

Witness Name: Gareth Harry

Statement No.: 1

Dated: 20 May 2026

LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF GARETH HARRY

I, Gareth Harry, will say as follows: -

1. NHS England welcomes the Lampard Inquiry, fully supports its work and is grateful for the opportunity to participate. We are committed to assisting the Inquiry and learning from the evidence provided to it, as well as its findings.
2. I want to extend my deepest sympathies to the families, friends, and carers of those who have lost loved ones or have been affected by the issues under review in this Inquiry. The events have had a profound and lasting impact, and we remain committed to listening with care, learning from what is shared and turning those lessons into meaningful change.

Background

3. In June 2022, I was appointed as the National Delivery Director for Mental Health, Learning Disability and Autism for NHS England. I am an NHS General Manager by background and a graduate of the NHS Management Training Scheme. I have worked for the NHS since 2000. Most of my career has been working in primary care, community services and mental health services at local, regional and national levels.
4. Prior to this role, I was an Executive Board member at Derbyshire Healthcare Foundation Trust, a mental health and children's services provider in Derbyshire for

four years. I was Chief Commissioning Officer for NHS Hardwick CCG and in that role was lead commissioner for mental health services across Derbyshire for four years before that.

Approach to the NHSE Rule 9(9) Request

5. This witness statement was drafted on my behalf by the external solicitors acting for NHS England in respect of the Inquiry, with my oversight and input. The scope of the request is broad and goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals in writing, by telephone and video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief. References throughout this statement to 'NHS England' and 'we' represent the voice of the organisation.
6. The statement has been produced following a targeted review of documents collated to date. In the time available, it has not been possible to review every potentially relevant document, and it is highly likely that relevant documents exist that have not been reviewed or cannot be located. I cannot exclude the possibility that it will require updating as further evidence emerges through our ongoing process of internal investigation and document review. NHS England will, of course, notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was known to us before the deadline for its production.
7. NHS England is only one part of the NHS. The NHS itself is an ecosystem of thousands of organisations, including NHS bodies (such as Trusts) and independent providers (such as GP practices and pharmacies, who hold NHS contracts). These organisations work collaboratively but have specific legal duties and operational independence (for example, they usually employ their own staff and buy their own supplies). In this statement where there are references to 'the system' I refer to the NHS and non-NHS organisations who provide NHS-funded health services to patients, commissioners of those services, and applicable regulators.

Outline of this corporate witness statement

8. This witness statement consists of two sections:

- a. Section one: Introducing new technologies in healthcare by providers
- b. Section two: Oxevision

Executive summary

- 9. Following the merger of NHS Digital and NHS England on 1 February 2023, NHS England is responsible for designing and operating national data infrastructure and digital systems. The overall responsibility for the use of digital health technology products sits with care providers and commissioners at a local level, however NHS England has produced various supporting frameworks, standards and policies that guide the assurance of digital health technology products, so they are safe for use within the NHS.
- 10. NHS England recognises the important role that digital technologies have in delivering patient care. This is aligned to the 10-Year Health Plan and NHS England's objectives under its digital transformation and patient safety strategies, which encourage the adoption of tools that support timely intervention and consistent care standards.
- 11. Whilst digital technologies can enhance safety and patient experience, they are not a substitute for good patient care and therapeutic clinical relationships and there is a risk that their use without clear safeguards could lead to harm.
- 12. NHS England is accountable at a national level for patient safety risks posed by technologies it directly commissions for deployment across the NHS in England.
- 13. Providers who commission new technologies, as is the case with vision-based monitoring systems ("VBMS"), are responsible for their procurement, evaluation and deployment. Therefore, responsibility for patient safety rests with the individual NHS Trust or provider organisation implementing and using the technology in clinical practice.
- 14. NHS England has been made aware of feedback and issues associated with Oxevision's implementation across NHS-funded services from various sources as set out below. NHS England has used this feedback alongside its own commissioned

research and the work of others to inform its overall approach to VBMS¹.

