



East London

NHS Foundation Trust

Information Governance

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11th September 2026

Our reference: FOI DA6617

We are responding to your request for information received 18th May 2026. We are sorry for the delay in responding to your request. This has been treated as a request under the Freedom of Information Act 2000.

We are now enclosing a response which is attached to the end of this letter. Please do not hesitate to contact us on the contact details above if you have any further queries.

Yours sincerely,

FOI Team

If you are dissatisfied with the Trust's response to your FOIA request then you should contact us and we will arrange for an internal review of this decision.

If you remain dissatisfied with the decision following our response to your complaint, you may write to the Information Commissioner for a decision under Section 50 of the Freedom of Information Act 2000. The Information Commissioner can be contacted at:

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

Tel: 0303 123 1113
Web: www.ico.org.uk

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Chair: Eileen Taylor

Request:

Under the Freedom of Information Act 2000, please provide recorded information relating to recognition, identification and monitoring of adverse effects associated with antipsychotic and other psychotropic medications.

Question 1: Policies, guidance or training materials relating to recognition of:

- * akathisia
- * emotional blunting
- * agitation or behavioural activation
- * cognitive impairment
- * withdrawal-related symptoms
- * medication-induced suicidal ideation

Answer: No specific policies, guidance or training are in place within ELFT regarding these medication related side effects.

Question 2: Any audits, incident reviews, governance reports relating to:

- * delayed recognition of medication adverse effects
- * misinterpretation of adverse effects as relapse or behavioural disturbance
- * variability of recognition of adverse effects across services

Answer: Audits:

The Trust does not hold any specific audits relating to delayed recognition of medication adverse effects, misinterpretation of adverse effects as relapse or behavioural disturbance, or variability of recognition of adverse effects across services.

The Trust maintains a programme of clinical audit activity focused on a number of defined priority areas (for example, high-risk medications and structured monitoring requirements). The topics described above have not been identified as a discrete priority audit area.

These themes are not readily amenable to standardised audit methodology at scale. Unlike audits where a clearly defined patient cohort can be identified (e.g. patients prescribed high-dose antipsychotic therapy or other high-risk medicines), the recognition and interpretation of adverse effects typically occur on an individual patient basis across a wide range of clinical contexts. As such, these factors are not consistently captured as measurable or coded parameters suitable for routine, large-scale audit, and are more commonly addressed through individual clinical review, incident investigation and governance processes.

Incident reviews and governance reports:

Medication-related adverse effects are required to be recorded via the Trust's incident reporting system and through the Yellow Card Scheme, in line with the Medicines Policy, this is also emphasised during safe administration of medicines training and safe prescribing training.

However, incidents relating to delayed recognition or misinterpretation of adverse effects are not captured as a discrete, routinely coded category within the incident reporting system. As such, there is no standard report or dataset that can be extracted specifically for these themes.

Incidents involving adverse drug reactions can be identified using the national Learn from Patient Safety Events (LFPSE) data fields (e.g. where "adverse drug reaction" is selected). Identification of incidents specifically relating to antipsychotic or other psychotropic medications, or to the themes described above, would require a manual review of individual incident records extracted using this filter.



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All reported incidents are subject to local review and investigation processes, and learning is shared through appropriate governance structures where relevant.

See Appendix 2 attached for the Medicines policy.

Question 3: Any recorded learning, safety alerts or internal communications concerning improvement of recognition of psychotropic medication adverse effects.

Answer: Yes, the Trust holds recorded examples of learning, safety alerts and internal communications relating to the recognition and management of adverse effects associated with psychotropic medication. Learning is shared through a range of mechanisms including Trust-wide clinical alerts, medicines safety communications and education sessions.

Examples include:

- Trust-wide Medicines Safety Learning Seminar – Antipsychotic Depot Safety
- Covered the high-risk nature of depot antipsychotics, including associated adverse effects and monitoring requirements.
- Included learning from serious incidents, such as omission of post-injection monitoring following olanzapine depot and recognition of post-injection syndrome (POIS).
- Emphasised themes of system-based risk, recognition of adverse effects and the need for robust monitoring processes.
- Clinical Alert – Neuroleptic Malignant Syndrome (NMS)
- Issued following patient safety incidents involving delayed recognition and prescribing despite prior adverse reactions.
- Provided guidance on early recognition of symptoms (e.g. fever, rigidity, confusion) and urgent management.
- Included system changes requiring documentation of NMS as an “allergy” in EPMA to support recognition and prevent re-prescribing.
- Clinical Alert – Risk of Respiratory Depression with central nervous system Depressant Medicines
- Highlighted risks of cumulative sedative effects when psychotropic medications are combined with other medicines, alcohol or illicit substances.
- Included learning from a patient safety incident involving drug toxicity and polypharmacy.
- Emphasised the need for clinicians to recognise adverse effects, discuss risks with patients and monitor for signs of central nervous system depression.



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Under the Freedom of Information Act 2000, please provide recorded information relating to classification and escalation of patient safety incidents involving psychotropic medication.

