Witness Name: Mark Winstanley

Statement No: 1

Exhibits: 23

Dated:26/03/25

First Witness Statement of Mark Winstanley

Introduction

1. I am Mark Winstanley, Chief Executive of Rethink Mental Illness since 2014.

2. Rethink Mental Illness is a leading charity provider of mental health services in England. Our mission is to deliver a better life for people severely affected by mental illness. Our vision is equality, rights, fair treatment, and the maximum quality of life for all those severely affected by mental illness

3. I am authorised by Rethink Mental Illness to make this statement on its behalf, and I do so in response to a Rule 9 request received from the Lampard Inquiry, dated 26/03/25.

Summary of Rethink Mental Illness's insights and activities related to inpatient mental health care

Rethink Mental Illness is a charity and provider of mental health services in England (Registered Charity Number (England and Wales): 271028 Company Registration Number: 1227970). People with experience of mental illness are at the heart of everything we do. Our aims are:

(a) to improve the lives of people severely affected by mental illness and their families and carers through local support groups and services

(b) to provide expert advice, information and training to the public in the field of mental health and welfare, including influencing Government and decision makers more widely

(c) to advance awareness and understanding as to the causes, consequences and management of mental illness, working to decrease the stigma surrounding it.

Our mission is to deliver a better life for people severely affected by mental illness. Our vision is equality, rights, fair treatment, and the maximum quality of life for all those severely affected by mental illness

Rethink Mental Illness is governed by a board of trustees comprising a Chair, eight trustees appointed from the regions and up to seven co-opted trustees. The board of trustees is responsible for the overall direction and control of the activities of Rethink Mental Illness. The board holds five formally constituted meetings a year, one of which is a facilitated two-day event looking at forward planning, strategy and board development. The Chair of the board of trustees, the Vice-chairs and the Treasurer are elected by the board from the existing trustees. There is one trustee for each of eight regions of England. Regional trustees must be either a carer, relative, user of mental health services or otherwise considered by the board to have relevant experience or expertise. Co-opted trustees are appointed by the board and are chosen for their skills, for example, fundraising, finance or business development, which may not be provided by the regional trustees. We also take into account the balance on the board of carers, people who use mental health services and others and of representation by gender, age and ethnicity. Board members are formally appointed at the AGM to serve up to a three-year term and can serve no more than nine years in total, except for the Chair who may serve up to 12 years. To assist the board in its work there are four formally constituted national committees, each with its own terms of reference:

(a) The Honorary Officers Committee (HOC) performs the function of an Executive Committee.
(b) The Audit and Assurance Committee (AAC) is responsible for overseeing all aspects of the charity's external and internal audit arrangements, internal control procedures and risk management.
(c) The Finance and Investment Committee (FIC) agrees fundraising and service development strategies, monitors income and expenditure against budget and the effectiveness of financial management. It recommends relevant budget priorities in the form of a draft annual budget to the board of trustees.
(d) The Council of Rethink (COR) exists to improve and strengthen the work and governance of Rethink Mental Illness by its oversight of engagement involvement throughout the charity

The charity also has three Governance Link Groups that involve a wider range of members interested in contributing to the work of the charity at a national level.

(a) The Lived Experience Advisory Board consists of up to 20 members plus any trustees who use, or have used, mental health services. Key areas of work include monitoring the progress of the Involvement Strategy, making suggestions and providing constructive feedback on issues relating to the involvement and support of people who use mental health services.

(b) The Carer's Advisory Board continues the long tradition of carer involvement within the charity and provides a distinct and strong voice for the carers of people severely affected by mental illness.

(c) The Clinical Advisory Group is made up of clinicians and experts who provide advice to inform the charity's policy and campaigning activity.

Regional involvement takes the form of membership of Regional Forums. These recently developed groups aim to have stakeholders from local areas, including Rethink members, supporters and service users to provide local intelligence and a voice for local communities. Regional Forums will then help shape the direction of the charity through a reporting mechanism to the board.

Our workforce as of our most recent annual report (2023-2024) comprises a diverse and committed colleague base of 979 people. For further details of the charity, it's structure and governance please refer to the submitted document *"2025.03.26 Rethink Mental Illness Annual Report and Accounts 2023-2024"*.

Rethink Mental Illness interact with healthcare providers and national organisations in relation to the provision of inpatient care in a myriad of ways through both a. being commissioned to carry out services and b. through our representation on boards and groups and c. through our influencing activity.

Commissioned work

We have been commissioned by several of these organisations/bodies to carry out research, as outlined below.

Representation on boards and groups

Mark Winstanley, our CEO, currently sits on the Mental Health, Learning Disabilities and Autism Quality Transformation Oversight Group and co-chairs the Mental Health Independent Advisory and Oversight Group and Programme Board. He also previously co-chaired the Steering Group of the Rapid Review into Data on Mental Health Inpatient Settings and sits on the Advancing Mental Health Equalities Taskforce.

Ian Callaghan, our Lived Experience Programme Manager, sits on the Culture of Care Lived Experience Group, and was an NHSE Patient and Public Voice Partner for the Adult Secure Care Clinical Reference Group between 2012-2021 with and sat on the Mental Health, Learning Disabilities and Autism Programme of Care Board. He also worked with CQC on the development of their new methodology for inspections.