15. In Autumn 2022, NHS England commissioned Public Digital to identify the key needs of patients and health professionals which VBMS must satisfy, the report was published in May 2023. In Summer 2023, NHS England also commissioned research into surveillance based technology in inpatient mental health settings. The research, published in November 2024 considered the effectiveness, ethical implications, and practical impact of technologies including VBMS. In parallel, NHS England organised the Digital Technologies Conference on 26 February 2024, which included a presentation from the British Institute of Human Rights on Human Rights and Digital Technologies. The *Principles for using digital technologies in mental health inpatient treatment and care* (the "*Digital Principles*") were subsequently developed with NHS representatives, other stakeholder organisations and people with lived experience and published by NHS England to help clinicians consider whether use of a digital technology is the most appropriate, effective and least restrictive method of caring for or treating a patient in inpatient mental health settings.
16. NHS England has also been following the evidence relating to Oxevision being shared with the Inquiry.
17. NHS England recognises that research into the use of VBMS is still developing and it continues to monitor its guidance and the *Digital Principles* to ensure guidance is up to date and aligned to the Patient Safety Strategy and Culture of Care.

¹ Note that different organisations may refer to vision based monitoring systems as VBMS, VBPM or VMPMS. Terms are used interchangeably throughout this statement.

Section One: Introduction of new digital healthcare technologies by NHS providers

Introduction of new technologies

18. Where NHS providers introduce new technologies, as is the case with VBMS, they are responsible for identifying and managing patient safety risks. The Provider must adhere to applicable national requirements and retain full accountability for procurement, assessment, and implementation decisions. Providers who are implementing new technologies within their own budget are responsible for their procurement, evaluation and deployment. At a site level, responsibility for patient safety rests with the individual NHS Trust or provider organisation implementing and using the technology in clinical practice.
19. NHS England has issued two digital clinical safety assurance standards (the “Standards”) to ensure new technologies are assured as safe and to ensure both manufacturers and providers conform to a national standard [Exhibit KEN-00008483, GH001]. The Standards are:
 - a. *DCB0129 – Clinical Risk Management: its Application in the Manufacture of Health IT Systems*. This standard is designed to help manufacturers of health IT software evidence the clinical safety of their products. [Exhibit KEN-00008479, GH002]
 - b. *DCB0160 – Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems*. This standard is designed to help health and care organisations assure clinical safety of their health IT software. [KEN-00008480, GH003]
20. The Standards ensure that digital clinical risk management is rigorous, methodical and clearly documented to ensure clinical risks have been assessed and if required, mitigated appropriately, to ensure the product is safe for patients. They require manufacturers and providers to establish formal processes for the evaluation, approval and governance of new technologies. The Standards are mandatory under the Health and Social Care Act 2012. They also apply to independent sector providers of NHS-funded services.
21. The Standards require Trusts to have in place appropriate clinical risk management arrangements, including completion of a clinical safety assessment and approval of a

Clinical Safety Case, prior to a system being put into live operational use. In parallel, Trusts would ordinarily be expected to obtain and consider evidence of the manufacturer's compliance with DCB0129 as part of pre-implementation assurance, to inform deployment decisions and local risk mitigation. NHS England is currently reviewing the Standards to ensure they are practical and in alignment with the latest healthcare technological advancements and clinical practice. Focus groups consisting of a wide range of stakeholders, including those involved in digital risk management, were held in June 2025. The feedback from these focus groups has informed revisions to the Standards, and we are currently in the process of going out to public consultation, with an aim of publication in autumn 2026.

