The Trust is not obliged to obtain information held by other public authorities to respond to the request. However in order to determine what is held by the Trust, in relation to the three questions set out above, it would be required to search the records of 74 patients. The Trust has said it would take 104.5 hours to search these records and extract/collate the information held falling within the scope of the request. However even if this estimate was reduced to 20 minutes per patient record this would equate to over 24 hours work and would exceed the cost limit.

16. As the Trust has pointed out, these are only 3 of 110 questions posed and so the total cost of compliance would be much greater.

17. Based upon the Trust's submissions, the Commissioner accepts that it would exceed the cost limit to comply with the requests and therefore section 12 was correctly engaged in this case.

Section 16 – Advice and Assistance

17. Under section 16 FOIA the Trust is obliged to provide the complainant with advice and assistance to help enable the complainant to refine the request to fall within the cost limit or explain why this would not be possible.

18. The Trust has not provided any advice and assistance to the complainant in this case.

19. As the Trust has not provided advice and assistance in this case it has not complied with its obligations under section 16 FOIA.

Right of appeal

20. Either party has the right to appeal against this decision notice to the First-tier Tribunal (Information Rights). Information about the appeals process may be obtained from:

    First-tier Tribunal (Information Rights)
    GRC & GRP Tribunals,
    PO Box 9300,
    LEICESTER,
    LE1 8DJ

    Tel: 0300 1234504
    Fax: 0870 739 5836
    Email: grc@Justice.gov.uk
    Website: www.justice.gov.uk/tribunals/general-regulatory-chamber

21. If you wish to appeal against a decision notice, you can obtain information on how to appeal along with the relevant forms from the Information Tribunal website.

22. Any Notice of Appeal should be served on the Tribunal within 28 (calendar) days of the date on which this decision notice is sent.

Signed……

Gemma Garvey
Senior Case Officer

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Annex A

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

1. Please supply patient's information ECT leaflet.

2. Please supply patient ECT consent form.

3. Please supply any ECT reports/investigations

4. How many ECT in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving ECT for the first time?

10. How many patients consented to ECT?

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

12. How many patients died during or soon after ECT and what was the cause (whether or not ECT was considered the cause)?

13. How many patients died a few months after ECT and what was the cause (whether or not ECT was considered the cause)?

14. How many patients died by suicide within a few months of receiving ECT (whether or not ECT was considered the cause)?

15. How many patients have suffered complications during and after ECT and what were those complications?

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

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

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

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

21. If so what was the conclusion?

22. How does the Trust plan to prevent ECT in the future?

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

1. Please supply SERIOUS INCIDENT REPORTS patient's information leaflet.

2. Please supply patient SERIOUS INCIDENT REPORTS consent form.

3. Please supply any serious incident reports/investigations

4. How many SERIOUS INCIDENT REPORTS in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving SERIOUS INCIDENT REPORTS for the first time?

10. How many patients consented to SERIOUS INCIDENT REPORTS?

11. How many SERIUOS INCIDENT REPORTS were investigated outside the NHS and CCG?

12. How many patients died during or soon after SERIOUS INCIDENT REPORTS and what was the cause (whether or not SERIOUS INCIDENT REPORTS was considered the cause)?

13. How many patients died a few months after SERIOUS INCIDENT REPORTS and what was the cause (whether or not SERIOUS INCIDENT REPORTS was considered the cause)?

14. How many patients died by suicide within a few months of receiving SERIOUS INCIDENT REPORTS (whether or not SERIOUS INCIDENT REPORTS was considered the cause)?

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

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

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

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

20. Have MRI or CT scans been used before and after SERIOUS INCIDENT REPORTS?

21. If so what was the conclusion?

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

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

1. Please supply RESTRAINTS patient's information leaflet.

2. Please supply patient RESTRAINTS consent form.

3. Please supply any Restraints/investigations

4. How many RESTRAINTS in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving RESTRAINTS for the first time?

10. How many patients consented to RESTRAINTS?

11. How many RESTRAINTS were investigated outside the NHS and CCG ?

12. How many patients died during or soon after RESTRAINTS and what was the cause (whether or not RESTRAINTS was considered the cause)?

13. How many patients died a few months after RESTRAINTS and what was the cause (whether or not RESTRAINTS was considered the cause)?

14. How many patients died by suicide within a few months of receiving RESTRAINTS (whether or not RESTRAINTS was considered the cause)?

15. How many patients have suffered complications during and after RESTRAINTS and what were those complications?

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

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

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

20. Have MRI or CT scans been used before and after RESTRAINTS?

21. If so what was the conclusion?

22. How does the Trust plan to reduce restraints in the future?

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

1. Please supply patient's information SECLUSION leaflet.

2. Please supply patient SECLUSION consent form.

3. Please supply any SECLUSION reports/investigations

4. How many SECLUSION in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving SECLUSION for the first time?

10. How many patients consented to SECLUSION?

11. How many SECLUSIONS were investigated outside the NHS and CCG ?

12. How many patients died during or soon after SECLUSION and what was the cause (whether or not SECLUSION was considered the cause)?

13. How many patients died a few months after SECLUSION and what was the cause (whether or not SECLUSION was considered the cause)?

14. How many patients died by suicide within a few months of receiving SECLUSION (whether or not SECLUSION was considered the cause)?

15. How many patients have suffered complications during and after SECLUSION and what were those complications?

16. Have there been any formal complaints from patients/relatives about SECLUSION?

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

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

20. Have MRI or CT scans been used before and after SECLUSION?

21. If so what was the conclusion?

22. How does the Trust plan to prevent SECLUSION in the future?

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

1. Please supply patient's information MEDICATION ERRORS leaflet.

2. Please supply patient MEDICATION ERRORS consent form.

3. Please supply any MEDICATION ERRORS reports/investigations

4. How many MEDICATION ERRORS in 2019?

5. What proportion of patients were men/women?

6. How old were they?

7. What were the diagnoses and in what proportions?

8. What proportion of patients were classified BAME?

9. How many were receiving MEDICATION ERRORS for the first time?

10. How many patients consented to MEDICATION ERRORS?

11. How many MEDICATION ERRORS S were investigated outside the NHS and CCG?

12. How many patients died during or soon after MEDICATION ERRORS and what was the cause (whether or not MEDICATION ERRORS was considered the cause)?

13. How many patients died a few months after MEDICATION ERRORS and what was the cause (whether or not MEDICATION ERRORS was considered the cause)?

14. How many patients died by suicide within a few months of receiving MEDICATION ERRORS (whether or not MEDICATION ERRORS was considered the cause)?

15. How many patients have suffered complications during and after MEDICATION ERRORS and what were those complications?

16. Have there been any formal complaints from patients/relatives about MEDICATION ERRORS?

17. If so, what was their concerns?

18. How many patients report memory loss/loss of cognitive function?

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

20. Have MRI or CT scans been used before and after MEDICATION ERRORS?

21. If so what was the conclusion?

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