Influencing activity

As an organisation we have several policy priorities related specifically to inpatient safety focused on improving the culture and workforce of inpatient settings, increasing accountability and oversight and reforming the Mental Health Act. As part of working on these priorities we engage with NHS England, the Care Quality Commission ("CQC") and the Department of Health and Social Care ("DHSC") through a series of meetings. This includes Lucy Schonegevel, our Director of Policy & Influencing, meeting with DHSC officials monthly to discuss updates. Members of our policy team sit on the External Strategic Advisory Group and the Observing,

Understanding and Improving Cultures Steering Group for the CQC and our CEO regularly attends their Executive Leader's Forum.

We have recently fed into the Health Services Safety Investigations Body's (HSSIB) investigation report on "Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services".

The Mental Health Policy Group (MHPG) is an informal coalition of six national organisations working together to improve mental health, comprised of the Centre for Mental Health, Mental Health Foundation, NHS Confederation Mental Health Network, Mind, Rethink Mental Illness and the Royal College of Psychiatrists. For some activities, the group is joined by the Association of Mental Health Providers, Young Minds or the Children and Young People's Mental Health Coalition and in these instances, it goes by the name MHPG+.

MHPG collaborates by sharing information about policy developments, jointly engaging with government officials or ministers and on occasion submitting jointly produced pieces of work such as consultation responses. Each member of MHPG takes it in turns to chair the group on a rota. For example, Rethink Mental Illness most recently had the role of chair between 1st July and 31st December 2024.

Apart from within MHPG and MHPG+, Rethink Mental Illness partners with its member organisations in a variety of ways:

- We partner with the Royal College of Psychiatrists to jointly provide the secretariat for the All Party Parliamentary Group on Mental Health. This is a collection of MPs and Lords with an interest in mental health from across the political spectrum
- We are a member of Equally Well UK which is an initiative which seeks to promote and support collaborative action to improve physical health among people with a mental illness. It is hosted by Centre for Mental Health and amongst other members it includes the Association of Mental Health Providers, Mind and the Royal College of Psychiatrists.
- We are a member of the Mental Health Leaders Group. This is a group of executive staff-members that was set up during the pandemic to provide peer support and sharing of information amongst its members. Its membership includes all of MHPG and MHPG+ as well as other organisations in the sector
- We are a member of the Richmond Group of Charities which is a coalition of health and social care organisations in the voluntary sector with the aim of improving care and support for people living with long-term conditions. Mind has recently also joined this group.
- Until March 2021, we partnered with Mind on Time to Change, a campaign to end the stigma and discrimination faced by people with mental health problems
- We have been working in partnership with a collective of organisations including Centre for Mental Health, Mind, the Association of Mental Health Providers and other

individuals and groups to produce the Black Mental Health Manifesto. This calls for structural reforms to tackle disparities in mental health care for Black people.

Campaigns

As a charity dedicated to improving the lives of people severely affected by mental illness, we have a range of policy priorities at any one that time cover issues people severely affected by mental illness are facing. We have a policy team of 8 and a campaigns team of 2 and therefore work to prioritise the issues we influence and campaign on based on flexible criteria including, but not limited to:

- Is it an issue people severely affected by mental illness are telling us about?
- Is there a window of opportunity to influence successfully on this issue?
- Do we have clear evidence of the issues?
- Is it a systemic and/or nationwide problem?

Rethink Mental Illness has an interest in patient safety within inpatient settings. While we have commented on specific instances of inadequate practice and care failures in various regions across the country, our approach, given resource constraints and our aim to achieve maximum impact, has primarily focused on responding to and influencing policy at the national level rather than campaigning or advocating at regional or local levels. This has been primarily focused on community transformation, a cross-Government plan for mental health and reform of the Mental Health Act.

In 2011 Rethink Mental Illness founded **the Schizophrenia Commission**, which published the *Schizophrenia - The Abandoned Illness* report the following year. It revealed a dysfunctional system that was not delivering the quality of treatment people needed for recovery and included key recommendations to promote change. In 2017, we released an updated report, which examined progress against 11 key recommendations. It found evidence of real success in some areas - including the introduction of access and waiting times standards for psychosis, with most people starting treatment within two weeks of referral. However, it also flagged that in other areas there is still significant progress to be made to improve access to supported housing, public understanding of schizophrenia and the physical health outcomes for people living with schizophrenia.

Rethink Mental Illness has campaigned for **reform of the Mental Health Act** for several years and continues to do so to the present day. This has involved the 2018 launch of the No Voice, No Choice; Making the Mental Health Act Person-Centred report and delivering a petition to the Prime Minister calling for the implementation of the Independent Report's recommendations in 2019. In 2021 we responded to the Mental Health Act White Paper and published two commissioned reports on the experience of people previously and currently detained under the Mental Health Act, as well as their carers and families, and submitted evidence to the Joint Committee in 2022. We launched a public campaign called 'Wrap It Up' in 2023 to persuade the government to reform the Mental Health Act before the next general election.