Monitoring and Oversight of new technologies

22. NHS England coordinates closely with a range of national bodies to support the identification, monitoring and mitigation of emerging risks associated with new technologies. Data from the Learn from Patient Safety Events (LFPSE) service is shared in a controlled way with organisations such as the CQC (which regulates all NHS providers, including independent sector healthcare providers providing NHS services, on all areas of quality), the MHRA, and the Health Services Safety Investigations Body (HSSIB) to support regulatory oversight, investigation, and national responses to safety concerns. Further information on each organisation's role and responsibilities has previously been provided in the First Witness Statement of Duncan Burton, Chief Nursing Officer for NHS England.
23. The National Patient Safety Team acts as the NHS's central mechanism for collecting, interpreting and responding to information about patient safety events, primarily through the Learn from Patient Safety Events Service (LFPSE). This enables the systematic collection of safety intelligence across the NHS (including that related to digital products).
24. The National Patient Safety Team uses specialist patient safety expertise to analyse both structured and narrative information supplied through LFPSE to inform national advice, guidance and improvement activity, including targeted surveillance of incidents recorded as resulting in severe harm or death. In addition, further structured governance has been established in January 2026 through the creation of the Digital Safety Review Group which brings together intelligence from multiple sources (including LFPSE and frontline feedback) to proactively detect and respond to safety

risks associated with digital technologies and to recommend national actions where required.

25. In addition to the Digital Principles, NHS England has also published guidance on the use of digital technology. This includes:

- a. NHS Digital Technology Assessment Criteria (DTAC) [Exhibit KEN-00008498, GH004] An assurance framework used to assess and assure digital health technology (DHT) products, covering clinical safety, data protection, technical security, interoperability and usability and accessibility (further information on DTAC is set out in paragraphs 30-31).
- b. What Good Looks Like (WGLL) Framework [Exhibit KEN-00008511, GH005] A framework directed at all NHS leaders and Integrated Care Systems (ICS) that will enable them to accelerate digital and data transformation, with seven success measures, including safe practice and empowering citizens.
- c. Digital Maturity Assessment (DMA) [Exhibit KEN-00008484, GH006] A self-assessment tool for organisations to determine their preparedness for the integration of digital technologies, focusing on themes such as readiness, capabilities and infrastructure.

26. Other organisations have also produced guidance on the use of digital technologies:

- a. NICE published the Evidence Standards Framework for Digital Health Technologies. [Exhibit KEN-00008494, GH007]
- b. MHRA published the Device Characterisation Regulatory Qualification and Classification. [Exhibit KEN-00008482, GH008]

Access pathways for new technologies

27. The NHS Innovation Accelerator (“NIA”) is a national programme established by NHS England to support the rapid adoption and scaling of high-impact, evidence-based innovations across the NHS in England. The programme focuses on innovations that address challenges in the NHS and are already sufficiently developed to be scaled. The NIA operates through an annual competitive application process. Successful applicants become NIA Fellows. Fellows receive tailored support that focuses on the

innovation itself, and on developing the individual leading it. The programme is funded by NHS England and is delivered by UCL Partners, working closely with England's 15 Health Innovation Networks. Since launching in 2015, the NIA has supported a significant number of innovations to scale, including Oxevision.

28. Oxevision engagement with the NIA was focused primarily on activities relating to evaluation and the generation of evidence. In this context, the NIA's role was to support the assessment of Oxevision's impact, effectiveness and potential value within NHS settings, rather than to approve, commission or mandate its use [Exhibit KEN-00008485, GH009]. Engagement through the NIA therefore centred on building an evidence base to inform adoption decisions, rather than on regulatory assurance or funding decisions.
29. To support innovators, the Health Technology Pathway: Navigation Tool for innovators in England [Exhibit KEN-00008497, GH010] sets out a 25-step pathway covering an end-to-end process, from creation, development, evidence, commissioning, and adoption. The detailed flow chart informs and guides people on how to navigate the pathway, so all relevant and necessary steps are considered.
30. The pathway also incorporates NHS England's Digital Technology Assessment Criteria (DTAC) embedding digital assurance requirements into the wider innovation process. DTAC is NHS England's national framework for assessing digital health technologies, to ensure that digital technologies meet minimum national standards before adoption.
31. DTAC also provides guidance on reporting concerns relating to safety concerns around medical device software and apps, outlining that this should be reported to the MHRA using the Yellow Card reporting system. If there is a patient safety event relating to the use of any digital health technology product (whether a medical device or otherwise) which impacts upon the safety of one or more patients accessing NHS services, it should be recorded to the LFPSE service in order to support both national learning and local response. This should be done in addition to a Yellow Card report if appropriate.
32. An example of a current 'call for innovation' in respect of an unmet need includes a call for work-related digital innovations for individuals with poor mental health [Exhibit KEN-00008512, GH011].

