

Empty words, false promises and window-dressing: An overview NHS England's new Digital Principles



StopOxevision Statement on NHS England Digital Principles, supported by NSUN

After almost a year since the Digital Technologies Conference, set up by NHS England (NHSE) to establish ‘principles’ for the use of digital technologies on inpatient mental health wards, they have been published – quietly on a Friday as if to avoid attention. They are available on the NHSE website, [here](#). The publication is nearly a year later than the March 2024 deadline outlined.

Overall, the principles seem empty; they merely reiterate the preexisting legal frameworks that have not been followed by many NHS Trusts in the implementation and use of Oxevision. NHS England have chosen to develop ‘principles’ which are weaker than guidelines, which in turn are less strong than regulations. The choice to present the document as a set of ‘principles’ renders it ambiguous and unenforceable. They have no regulatory power, and there is no clarity over who is responsible for their use. **The document lacks any accountability or recognition of the grave harms, and even deaths, which have been associated with the technology.**

The document attempts to offer a definition of ‘digital technology’ but fails to provide a single clear example, and fails to mention Oxevision by name, even though the document was developed in response to the concerns about this specific technology. Instead of clearly defining ‘digital technology’, it provides only vague examples, suggesting that the principles apply to technologies which are “intended to support patient safety”. **It is unclear what is considered within the definition, and thus easy for current and future products to be deemed as being outside its scope.**

This statement addresses the various issues with the principles, attending to the topics of co-production, human rights, equity of access, evidence, and data protection in turn. In each instance we conclude that **the principles are vague and unenforceable. Ultimately, they provide no safeguards, obligations, or accountability processes to ensure that digital technologies are used safely, legally and appropriately.**

“Co-production”

The fourth principle outlined in the document advises that *“providers are responsible for ensuring co-production has occurred with people who have lived experience of being a patient in an inpatient mental health setting”*. However, it is unclear from this statement exactly what providers are required to co-produce. **Despite what is ostensibly a**

commitment to co-production, the principles themselves have not been co-produced [\(although they have been referred to as such in multiple places\)](#).

In October 2024, Stop Oxevision received a draft copy of these principles. We shared numerous concerns about the document and offered (unpaid) advice on how to strengthen it. The majority of our concerns were ignored, and the issues remain in the published document. In fact, the key differences are matters of spelling and grammar we identified. Having patients proof-read a document does not constitute co-production. True co-production also cannot involve only selecting favourable opinions to listen to, or ‘picking and choosing’ who to engage with. We have included our emails and comments on the original document below to highlight our numerous concerns which have been ignored.

The publication of these ‘principles’ follows [NHS England’s previous shortcomings regarding taking action against the Serenity Integrated Mentoring model](#) (SIM). After working with the patient-led campaign group [StopSIM](#) for 15-months on a joint policy regarding coercive and criminalising responses to people experiencing a mental health crisis, NHS England refused to publish the policy. Instead, in a last minute u-turn, NHSE published a short letter which failed to provide the clear, enforceable position to protect patients from harms experienced at the hands of mental health services.

We are concerned that this pattern of posturing from NHS England means that they continue to fail to offer the leadership needed to address widespread harms in NHS mental health services. This is despite their self-defined purpose to “lead the NHS in England to deliver high-quality services for all”.

Human Rights: Simply reiterating the law

“Principle 1: Any use of digital technology will support a human rights approach to care”

In this ‘principle’, NHS England states that “*any digital technology must be used in accordance with the Human Rights Act (1998)*”, and advises clinical decision makers to consider consulting legal advice when using digital technologies in the care of a patient. The bulk of this principal’s description is a reiteration of what Human Rights are. **Framing Human Rights as a ‘principle’ positions Human Rights law as**

something healthcare providers should *aim to achieve* but is ultimately unenforceable – rather than something that should already be fundamental to all actions in mental health wards.