After both the Dispatches and Panorama documentaries, Rethink Mental Illness published a blog on "Five recommendations to improve inpatient safety" on 13th March 2023, the contents of which are below:

Five recommendations to improve safety on inpatient wards

13/03/2023

Anyone who has endured a mental health crisis will tell you what a frightening, bewildering experience it can be. It is often one of the most distressing events in someone's life. With this in mind, people who find themselves in a mental health hospital should expect to be kept safe, cared for with respect and dignity, and given appropriate treatment that helps them to recover. But sadly, this is too often not the case.

Rethink Mental Illness has been campaigning on longstanding issues around the safety of people in mental health hospitals for years, but recent exposés by BBC Panorama and Channel 4's Dispatches are stark reminders of the shocking levels of abuse and neglect which can take place.

These investigations echo what people have been telling Rethink Mental Illness and our partner charity, Mental Health UK, in recent months. We've heard distressing stories of poor care in unsafe environments, often as the result of a lack of empathy and compassion from some staff, alongside harmful practices such as the overuse of restraint and seclusion. Many say this fundamentally stems from the imbalance of power between the patient and the system.

> *"There is physical safety, things like self harm or from other service users. But there's also the psychological aspect to it. One of the things I found difficult is there were instances where people kicked off, restraint issues, things like that. The tension and fear that there would be violence, all the time. It wears you down." - Expert by experience*

The shocking cases of abuse and neglect in Essex and Manchester have bolstered our fight for better care and show that change must happen urgently to save lives. In this blog, we will outline our work in this area and provide recommendations for change. Improving safety on inpatient wards will require systematic change. The government recently announced an independent rapid review which will look at whether data and information is being used effectively to identify patient safety issues. While we fully support this review, on its own, it will not be enough to save lives. We would like to see a set of actions that will be taken to ensure that this data is responded to and where there are failings, that rapid action is taken to improve patient safety.

1 - Improve the mental health workforce

Experts by experience tell us time and time again that the low levels of staff, overworked staff and staff without appropriate qualifications and training, have led to unsafe and ineffective care. The government must ensure there are clear recommendations to improve this as part of the NHS workforce plan, with funding for the mental health workforce. This should include a mental health inpatient workforce plan which features peer support and the commissioning of the voluntary sector to deliver services on wards.

2 - Prioritise reforming the Mental Health Act

The government must also prioritise and properly resource the reform of the Mental Health Act. The reformed act should be guided by the principles of giving patients choice and autonomy, the use of least restriction, a focus on therapeutic benefit and ensuring people are treated as individuals. We believe this will go some way in addressing the power imbalance that currently exists between patient and practitioner.

3 - Address the continuing rise in out-of-area placements

We know that out of area placements can be very distressing for patients, and it is important that patients are able to receive care close to their homes and communities. However, out of area placements continue to rise in certain areas and the NHS Long Term Plan has failed to reach its target in eliminating them. The NHS must continue to focus on this issue and look at ways to incentivise the reduction of these placements so that people can be treated safely near their families and home.

4 - Work collaboratively with experts by experience

The Care Quality Commission (CQC) will continue to play a key role in independently assessing hospitals and ensuring best practice. To improve inspection practices, the CQC must ensure greater involvement of experts by experience, and their families and carers, as well as independent mental health advocates in inspections. The CQC must also actively engage with patients and their carers to weed out safety issues. The CQC must also strengthen its collaboration with local safeguarding boards in regard to inspections of hospitals. Concerns raised about a hospital or units are a critical source of information for inspectors and can help in the monitoring of patient safety.

5 - A change in attitude from policy makers

Finally, a change in attitude by policy makers is much needed. The government must focus on relational security - building better relationships between staff and patients - as much as physical security, such as ward design, and procedural security, such as safeguarding procedures. The DHSC, NHS England, and CQC must continue to speak with and work alongside experts by experience, and their families and carers, to understand what safety means to them and how to improve it.

Continuing reports of failures in mental health hospitals paint a bleak picture, but we must remember that there is good practice happening across the country, and that change is possible. Rethink Mental Illness is committed to continuing to work with experts by experience, their families/carers, mental health charities and the government to ensure that patients receive the best possible care and that their safety is prioritised.

> *"There were also some good things - some of the female nurses were exceptional and it was only due to their particular care, that I was overall, safe." - Expert by experience*

Research and surveys

Rethink Mental Illness has conducted a range of research and surveys into the standard of care provided on mental health inpatient wards. The most pertinent examples are summarised below. Many of these are not published publicly so please contact us for more information on any of the research or to access the reports.

The Care Quality Commission funded Rethink Mental Illness to carry out an engagement project about **patient safety and care in specialist inpatient mental health services** between January – February 2023. This entailed holding sessions with people from a range of different demographics with experience of being in services to better understand their views on what makes people feel safe and cared for or unsafe and at risk as an inpatient, what prevents people sharing their experiences of care and what can the CQC do to facilitate the sharing of experiences. The proposed recommendations were:

- A person-centred approach with regular reviews of individualised care plans
- Greater and improved access, options and knowledge for making complaints and/or providing feedback through closed feedback loop
- Widening engagement with the CQC Inspection team
- Encouraging reflection on CQC involvement on transitions of care

The DHSC funded a Rethink Mental Illness engagement project on **mental health crisis, preventions, response and discharge topics** between July – September 2023. The project involved engagement and co-production sessions and the key themes that came out of the project were:

- Need for preventative and responsive inpatient care through a person-centred, holistic, compassionate, therapeutic approach to care and safety; redressing of power imbalance between psychiatrists and patients; co-production.
- Greater accessibility to staff/healthcare professionals in inpatient settings
- A need for more community services and crisis support in the community
- Need to develop appropriate access points for people in crisis
- Improvements to Mental Health Act assessments through advocacy and improved information
- Improvements to discharge process through debriefs and follow ups

Rethink Mental Illness worked with a specific Provider Collaborative in April-July 2023 on an engagement project about **Health and Mental Health Inequalities with an Adult Secure Care Provider Collaborative**. Key themes that were raised included issues with diagnosis and care pathways, a lack of provision of preventative and responsive healthcare, inaccessible information, limited accessibility to staff/healthcare professionals, restrictive practices, literacy levels affecting understanding of vital information, impact of stigma, the perception of inequalities, a lack of LGBTQ+ support, inconsistent responses to substance-related behaviour. We recommended:

- Relationship-building: Positive feedback about staff; lacking relationship building between staff and service users affecting trust.
- Family engagement: Involve families in care decisions, and engagement opportunities.

- Understanding and expectation of inequalities: Varied understanding of "inequalities"; Focus on basic needs rather than protected characteristics; Further exploration needed.
- Further engagement and data collection: Snapshot; Broader representation needed.
- Education and literacy: Basic literacy skills and basic education for all in services.
- Feedback loop: Everyone involved wanted to see the report and know next steps.

As part of the NHS England stakeholder testing for the **Draft Managing a Healthy Weight in Practice Guidance** for Adult Secure services, Rethink Mental Illness gathered feedback from people living in secure services on the Draft Guidance through the Recovery and Outcomes network. There was support for the guidance, with suggestions to improve or develop it including:

- More education is needed around food and nutrition
- Alternatives to food are needed as an incentive or focus of Section 17 leave
- More funding and trained staff are needed for physical activity
- The role of peer support in physical activity needs to be reflected
- Better understanding of the link between drug treatment and hunger needs to be included

In collaboration with NHSE/I and in consultation with a group of Experts by Experience who work regularly with NHSE/I Adult Secure Specialised Commissioning and Secure Care Programme teams, Rethink Mental Illness developed a survey to gather the views and experiences of people in adult secure services and their families and carers, to find out the **impact of COVID-19** on them from March to June 2020. Analysis identified 9 common themes:

- Activities – for some having activities to keep them occupied was working well, for others their regular activities have been cancelled which had been difficult
- Outdoor access – people valued outdoor access but there was considerable variation in access and the processes for gaining outdoor access
- Leave and progress – people found restrictions difficult for a range of reasons and some linked them to the effect this was having on their progress and feelings of frustration that this was being held up. There was also frustration for people that lockdown easing in the community was not always reflected in the lifting of restrictions in their hospital.
- Communication – effective communication was very important for people and reassuring when it worked well, and the use of digital technology was helpful for some people. For some there was a lack of effective communication between people, services and in receiving updates about COVID-19.
- Digital access – people valued phones and digital access but this was not consistent across services with some having limited or no access at all, with examples of problematic processes for their effective use.
- Contact with family & friends – where visits and contact were reduced, people found this very difficult, but where contact was facilitated virtually, this made a positive difference to people's experience
- Preventing the spread of COVID-19 in secure services – overall people were very understanding of the measures that needed to be in place to keep them safe.

- Physical health – people told us about having both an increased and decreased access to physical activity, and there was marked variability in smoking policies across services.
- Staff – people valued and were grateful for staff support and kindness during this time, with some saying that reduced staffing levels were linked to difficulties on the ward.

Rethink Mental Illness supported the development of the **Carer support and involvement in secure mental health services toolkit**, which aims to provide clear information for carers, service users, service providers and commissioners about how carers of people who use secure mental health services should be engaged with, supported, involved and empowered.

As part of the NHS England consultation on the **new service specifications for Adult Medium and Low Secure Mental Health Services**, Rethink Mental Illness conducted two consultation groups with carers of people living in secure services. Key themes raised included:

- The importance of good communication between everyone involved in secure services at every stage of the care pathway, with the involvement of carers as much as possible.
- The need for clearer descriptions of care pathways, advocacy services and the management of risk.
- The need for clearer outcomes for every part of the care pathway.
- The provision of high quality holistic, person-centred care.
- The importance of adequate staffing levels.

As part of the same work, we also facilitated nine consultation events with 80 people living in secure services on their views on the new specifications. The key overall themes that emerged most strongly for incorporation into the specifications were:

- The need for a greater emphasis on person-centred care and support for recovery.
- Better information sharing and communication at every stage of the pathway.
- The need for accessibility for all
- A more robust description of the support for carers, family and friends, especially at discharge and transition.

Rethink Mental Illness worked collaboratively with the NHSE/I National Specialised Commissioning (Adult Secure) Team and Mental Health Secure Care Programme to develop **A Guide to Involvement and Co-Production for Provider Collaboratives**. The guide sets out core pillars and principles that can be used to underpin strategies and practical tools to enable involvement and co-production to become 'business as usual' at every level and the development of 'Involvement Pathways'.