Section Two: Oxevision

History of Oxevision

33. The introduction of Oxevision into NHS services began through pilot trials around 2021, when several mental health trusts tested its use in acute wards, psychiatric intensive care units (“PICUs”), and older adult services. These trials were intended to evaluate whether the technology could improve patient safety, reduce intrusive checks, and deliver operational efficiencies.
34. Following early trials, Oxevision’s deployment expanded gradually with increasing uptake across NHS mental health trusts. By 2023, the technology was in use in a significant number of inpatient settings. The rollout coincided with wider digital transformation programmes under the Long-Term Plan, which aimed to integrate technology into clinical workflows and improve patient safety through innovation.
35. Decisions to implement Oxevision were – and continue to be – made locally by individual NHS trusts, with each trust following its own governance process. Independent sector providers would also make their own decisions about procuring and deploying Oxevision. As implementation decisions are made locally there is no national policy on the roll out of Oxevision.

NHS England’s awareness of concerns with Oxevision

36. Despite its intended benefits, the introduction of Oxevision did give rise to concerns from patients, advocacy groups, and clinicians that were highlighted in the national media. In December 2021, The Guardian published an article raising concerns from mental health charities that Oxevision may breach patients’ right to privacy and exacerbate their distress [Exhibit KEN-00008500, GH012]. In March 2022, the Guardian published another article on Camden and Islington NHS Foundation Trust’s decision to stop using Oxevision [Exhibit KEN-00008468, GH013].
37. In March 2022, NHS England held discussions with Oxehealth to help understand the wider activity on digital mental health. Actions were agreed to further consider how Oxevision was being used and Oxehealth agreed to review its guidance and information on the application of Oxevision and informed consent [KEN-00008470, GH014]. Oxehealth agreed to brief the Nursing Director Forum which was also considering these issues (see para 38 below). NHS England continued to seek

patient feedback which was shared with Oxehealth [KEN-00008469, GH015].

38. On 22 September 2022, the National Mental Health and Learning Disability Nurse Directors Forum set up a working group to consider the use of VBMS. The Forum is independent of NHS England and has representatives from all relevant mental health trusts and various support groups. The discussions led to the Forum publishing "*Vision-based patient monitoring systems in mental health wards. National recommendations, guidance and best practice on safe use of VBPMS*" [Exhibit KEN-00008501, GH016] to provide guidance to mental health trusts on developing VBMS policies and protocols and to ensure there is a consistent, safe and ethical approach to meeting service users' needs. This document was not supported by NHS England.
39. On July 2023, the National Survivor User Network ("NSUN") and Stop Oxevision published an open letter [Exhibit KEN-00008502, GH017] to all mental health trusts in England and to NHS England setting out their concerns with the use of Oxevision in inpatient settings. NHS England acknowledged these concerns [KEN-00008472, GH018] and in response, NHS England sent a letter on 7 September 2023 to the Mental Health Provider Chief Nursing Officers and Chief Medical Officers setting out its view on VBMS and what it was doing in relation to the concerns that had been raised (see paragraph 61 below).
40. Since its initial letter in July 2023, Stop Oxevision has continued to share its concerns directly with NHS England. This has included:
 - a. On 26 February 2024, Stop Oxevision were one of the presenters at the Digital Technologies Conference which led to the development of the *Digital Principles* published in February 2025. Further information on the *Digital Principles* is set out from paragraph 67.
 - b. On 11 February 2025, Stop Oxevision issued a statement on the Digital Principles raising their concerns that the *Digital Principles* failed to address fundamental legal and ethical issues with Oxevision and similar technologies. [Exhibit KEN-00008493, GH019]
 - c. On 9 April 2026, Stop Oxevision issued a statement setting out its concerns that Oxevision continues to be used as a blanket restrictive practice and without patient consent [Exhibit KEN-00008489, GH020, KEN-00008490,

GH021, KEN-00008491, GH022, KEN-00008492, GH023]. In response, NHS England referred to the *Digital Principles* which include seeking patient consent and advising that digital technology (including VBMS) must never be used as a 'blanket approach' to care applied to all patients on a particular ward or a particular department [Exhibit KEN-00008488, GH024].