The Human Rights Act predates the use of Oxevision by over 25 years, yet has been ignored when Trusts have made the decision to implement the technology. Therefore, we question whether simply restating legal obligations, without making explicit the [Human Rights violations that are enacted through the use of Oxevision](#) specifically, will have an impact on decision making around digital technologies. **It should go without saying that Trusts must follow the law in all aspects of healthcare, but the very fact that these ‘principles’ were made highlights that trusts fail to do so.** In this instance clarity, closing loopholes, enforcement and holding individuals to account is paramount – these principles risk doing the precise opposite.

Equality and health inequalities impact assessment (EHIA): Another document to be ignored

“Principle 3: Equity of access”

Here, NHSE encourages against the discrimination of patients based on protected characteristics when considering the use of digital technologies in their care. Instead, they advise that “*An equality and health inequalities impact assessment (EHIA) should be undertaken before procurement of the digital technology before it is used and regularly reviewed to uphold this principle*”. However, as was shown in our Freedom Of Information (FOI) requests, while some Trusts failed to complete an EHIA related to the use of Oxevision, others did – some in great detail – which were then ignored and the technology implemented regardless.

For example, [TEWV NHS](#) Trust identified that the technology was likely to cause further discrimination against Gypsy and Traveller people, Muslim women who wear the Hijab, and transgender people. While clearly identified in this document, the potential impacts on these groups was not attended to, and the technology was implemented regardless.

Producing more EHIAs while failing to act on their contents is clearly not the answer to the harm and discrimination these technologies can cause. We shared this concern with NHSE on an earlier draft of these principles but this was ignored.

Evidence base and methods of 'evaluation': A dangerous lack of specificity

"Principle 7: Evidence base"

The principles argue for a critical evaluation of the evidence base for digital technologies to precede their implementation, with technologies supported by *"high quality, large scale and unbiased"* evidence to be selected. However, we are concerned about the lack of definition in these terms, leaving this open to interpretation (or manipulation).

Much of the basis through which Oxevision was legitimised was the 'studies' that specifically claimed to be based on high quality 'scientific' research. Yet despite the conflicts of interest and lack of robust research, trusts reference these in business cases, claiming to have a well evidenced case for their use in care. By not specifically defining what high quality (in what way?), large scale (how large?) or 'unbiased' (what does this mean in this context) evidence is, the same is likely to happen again.

Like SIM, Oxevision was awarded a fellowship from the NHS Innovation Accelerator (funded by the Health Innovation Networks (HIN), formerly Academic Health Science Networks. The fellowship provides financial and mentoring support to rollout innovations across NHS Trusts. In the cases of both SIM and Oxevision, this has been supported in the absence of evidence to prove that the product is safe, let alone effective. In this context, NHS England's advice to Trusts ignores the role the NHS Innovation Accelerator and HINs/AHSNs (who NHS England funds) played in promoting adoption of technology in the absence of *"high quality, large scale and unbiased"* research. Whilst trusts must be held to account to conduct due diligence of the products, technologies and 'innovations' they introduce in their services, this guidance from NHS England obscures the role of other agencies in upholding evidence based medicine.

Moreover, these 'principles' are advisory, and if a Trust wants to implement a technology without a sufficient evidence-base, it recommends that they complete their own evaluations/trials of technology where there is scant evidence. We are unsure how this would result in *"high quality, large scale and unbiased"* evidence. We shared this concern with NHSE on an earlier draft of these principles but this was ignored. We also have concerns that this has the potential for unethical practice, as ethical approval is deemed to not be required in such evaluations. **This further opens**

up the possibility that unevidenced technology is tested on patients without their knowledge or consent.

As we highlighted in our previous statement following BBC coverage of the campaign, “ultimately, no research should ever be given greater weight than the safety, autonomy, and mental health of patients, which may never be fully quantifiable by research”.

Guidance on data ‘protection’: Failure to address exploitative ‘loopholes’

Just as the reference to legal frameworks around the Human Rights Act and the Mental Health Act, NHS England’s Digital Principles seem to merely reiterate pre-existing GDPR regulation, failing to address the ‘loopholes’ and non-adherence that enable the harm these technologies can cause. Although this is already law within the GDPR articles 6 and 9, the ‘principles’ state:

“Personal data gathered from use of a digital technology should not be used for any purpose other than the care and treatment of the patient identified – unless the patient, or an individual lawfully acting on their behalf, has given informed consent for an alternative use or there is another lawful basis to enable the data to be used for other purposes”. Of course, this is already the law under the GDPR (Articles 6 and 9).