Within the constraints of organisational memory, this is as accurate a record of the campaigns, schemes and programmes organised by Rethink Mental Illness to assess or improve the standard of care provided by mental health inpatient services within the Relevant Period, as far as we can recall.

There have been specific examples of policy changes during the Relevant period, although there seems to be limited evidence available as to how practice has changed or improved, particularly over the past 5 years, and any subsequent effect on outcomes for patients. The fragmented nature of changes has also made it difficult to judge their relative success.

Examples of changes to national policy include the Mental Capacity Act 2005, Mental Health Act amendments in 2017 and Mental Health Units (Use of Force) Act 2018. The 2023 Rapid Review into data and evidence on mental health inpatient pathways also produced several significant recommendations aimed at improving standards of inpatient care, which were accepted by the Government and are being worked towards. The NHS Five Year Forward View (2014) and the Long Term Plan (2019) led to greater scrutiny of inpatient care standards via the Mental Health Independent Advisory and Oversight Group. The NHS Long Term Workforce Plan (2023) also aimed to improve quality.

NHS England has also implemented several significant changes including the Mental Health, Learning Disability and Autism Quality Transformation Programme which gave rise to the Culture of Care Standards for Mental Health Inpatient Services and ending the use mixed sex wards.

Involvement with mental health inpatient care providers in Essex

Rethink Mental Illness is not currently delivering any services in Essex. Please find details of work we have previously delivered below. There is a volunteer-run peer support group called Braintree Rethink Carers Support Group which meets once a month and aims to offer support to members and help increase the awareness of mental illness and the effect it can have on carers, and those experiencing mental illness. They also try to stop the stigma associated with mental illness with community events and fundraise to help those that need in most in the local community. We previously ran the Improving Access to Psychological Therapies service in North East Essex over 10 years ago, but we transferred our records of this to the new provider when the contract changed hands and then deleted them from our systems, in accordance with data protection laws.

Involvement work

Rethink Mental Illness convened a regional group in East of England in some Essex secure units as part of the National Recovery and Outcomes Network commissioned by NHSE between 2012-2019. This work consisted of running involvement groups for people in adult medium & low secure services to influence design delivery and monitoring of secure services.

Advocacy work

Rethink Mental Illness previously provided Essex All Age advocacy services during the time period covered by the Inquiry. Rethink Advocacy provides services under the Care Act, Mental Health Act, Mental Capacity Act, and in other situations where advocacy is not a legal right. In Essex, we supported people of all ages, including those who live with mental illness and learning, physical and sensory disabilities. Our services included Independent Mental Capacity Advocacy, Independent Mental Health Advocacy, Independent Care Act Advocacy, NHS Complaints Advocacy, Relevant Person Paid Representative, Community advocacy and Self-advocacy.

Our Communications and Campaigns team have supported our Policy and Influencing team in highlighting patient safety issues on inpatient wards. In late 2022 and early 2023, investigations

by BBC and C4 Dispatches revealed systemic failings in Essex, Manchester, and Stockport. We responded to these investigations and the NHS/DHSC Rapid Review findings, aimed at improving care and drawing national lessons rather than focusing on specific counties or areas. Please find screenshots of our public statements on patient safety as seen on our website in separate submitted documents.

In 2019 Rethink Mental Illness were contacted directly by a bereaved mother of a young man who was treated in an inpatient facility in Essex who asked us to actively get involved in a campaign focused on initiating a public inquiry. She also contacted the Rethink peer group coordinator in Braintree Essex with the same request. Our organisational policy at the time was that we didn't get involved in individual case campaigning and instead identified common issues across England as a nation to raise with decision makers. We wrote to the bereaved mother directly to express our sympathy, directed her to our Rethink Mental Illness Advice and Information Service for more support and information and share the work we were and are doing to influence system change including on the Mental Health Bill. Further engagement took place over the following months through email and social media channels.

In 2021, Inquest contacted Rethink Mental Illness to support a public call for a statutory inquiry into the deaths and systemic failures in Essex. We took the decision to not support this request as we held the opinion that a non-statutory inquiry would be the quickest way to achieve the terms of reference of the inquiry, as they existed at that time. After Dr Geraldine Strathdee's open letter of 12th January 2023, we then supported the move to a statutory Inquiry. We met with Dr Geraldine Strathdee ahead of the non-statutory phase of the inquiry, and we submitted evidence in 2023 supporting the change of Terms of Reference of the Inquiry.

We have looked back over our data from the Relevant Period and whilst we were providing the Essex All Age Advocacy service, which was between July 2018-June 2024. In this period, we raised 109 safeguarding concerns with the local authority in line with our organisational processes and in line with what would be expected of an advocacy service provider. Most of the concerns would have related to where the Advocate was making a referral to the local authority on behalf of the vulnerable person they were supporting. This could be in relation to a fall, care plans not being reviewed and/or updated by a care home, altercations between our service user and another resident in a care home, and/or allegations relating to staff conduct, or concerns being raised by service users with the care home / ward not being acted upon.

Of the 109 concerns, around 20 related to the local authority or NHS Trust and their action or inaction that negatively impacted on a person we were supporting. For example, social care funding being withdrawn which meant 1-2-1 support was withdrawn and person then had a fall, or a service user falling ill in their care home, the care home staff calling for a GP who didn't attend and the person passed away.