41. NHS England is grateful to the user led organisations including Stop Oxevision for their ongoing commitment to sharing service user feedback and concerns. This feedback has helped inform NHS England's commissioning of evidence-based research on VBMS (see para. 53-60 below) and the development of the *Digital Principles*.
42. In August 2023, the British Institute of Human Rights ("BIHR") published the document "Surveillance: A restrictive practice and human rights issue" [Exhibit KEN000008508, GH025]. Following its publication, NHS England met with the BIHR to discuss the current approaches to Oxevision and to seek BIHR input in supporting trusts on the use of Oxevision and its potential impacts from a human rights perspective. This led to the BIHR invitation to speak at the Digital Technologies Conference (see paragraph 67 below).
43. On 20 November 2023, the charity Rethink Mental Illness issued a statement on the use of Oxevision in mental health units [Exhibit KEN-00008503, GH026]. The statement referred to the concerns identified by Stop Oxevision and called for monitoring systems only to be used with consent (and clear safeguards for those who lack capacity to consent), in the best interests of patients and with clarity on how data would be used. The statement recognised the ongoing reviews by NHS England and the National Mental Health and Learning Disability Nurse Directors Forum. The statement was updated on 20 April 2024 calling for independent, co-produced research on the impact of monitoring systems.
44. In January 2025, in a BBC article the Royal College of Psychiatrists said the rollout of digital monitoring should be paused to allow for significant independent research into VBMS, co-produced with patients, their carers and their families. In response, NHS England confirmed that it had instructed mental health trusts to review the use of camera surveillance and that it would be updating its guidance in the coming months (with the publication of the Digital Principles following in February 2025) [Exhibit KEN-00008495, GH027].

45. NHS England was aware of the work EPUT were doing to roll out and evaluate Oxevision through the Regional Mental Health Team's attendance at EPUT and ICB meetings, including the EPUT Trust Board meeting held on 26 January 2022, the Essex Mental Health Partnership Board meetings throughout 2023, and EPUT Quality Together meetings throughout 2023.
46. Following an inspection of wards for adults of working age and psychiatric intensive care units on 5 and 6 October, the CQC raised urgent concerns with EPUT, including that there was no evidence for consent for Oxevision use being given by some patients. EPUT was asked to address this and ensure that consent was provided. As part of its wider system role, NHS England attended meetings in which the CQC action plan and associated improvements were discussed. This included a Rapid Quality Review meeting which was held on 14 December 2022. EPUT set out that they had met immediately with all patients on Willow and Galleywood wards to discuss the use of Oxevision and had reviewed the Oxevision Standard Operating Procedure (SOP) to strengthen guidance regarding the consent process.
47. A consolidated action plan from various CQC reports in October 2024 shows that EPUT was considering consent of individual patients on an ongoing basis at both Willow and Galleywood wards [Exhibit KEN-00008505, GH028, KEN-00008506, GH029].
48. NHS England is aware that EPUT revised their Oxevision Standard Operating Procedure (SOP) in April 2025 to align it with the *Digital Principles* published in February that year.
49. Throughout this period, NHS England was also aware of media coverage of the use of Oxevision within EPUT, including coverage of patient inquests where Oxevision was cited as being a factor. During this period, there was also positive coverage, including that EPUT and Oxehealth were highly commended in the Best Patient Safety Initiative category of the Building Better Healthcare Awards for the use of Oxevision [Exhibit KEN-00008507, GH030].

NHS England's response to concerns with Oxevision

50. While Oxevision is not an NHS England tool we have been clear with NHS commissioned providers that any vision-based monitoring technology must support a human rights-based approach to care and should only be used in line with legal requirements as set out in the *Digital Principles*.
51. Any form of VBMS should never be implemented in a blanket way. Any decisions to use VBMS in patient bedrooms should be made in a person-centred way, with the patient themselves where they have capacity to make a decision or through a Best Interest process which is compliant with the Mental Capacity Act 2005 where the patient lacks capacity to consent to the monitoring system.
52. Following concerns with the increasing deployment of Oxevision across mental health trusts, NHS England recognised the need for clear evidence-based guidance to ensure it was implemented in a consistent and ethical way. We have set out the steps below which led to the development of the *Digital Principles*.