Question 4: Policies or guidance describing how the Trust determines whether medication-related adverse events are classified as:

- * Serious Incidents**
- * internal incidents**
- * or non-reportable events**

Answer: Policies and guidance describing classification and escalation of medication-related incidents:

All medication-related incidents are required to be reported on the Trust's incident reporting system (InPhase). The system incorporates mandated Learn from Patient Safety Events (LFPSE) data requirements, and reported incidents are submitted to the national patient safety database. The Trust has an overarching policy: "Patient Safety Incident Response Framework (PSIRF) and Incident Reporting and Management Policy for East London NHS Foundation Trust (ELFT)", which sets out the approach to the reporting, classification and management of all patient safety incidents, including those involving medication.

Medication incident reporting is also addressed within the Trust's Medicines Policy, which includes guidance on adverse drug reactions, safe prescribing and administration. (This policy is currently undergoing revision.) All reported medication incidents are reviewed through established governance processes. Oversight is provided by the central patient safety/incident management team, with additional input from Directorate Lead Pharmacists and Medicines Safety Officers.

Classification and escalation of incidents, including whether an incident is managed as a Serious Incident, are determined in line with the PSIRF policy framework. This decision-making process is based on the nature of the incident and involves professional judgement. Factors considered include:

- The level of patient harm or potential of serious harm
- The nature and severity of the incident
- The potential for recurrence and wider system risk

Where required, incidents may be discussed at formal review forums such as the incident grading panel, attended by patient safety leads and senior clinical representatives (e.g. medical or nursing leads), to support consistent classification and appropriate escalation.

See Appendix 1 attached for Patient Safety Incident Response Framework (PSIRF) policy

See Appendix 2 attached for the Medicines policy

Question 5: Any criteria or decision-making frameworks used to determine escalation thresholds for:

- * suspected medication adverse effects**
- * deterioration following dose changes**
- * withdrawal or discontinuation effects**
- * medication-related behavioural change**

Answer: There are no separate, condition-specific criteria or decision-making frameworks used exclusively for suspected medication adverse effects,



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deterioration following dose changes, withdrawal or discontinuation effects, or medication-related behavioural change.

All such incidents, where identified, are managed within the Trust's overarching Patient Safety Incident Response Framework (PSIRF) and Incident Reporting and Management Policy.

All reported medication-related incidents are reviewed through established governance processes. Oversight is provided by the central patient safety/incident management team, with additional input from Directorate Lead Pharmacists and Medicines Safety Officers.

Classification and escalation of incidents, including whether an incident is managed as a Serious Incident or through local processes, are determined in line with the PSIRF policy framework. This decision-making process is based on the nature and context of the incident and involves professional judgement.

Factors considered include:

- The level of actual or potential patient harm
- The nature and severity of the incident
- The potential for recurrence and wider system or organisational risk

Where required, incidents may be discussed at formal review forums such as incident grading panels, attended by patient safety leads and senior clinical representatives (e.g. medical or nursing leads), to support consistent classification and appropriate escalation.

See Appendix 1 attached for Patient Safety Incident Response Framework (PSIRF) policy

Question 6: Any audit reports, governance reviews or thematic analyses comparing:
* **Serious incidents involving psychotropic medication**
* **non-escalated incidents involving psychotropic medication concerns**

Answer The Trust does not hold any specific audit reports, formal governance reviews or thematic analyses that directly compare Serious Incidents involving psychotropic medication with non-escalated incidents involving psychotropic medication concerns.

Medication-related incidents, including those involving psychotropic medications, are reported and managed through the Trust's incident reporting system and reviewed in line with the Patient Safety Incident Response Framework (PSIRF). While incidents are reviewed individually and learning is shared through governance processes, there is no routinely produced comparative analysis or dataset that distinguishes and analyses Serious Incidents versus non-escalated incidents specifically for psychotropic medications.

Question 7: Any recorded learning or governance decisions relating to consistency or inconsistency in classification of medication-related harms.

Answer Guidance relating to harm classification and the consistent grading of patient safety incidents is set out within the Trust's Patient Safety Incident Response Framework (PSIRF) and Incident Reporting and Management Policy. The policy provides a structured approach to harm grading, including defined levels of physical and psychological harm (e.g. no harm, low, moderate, severe, and death), which supports consistent classification of incidents across the organisation.



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The Trust does not hold any specific standalone reports or governance reviews solely focused on consistency or inconsistency in the classification of medication-related harms.

However, consistency in classification is supported through established governance processes, including:

Oversight from patient safety teams, investigating manager, clinical leads to ensure a proportionate and consistent approach

Any learning relating to classification of harm for medication incidents is incorporated into governance forums and processes e.g. Medicines Safety report presented bi-monthly to the Medicines Committee , rather than recorded as a discrete, standalone report for specific drug categories.

See Appendix 1 attached for Patient Safety Incident Response Framework (PSIRF) policy



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