This does not address the ways in which data collected through Oxevision was being used in research, as ‘deidentified’ video footage of patients was analysed without patients’ consent. Simply reiterating GDPR law does not address the ‘loopholes’ through which patients’ supposedly ‘deidentified’ data can be used for purposes beyond their care.

Conclusion

The new ‘principles’ fail to address fundamental legal and ethical issues with Oxevision and similar technologies. Without direct, decisive action that has real-world implications, private and for-profit technologies will continue to cause harm. In the absence of transparency and accountability, claims of ‘co-production’, ‘human rights approaches to care’, and ‘high-quality evidence’ will remain inauthentic and unenforceable.

We call upon NHS England to take a clearer position on Oxevision and similar technologies, and to commit to the development of enforceable regulation around

their usage. Stop Oxevision will continue to push for a stronger and more decisive approach, to protect patients' rights and defend mental healthcare from creeping privatisation.



Stop Oxevision

6:39 PM Oct 16

I would add re the Mental Capacity Act:

reiterate that everyone should be assumed to have capacity unless an assessment indicates otherwise

principles of the least restrictive option

Capacity as related to an individual decision



Stop Oxevision

6:45 PM Oct 16

Add something along the lines of this should consider how technologies may have disproportionate negative impacts for some groups



Stop Oxevision

6:46 PM Oct 16

Add that the EIA should be done AND actions should be taken to address and mitigate concerns identified

Stop Oxevision email sent 18th October 2024

(This email is copied in full, xxx indicates sections we have redacted. We apologise for the original typos).

“Hi xxxxx,

xxxxx

We have a google doc with comments and suggestions, what is the best way for us to share this with you? Do you have access to google docs with your NHS email?

This email outlines a few (quite a few sorry!) points and suggestions and ideas for the principles. I know this is the “final draft” but to be really blunt and honest, we think it lacks clarity and risks worsening the issue of confusion. We really want these points and comments to be helpful and constructive to the aim of making sure these principles do what they need to but we do understand it’s a lot of comments and criticism so thank you for your patience with us. We can discuss all of this further.

There are some small and more specific comments in the document as well as a few proof reading points but this email outlines the more substantial points. They’re numbered but in no particular order.

1. Structure: I think the structure could be improved. I guess we can assume that nobody really reads documents cover to cover so all the important stuff needs to be on the first couple of pages. I know this is not a great example given NHSE refused to publish it but I’d recommend looking at the structure of the SIM policy <https://stopsim.co.uk/2023/05/18/draft-stopsim-nhse-policy/>

It’s much clearer in having the key points outlined at the beginning then explained further in the body of the policy.

2. Clarifying what is new and what is existing law and legislation: Generally what we’ve found with campaigning is that the harmful stuff (models, technologies) trusts do is not legal in the first place, they just use misinterpretations of existing laws to get around it (or they just ignore that altogether and it’s outright malpractice).

That’s kind of why documents like this need to clarify the bits of law which have been misinterpreted. To be blunt and honest, we don’t think this does that currently. There is a lot which is left to (mis)interpretation.

It would be helpful to set out at the beginning a reminder and link to some of the relevant policy/legislation.

3. Mental capacity act: I think this can be strengthened a bit to mention the least restrictive option, the need to evidence that reasonable adjustments have been offered to support consent, assumption of having capacity etc. Also important to

emphasise where you discuss risk that technology is unlikely to be the only way of managing patient risk. Technology should only be used if there's a clear rationale AND that can't be addressed in an alternative way. E.g. trusts try to argue that Oxevision is needed for patient safety but there's no clear reason why that NEEDS to be met through technology rather than in person care.