Public Digital Report

53. In Autumn 2022, NHS England developed the “*Good practice principles in implementing vision-based patient monitoring technology in Mental Health inpatient settings*” [Exhibit KEN-00008496, GH031]. However, this was not published as NHS England recognised there was a need for further exploration of service users’ and clinicians’ views on VBMS. NHS England commissioned Public Digital to explore with service users and clinicians how the technology could contribute to holistic therapeutic patient care. Public Digital conducted 20 user research interviews which included, patients, carers and NHS representatives.
54. In May 2023, Public Digital presented its Discovery Report [Exhibit KEN-00008504, GH032]. The report identified key needs of patients and health professionals which VBMS must satisfy. Actual benefits included ensuring patient safety and protecting staff from false accusations. There were also perceived benefits that VBMS may reduce or prevent aggression and violence on the ward and the potential for it to be used for learning and reflection. There were concerns that VBMS could increase patients’ anxiety, paranoia and mistrust as well as issues around privacy and consent.
55. The report provided four strategic observations and recommendations:

- a. *Mental health care is emotive and so is vision based patient monitoring. Therefore, focus the narrative on the use cases and scenarios where VBMS can be implemented to support a nuanced approach.*
- b. *Vision Based Patient Monitoring ("VBPM") intervenes in the system at a low leverage point. It won't solve the systemic challenges of the healthcare system. Support VBPM implementation nationally in a way that increases high-quality care and does not risk exacerbating bad practice.*
- c. *There isn't a common understanding/agreement on what good looks like in relation to VBPM, so different places are implementing it differently. Set a national vision on how digital health technologies can be part of a bold, radical and reimagined model of care, where any use of technology supports a human-rights based approach to care that is anchored in citizenship and inclusion, and ultimately providing therapeutic, safe, personalised, holistic care.*
- d. *New digital health technologies are being created at an exponential rate. They will be key enablers to meeting the vision of holistic therapeutic care. Identify learnings we can take from what has happened in VBPM to apply to future new technologies, particularly where there is a real risk to human rights.*

56. The report findings also informed NHS England's further research and development of the *Digital Principles*.

National Institute for Health and Care Research review into Surveillance based technology in inpatient mental health settings

57. In summer 2023, in response to a request from NHS England, the National Institute for Health and Care Research ("NIHR") Policy Research Unit in Mental Health conducted a systemic review into Surveillance based technology in inpatient mental health settings. This resulted in the publication of a systematic review titled *"The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings"* on 29 November 2024 in BMC Medicine [Exhibit KEN-00008509, GH033]. The review examined the effectiveness, ethical implications, and practical impact of technologies such as VBMS, which were increasingly adopted by NHS Trusts.

58. The systematic review aimed to assess whether surveillance-based technologies deliver measurable improvements in patient outcomes, safety, and staff efficiency, while also considering potential risks such as privacy breaches, loss of dignity, and restrictive practices.
59. The findings highlighted a lack of robust evidence supporting the clinical effectiveness of these technologies and raised concerns about their ethical and legal implications. The review emphasised the need for clear governance, consent processes and safeguards to ensure that technology use does not compromise human rights or therapeutic engagement.
60. The conclusions of the NIHR review directly informed the development of NHS England's *Digital Principles*.