In response to the 2022 Dispatches programme, we took it upon ourselves to conduct an internal review overseen by our Integrated Governance Overview Group, an internal governance group responsible for overseeing matters related to service user and staff safety. The purpose of the review was to assure ourselves of the extent of our knowledge of events in Essex, establish whether we held data (for example, incident reports) which reflected issues raised in the

programme, review our processes for reporting and recording incidents and to adjust our processes and policies as required. Our review found that our advocates were not aware of the issues highlighted in the programme, and none of the individuals featured were known to us. For the full report please see submitted exhibit *'2025.03.26 Rethink Mental Illness Essex Insights Disptaches IGOG Report'*.

Of the concerns we reported to the local authority, one related to Rochford Hospital and one to the Linden Centre, sites featured on the programme. On review of each report, it was considered that appropriate actions were taken. None of the people featured on the Dispatches programme were known to the advocacy service.

More broadly, whilst the review did not identify any connection between data we held and the issues raised in the programme, we made adjustments to policies and processes, including reviewing our safeguarding policies to make it explicit about how colleagues should raise and report concerns, particularly where those are observed within third party settings, and ensuring we have established appropriate routes of escalation both internally and externally

We have not conducted any research specifically into inpatient experiences in Essex.

From May to July 2021, we were commissioned by South East Essex Clinical Commissioning Group to facilitate the coproduction of a roadmap for South East Essex mental health transformation and whole system culture change. During this time, we facilitated a series of four workshops that brought together different stakeholders and wrote a report based on those workshops. It is worth noting that this work was carried out with a focus on community mental health services. Please find this report in submitted document *"2025.03.26 Rethink Mental Illness South East Essex CMHS Transformation Report"*.

The workshops explored the topics: 1. Learning from other places 2. Key enablers: what needs to be in place for culture change and a joined-up mental health system? 3. Working together as a whole system How can collaborative, partnership working happen? 4. A way forward A road map that incorporates an aspirational shared vision and captures ways of working together with shared purpose across SE Essex to move towards transformation.

The workshops were designed in an iterative way, each one building on what participants said from one workshop to the next. There were 70 participants over the four workshops, representing 14 different partner perspectives, including service user and carer. The collective total time given was 450 hours. This resulted in a wealth of views and recommendations, culminating in key goals/challenges to guide the focus of the next two years. There was a clear drive from the workshops to work together towards a shared vision for integrated and holistic care for people living with serious mental illness and complex needs, their families and carers, and the people working to support them. Challenges and solutions were identified for reaching the different milestones on the roadmap, and a collective commitment to work through these was achieved. Top priorities for 2023 were developed which consisted of:

- A joined up, responsive system with no barriers
- Easy access to the right expertise, for all
- Trusted assessors across the whole system

- More choice and more holistic support

Rethink Mental Illness has identified several priority areas for influencing for improved inpatient care, focused on improving the culture and workforce of inpatient settings, increasing accountability and oversight and reforming the Mental Health Act. There are numerous barriers involved in this work including a lack of focused funding, inconsistent approaches to engaging with Voluntary, Community and Social Enterprise (VCSE) organisations and people with lived experience across geographic areas and longstanding problems with recruiting, training and retaining the frontline workforce. These are often compounded by a complex, out of date and oftentimes contradictory legislative framework (e.g. the Mental Capacity Act's interface with the Mental Health Act). There has also been consistent change within institutions such as DHSC and particularly CQC over the past few years, creating difficulties in meaningfully engaging with decision makers to enact long-term, tangible change that has an impact for people in inpatient care. In terms of organisational challenges, we are a small team of 8 people working in policy and 2 people working in campaigns across a very wide range of issues affecting people affected by severe mental illness. We focus on influencing on a national scale but given there are 42 ICBs and many more Trusts, we are unable to monitor everywhere due to the size of our team unless commissioned to do so.

It is our ambition that the implementation of a reformed Mental Health Act and associated Code of Practice represents a key opportunity to advocate for improved inpatient care and safety. As described in our answer to question 2 above, we are continually engaging with VCSE sector partners, healthcare providers and national organisations in order to ensure the prioritisation and improvement of inpatient care experiences. Through the work of our Programmes team, we also plan to continue our work engaging with people with lived experience of severe mental illness and inpatient mental health settings to ensure that their voices are central to developments at a local, regional and national level. We have now adopted a much more flexible approach to our previous policy of not campaigning on individual cases after reflection on events in Essex.

Our Lived Experience Advisory Board consists of up to 20 members plus any trustees who use, or have used, mental health services. Key areas of work include monitoring the progress of the Involvement Strategy, making suggestions and providing constructive feedback on issues relating to the involvement and support of people who use mental health services.

Our Carer's Advisory Board continues the long tradition of carer involvement within the charity and provides a distinct and strong voice for the carers of people severely affected by mental illness.

At Rethink Mental Illness, we gather feedback from people who use our services, as well as their families, carers, and professionals involved in their care. This helps us ensure our services remain effective and person-centred while also informing our wider campaigning and policy work.