4. The legal bit: it's strong but very wordy, I know the meaning can't be changed but can some of the sentences be shortened? I also think it reads a bit strangely having that right at the end as it's the most important but really. A couple of possible options: bring a headline of this to the beginning and refer to an appendix where the full thing is? Or bring the whole section further up the document? There's nothing about freedom from torture or degrading treatment which is also an Absolute Right.

5. Defining digital technology: I think it needs a clearer definition and distinction. It's completely unclear whether this refers to (digital) technologies which are individually prescribed for patients like a digital diabetes monitor or an epilepsy bed sensor and more be things which are installed across a ward or available for use with any patient (eg door alarms or body worn cameras) but it would be worth giving examples to be clearer. I know you don't want to list brand names but it is quite confusing.

Is there a distinction between technology and equipment? I reckon it would be worth working with RCOT as they have existing guidelines around equipment prescription.

I see a few distinctions which you could list with examples and it would hugely strengthen this:

1. Technologies which are individually prescribed and precured for a patient, for example a bed sensor mat which monitors for signs of seizures.
2. Technologies which are available on the ward for use by staff if assessed to be appropriate (body worn cameras or if you move more broadly this would include things like safety pods or equipment for taking observations like a blood pressure cuff)
3. Technologies which are installed into the ward (this would be oxevision, CCTV, alarms on doors, or again if this is more broad this could include adapted half cover bathroom doors)

Splitting it like this would then allow guidance to be given for each of these situations. E.g. if equipment is procured for one patient it must not then be used for other patients; if equipment is installed into bedrooms there should be plans and mitigations in place for where it is not indicated/proportionate for a particular patient e.g. having rooms without the tech installed. And with things like safety pods these should be assumed to be suitable for all patients just because they're available to be used.

I think this would be MUCH more useful for trusts and could actually lead to something impactful (e.g. rethinking the approach of installing Oxevision in every room and instead having it in just some rooms to support individual assessment, patient choice and the principles of the least restrictive option)

6. Digital technologies or ALL technology? It generally refers to digital technology (though in some places this isn't distinguished) is there anything that wouldn't apply to a non digital technology? Say an adapted bathroom door or safety pods or mechanical restraint equipment?

7. Digital technology or medical equipment: One way to make this stronger and further emphasise the importance of technology needing to be assessed on an individual case by case basis would be to use the terminology of medical equipment and talk about equipment being prescribed. It's kind of horrible language as it sounds like the patient has no say (which is the case anyway tbh) but it might slightly re-centre the way people see these technologies (pieces of equipment)

8. Speaking to the issue of technology developing faster than legislation/policy: I think a real issue the NHS faces is that tech is developing quickly which leads to confusion around how new technologies fit into the legislation that predates them. (stuff like safety pods being introduced and it being unclear how these fit in the space between physical and mechanical restraint). I reckon a couple of sentences to speak to this point would be valuable. Where there is uncertainty legal advice should always be sought.

9. General language points: We recommend not using the DT abbreviation, it's a bit tedious to repeat the phrase again and again but it's only two words and it quite confusing with the DT (and not very accessible). There's also some very long sentences and slightly odd phrases so I'd recommend a general, thorough proof read.

Thank you for your patience with this long email.”

[stopoxevision](#) [11th February 2025](#) [Blog](#) [Blog](#)

One response to “Empty words, false promises and window-dressing: An overview NHS England's new Digital Principles”

[Trust ordered to pay compensation to patient over use of Oxevision – Stop Oxevision](#)

[April 29, 2026 at 9:59 am](#)

[...] publication of the Principles, Stop Oxevision reiterated the concerns we had expressed repeatedly throughout stages of development. These had not been addressed in the final publication. We expressed concerns that the Principles [...]

Loading...

[Reply](#)

Leave a Reply

Stop Oxevision

Email:

stopoxevision@gmail.com

[About](#)

[Blog](#)

[Lived Experience](#)

[Resources](#)

[Frequently Asked Questions](#)

[Statement on non-camera surveillance](#)

[Asylum Magazine](#)

[Lampard Inquiry](#)

[Papers](#)

[Guest writing and talks](#)