September 2023 letter

61. The work carried out and research commissioned by NHS England during 2022 and 2023 and concerns that had been shared helped NHS England consolidate its understanding of VPMS technology in mental health settings and the associated risks. This research informed NHS England's first formal communication in September 2023, specifically relating to Oxevision, and was sent to Mental Health Provider Chief Nursing Officers and Chief Medical Officers, ICB Mental Health SROs and NHS England Regional Mental Health SROs [Exhibit KEN-00008510, GH034]. The letter was in response to the concerns raised in the open letter sent by the NSUN and Stop Oxevision in July 2023, and concerns from provider colleagues who recognised a variation in the application of VBMS in practice who were asking for a national steer.
62. NHS England's letter provided clarification that any VBMS which operates as a form of surveillance should never be implemented in a blanket way. Any decision to use VBMS in patient bedrooms should be made in a person-centred way, with the patient themselves where they have capacity to make a decision or through a Best Interest process compliant with the Mental Capacity Act 2005 where the patient lacks capacity to consent to the monitoring system.
63. We have set out below a copy of the table sent to providers which outlines what NHS

England was doing, and how they proposed achieving this objective.

What we are doing:	How we are doing it:
Launch a national programme to support providers in developing the culture of care in inpatient settings	Co-producing a set of Core Commitments and Standards for the culture of care in mental health, learning disability and autism inpatient settings – these standards describe clear principles for ensuring that inpatient care is safe, therapeutic, compassionate, personalised and least restrictive, from which the development and use of any technological innovations can be considered and aligned.
Explore the evidence base for the use of VBMS	The Mental Health Policy Research Unit have been commissioned by DHSC and NHSE to draw together evidence (where it exists) for the use of surveillance technologies in mental health settings
	Completed a user-based research review of vision-based technologies in mental health settings
	Liaising with the British Institute for Human Rights to understand the human rights considerations regarding the use of cameras in health and care settings
Hold a set of workshops together with providers, academics and experts-by-experience to co-produce a set of principles regarding the role and use of digital technologies in inpatient settings	These principles will include consideration of key legal frameworks and focus on the following: ○ Therapeutic Relationship ○ Patient Voice ○ Restrictive Practices ○ Patient Outcomes and Experience ○ Safety ○ Releasing Time to Care

64. This letter outlined that the use of VBMS should be carefully considered on a case by case, patient by patient, basis to ensure that any decision to use such systems has a legitimate aim and is both lawful and fair. Their use must also be proportionate to the aim.

65. It was outlined in the letter that NHS England was therefore asking all services to review current VBMS practice within the provider organisations to ensure their use of these technologies aligns with the principles of least restrictive, compassionate, therapeutic and personalised care.

66. Providers were also encouraged to review the information governance arrangements in place in their organisation with specific focus on what records were kept about the decision to use and the use of such systems, what information was provided to patients, their families and staff about the use of such systems, how informed consent was obtained, and how information gathered through VBMS was stored, accessed and utilised.

Principles for using digital technologies in mental health inpatient treatment and care

67. In January 2024, all mental health inpatient providers were invited to attend the Digital Technologies Conference on 26 February 2024 to support the co-production of principles regarding the role and use of digital technologies in mental health inpatient settings. Speakers at the conference included representatives for the BIHR, Stop Oxevision, the Restraint Reduction Network and the Mental Health Policy Research Unit [Exhibit KEN-00008476, GH035]. Other attendees at the conference included mental health trusts (including EPUT), independent sector providers and lived experience representatives [Exhibit KEN-00008481, GH036]. The CQC, who has also commissioned research and produced guidance on surveillance and digital monitoring technologies, were also represented.
68. In May 2024 a selection of stakeholders who attended the Digital Technology Conference were invited to attend a virtual feedback session on the draft principles [Exhibit KEN-00008487, GH037]. Additional meetings were held with stakeholders including Stop Oxevision during the process of developing the *Digital Principles*.
69. On 7 February 2025, NHS England published eight Principles for using digital technologies in mental health inpatient treatment and care ("the *Digital Principles*") [Exhibit KEN-00008499, GH038].
70. The *Digital Principles* were developed to support providers in making decisions about whether technology is the most effective and least restrictive way to deliver care. The principles emphasise compliance with the Human Rights Act 1998, the Mental Capacity Act, and data protection legislation, while promoting dignity, consent and therapeutic benefit. Due to the ever-evolving nature of digital technologies, and to future proof the principles, specific names of products were not included.
71. The Digital Principles apply to all NHS-funded mental health inpatient services. This means the principles apply to independent sector providers of inpatient mental health services where the individual's care is being funded by the NHS. The principles cover technologies intended to:
- i. Deliver or support direct care and treatment

- ii. Enable patient safety monitoring
- iii. Enhance communication and feedback between patients and staff.