How We Collect Feedback

- **Surveys**: We collect structured feedback at the start and end of advocacy support to assess experiences and the impact of our work. These surveys are informed by the **NDTI Outcomes Framework**, which helps us evaluate how well advocacy services enable individuals to have a voice in decisions affecting their care.
- **Advocate Self-Review**: For those lacking capacity to complete the survey, advocates complete a structured review. This focuses on the areas where they have supported the individual and the impact this has had.
- **Friends and Family Survey**: To capture broader perspectives, we invite families and carers to provide feedback through our Friends and Family Survey, which is available across all our services.
- **Stakeholder Survey**: We also gather insights from health and social care professionals who work with our services via our Stakeholder Survey. This helps us understand how our advocacy and wider provision is perceived within the wider system and identify areas for improvement.

How Feedback Informs Our Work

- **Campaigning, Policy and Influencing**: Feedback from people with lived experience, their families, and professionals informs our policy recommendations and public campaigning. By identifying key themes and challenges, we ensure our advocacy is evidence-based and responsive to real-world experiences.
- **Service Improvement**: Feedback directly influences how we shape and refine our advocacy provision, helping us to improve the support we offer.
- **Strategic Recommendations**: By analysing trends in the data, we contribute to policy discussions and make evidence-based recommendations to policymakers and service providers. This ensures that the voices of people affected by mental illness play a central role in shaping inpatient care and mental health services more widely.

Through this approach, we ensure that the perspectives of individuals, families, carers, and professionals are central to both our advocacy efforts and the broader mental health policy landscape.

The work Rethink Mental Illness undertook in response to the Channel 4 documentary, 'Dispatches – Hospital Undercover: Are Our Wards Safe?' was focused on behind the scenes influencing activity and also at a national level. This involved sitting on the board for the Rapid Review into Data on Mental Health Inpatient Settings, meeting with the Health Services Safety Investigation Body and engaging with Dr Geraldine Strathdee with regards to the initial, non-statutory inquiry.

The organisation Mind predominantly led the public campaigning aspect after the Dispatches documentary, so we balanced roles and responsibilities within the Mental Health Policy Group. The evidence from the documentary also fed into our behind the scenes influencing and public campaigning activity to reform the Mental Health Act.

We were speaking with Manchester Hospital Trust senior management team on improving the use of involvement with the aim to improve patient safety in mental health inpatient settings in 2022, but after the Panorama documentary "Undercover Hospitals: Patients at Risk" programme aired, this work did not continue. The work had been funded by Greater Manchester Mental Health Trust, as the lead provider in the provider collaborative at the time. They then stopped being the lead provider and the work was no longer commissioned by the provider collaborative.

As outlined in above, Rethink Mental Illness carried out behind the scenes influencing activity aimed at Government and officials, as Rethink and MHPG, where we raised the issues outlined in Dispatches and Panorama, as part of systemic concerns around safety on inpatient wards that we have continually seen across the country.

Apart from our peer support group in Braintree, we have limited local representation in the area.

Mark Yates & Mark Winstanley had a meeting with The Essex NHS Trust Chair (Shiela Salmon) and CEO (Paul Scott) on 10th August 2021 to discuss building confidence in day-to-day activity of the Trust and improving external partnerships including with the Voluntary, Community & Social Enterprise sector. There was a subsequent meeting between Mark Winstanley and Paul Scott on 17th January 2022 discussing similar issues, and on 16th May 2022 Mark Yates met with Johnny Townsend (Senior Business Support Manager) and Alexandra Green (title unknown) but after this, there was no follow up from the Trust on progressing the work further.

As previously mentioned, before the initial Inquiry, Rethink Mental Illness had a policy of not responding to specific cases due to capacity constraints as a small team, and where we believed we can have maximum impact. We have since reviewed this policy off the back of the events in Essex to adopt a more flexible approach and now use individual cases as examples of more widespread problems and systemic issues.

For example, the below statement on the tragic deaths of Beth Matthews, Deseree Fitzpatrick and Lauren Bridges:

Our response to the BBC investigation into the Priory Group - 26 April 2023 Today (Wednesday April 26th) we respond to a BBC investigation which features claims from former senior managers at the Priory Group who shared concerns about the safety of patients and staff. This story follows the tragic loss of Beth Matthews and two other women, Deseree Fitzpatrick and Lauren Bridges, who died while inpatients at the Priory Group's Cheadle Royal Hospital in Stockport.

Brian Dow, Deputy Chief Executive of Rethink Mental Illness and Chief Executive of Mental Health UK:

"We keep Beth Matthews' loved ones in our thoughts today, alongside other families who have been let down by services that failed to keep their loved ones safe and provide the appropriate, dedicated support they needed.

"The BBC investigation into the delivery of services by the Priory Group raises important questions not just for the Priory Group but the wider environment in which services are

delivered. The availability of a trained, committed workforce is the foundation on which appropriate and safe care that aids recovery is built. Everyone will appreciate that recruiting and retaining this skilled workforce comes at a cost and too often the consequence of this is a lack of focus on quality. If we want our sons, daughters, loved ones and friends to have the care they need and deserve we have to demand better. There can be no avoiding the reality that this requires the Government to adequately fund mental health services – both those in clinical settings and those in the community.

"In tandem, we need to reform the Mental Health Act to give people in crisis more say in their care and to address many of the systemic issues placing patient safety at risk, alongside a robust inspection system that hears the voices of people using services and holds all providers to the same high standards.