72. Administrative systems like electronic patient records and e-prescribing are excluded, but the Digital Principles encourage applying the same ethical considerations wherever relevant. The overarching aim is to help clinicians and providers decide whether a digital tool is the most suitable option for care, and to ensure its implementation is safe, evidence-based, and respectful of patient rights.

73. The eight principles outlined are:

- i. Human Rights Compliance – Technologies must align with the Human Rights Act 1998, protecting rights to life, liberty, privacy, and freedom from degrading treatment.
- ii. Consent and Capacity – Clear, individualised consent processes are required, avoiding blanket approaches. Where patients lack capacity, decisions must follow legal frameworks such as the Mental Capacity Act.
- iii. Equity and non-discrimination – implementation must safeguard against bias and ensure equal access for all patient groups.
- iv. Co-Production and Engagement – Patients, carers, and staff should be involved in procurement, testing and evaluation.
- v. Therapeutic and Personalised Care – Technologies should enhance therapeutic outcomes and not replace human interaction.
- vi. Safety and Governance – Robust policies for data protection, staff training, and integration into care plans are essential.
- vii. Evidence-based practice – Use must be supported by research and evaluation demonstrating effectiveness.
- viii. Transparency and accountability – Clear documentation of decisions and ongoing review of technology use is required.

74. These principles are publicly available and are accompanied by practical recommendations on governance, policy development, and staff training, ensuring that digital innovation strengthens care rather than undermines it.

75. The Digital Principles outline that technologies should only be used following a person-centred approach and never as a blanket measure. Patients must be given

clear, accessible information about what the system does, why it is being used, and how it supports their care. Consent should be sought wherever possible, and patients should be able to decline or withdraw consent without any impact on the quality of their care. However, where a patient is assessed as lacking capacity to make a decision about the use of digital technology, decisions must be taken in accordance with the Mental Capacity Act 2005. In such circumstances, the continued use of technology may be appropriate where it is assessed to be in the person's best interests, where it represents the least restrictive way of effectively achieving the purpose for which it is needed, and is necessary and proportionate to support their safety or care. Any such decision should be clearly documented, subject to regular review, and involve the patient and those close to them as far as practicable and appropriate.

76. The principles set out that providers must develop a policy and Standard Operating Procedures (SOPs) in place specific to the product, including to record consent decisions, involve patients and carers in discussions, and review these processes regularly to ensure transparency and compliance.
77. These consent requirements reflect NHS England's broader commitment to a "Culture of Care" and the principles set out in the Patient Safety Strategy. The strategy emphasises three pillars - Insight, Involvement, and Improvement - encouraging organisations to use technology responsibly to reduce harm while maintaining dignity and choice. VBMS are positioned as tools to support safer care, but their use must be proportionate, the least restrictive option available, and subject to ongoing review. NHS England highlights that embedding these safeguards is essential to ensure that digital innovation enhances patient safety without compromising rights or trust.
78. The Digital Principles re-emphasised the importance of human rights-based provision of care in national policy documents (including the Culture of Care standards (see below)).
79. NHS England shared the Digital Principles with a range of stakeholders, including Directors of Nursing, Chief Information Officers and Chief Executive Officers at both NHS Trusts and ICBs.

Culture of care standards for mental health inpatient services

80. The Digital Principles sit alongside the Culture of Care standards for mental health inpatient services (the "Care Standards") [Exhibit KEN-00008478, GH039]. The Care Standards were introduced in April 2024 and are aimed at instilling a culture of care within inpatient settings that patients want to experience and were co-produced with people with lived experience of inpatient services.

81. The Digital Principles were developed with the Care Standards in mind and ensuring that inpatient care is safe, therapeutic, compassionate, personalised and the least restrictive. It is from this starting point that the new technologies should be considered and aligned.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

[I/S]

Dated: 20 May 2026