"The ongoing rapid review into mental health care is of critical importance. A statutory public inquiry could also act to address many of the systemic issues placing patient safety at risk, but every day waiting for the findings and recommendations of such an inquiry leaves people in inpatient mental health units at risk. We need more urgent action to push standards up."

The author of the 'Inpatient care?' blog on our website did not specify where her experience occurred while engaging with our Experts by Experience Story Coordinator.

Oxevision

The only available peer-reviewed study on the use of Oxevision technology on mental health wards is the Griffiths et al. 2024 systematic titled "**The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: a systematic review"** which concluded that "There is currently insufficient evidence to suggest that surveillance technologies in inpatient mental health settings are achieving their intended outcomes, such as improving safety and reducing costs. The studies were generally of low methodological quality, lacked lived experience involvement, and a substantial proportion (28.1%) declared conflicts of interest. Further independent coproduced research is needed to more comprehensively evaluate the impact of surveillance technologies in inpatient settings. If they are to be implemented, all key stakeholders should be engaged in the development of policies, procedures and best practice guidance to regulate their use, prioritising patients' perspectives." It can be found at https://pubmed.ncbi.nlm.nih.gov/39614242/.

As referenced in the conclusions above, there are several other studies that have been done on the use of Oxevision technology, although these were paid for by Oxehealth (the company that makes Oxevision) and therefore there is a conflict of interest. Some of these studies are also not peer reviewed and/or are based on a very small sample size. These studies can be found on the Oxehealth website at https://www.oxehealth.com/scientific-studies

Ian Callaghan, our Lived Experience Programme Manager, attended a conference in 2024 at which the NHSE principles for using digital technologies in mental health inpatient treatment and care. It is worth noting that StopOxevision, a campaign led by people with Lived Experience are not supportive of these principles. Ian Callaghan was also interviewed for research on the

use of Oxevision by the CQC, although we do not believe that the outcomes of this work have been published yet.

Position 20/22/2023

We need to openly discuss both the opportunities and risks posed by the adoption of new technology to support the care and treatment of people severely affected by mental illness, such as monitoring systems like Oxevision. There are already fault lines, and this is an issue that will only intensify in the years to come. In the case of Oxevision, we think it is helpful to understand the status quo. As things stand, people in inpatient services are routinely checked day and night to make sure that they are safe and well. At times, people may need to be observed much more frequently. Oxevision can allow staff to check on someone's welfare remotely and check their vital signs, without disturbing their sleep. Some people might prefer a less disruptive method of observation that helps to keep them safe and may wish to give consent for Oxevision to be used during their treatment.

“However, there are also risks, as identified by Stop Oxevision campaigners, around its use being a form of restrictive practice that breaches people’s rights, with potential short and longer-term effects on people, even when the camera is not in use. The concerns identified around data usage and consent risk compromising privacy for all, with specific risks for marginalised groups, including trans people and those whose religious beliefs prohibit them being observed by members of a different gender. We are also concerned about its potential impact on people living with OCD, psychosis or paranoia, and those who have experienced trauma, in that its use can be triggering and re-traumatising. Therefore, we believe these monitoring systems should only be used where there is regular, specific consent gained from people who have been given all the information about how their data, including any video footage, is used within services. This information must be presented in a clear, digestible format, for example with easy read versions and video talk-throughs available. Where someone lacks capacity, it is essential that clear safeguards are put in place to ensure its use is in the best interest of the patient’s safety, for example that it is used for the shortest amount of time possible, and that family and carers’ views are sought. In order to have faith in new technologies and ultimately have them used in a way that helps rather than causes harm, this must always be the basis of their use.

“Alongside the debate around new technology sits the complex issue of workforce. With mental health services facing widely documented staffing shortages there is also a danger that technologies such as Oxevision could be used by providers to “short-circuit” the kind of person-centred care people need. This would be unacceptable when too often we have seen restrictive practices being imposed on people.

“We are pleased that NHS England and the National Mental Health and Learning Disability Nurse Directors Forum will be reviewing the consent model used around Oxevision. We hope to be part of this review and have agreed the importance that it is co-produced in partnership with those with lived experience, families and carers, including people who have already experienced the use of Oxevision as part of their care – an approach we know Oxehealth fully supports. We also believe further guidance is needed around the information provided to

people that sets out how this kind of monitoring works, with different formats and languages available to ensure consent is fully informed.

"Above all, use of this kind of technology should always clearly be in the best interests of the person being treated, who should have an informed choice and be able to withdraw consent at any time. Good and safe care is built on the principles of co-production, with people in services and providers working together to develop good standards of safe care."

Update 10/4/24

"We're aware of two major reviews currently taking place, which we hope will clarify whether there is sufficient and robust evidence to support the further roll-out of this technology, and we will be carefully monitoring further developments. We urgently call for more independent, co-produced research that thoroughly evaluates the impact of monitoring systems, including the full range of potential harms, to ensure the use of this technology is in no way detrimental to the therapeutic relationship between people in services and their caregivers."

4. We have provided as much information as possible, within the constraints of organisational memory over the Relevant Period. There has been significant change in staffing and systems over this period so some details, particularly from earlier on the period were not accessible.

5. N/A

I believe the facts stated in this witness statement are true.

Signed: [I/S]

Date: 26.03.25