
From: Charlotte Wood [redacted] [I/S]
Sent: 4/28/2022 5:03:28 PM
To: PRATAP, Bobby (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S]; JENNINGS, Sarah (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S]; HOLLOWAY, Sarah (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S]; KEHOE, Jemma (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S]; Sophie Davies [redacted] [I/S]
CC: FARROW, Christina (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S]
Subject: RE: Feedback on concerns about Oxevision

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Thank you, Bobby.

This is very useful in helping us to understand your concerns and the nuances around them. It will be a helpful lens to apply to the nurse directors working group inputs/outputs too.
It is also nice to hear that positive feedback has rippled up to the team as well.

I found the conversation yesterday to be very productive too, and felt like we reached a set of actions/steps that will support in driving the agenda forwards on how to use technology like ours as part of clinical practice in a safe and appropriate way that benefits patients in mental health care.
Building on your comments, we want to learn with the NHS and help the NHS to learn how to best implement our technology in a safe and effective way that gives staff more meaningful time with patients – and crucially makes patients feel safer, sleep better and receive more personalised care.

I would like to reiterate how grateful we are for the offers of advice and areas of support that the national team are willing to work with us on. (I will send a separate email summarising actions shortly).

Thank you,
Charlotte

From: PRATAP, Bobby (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S] >
Sent: 28 April 2022 12:23
To: Charlotte Wood [redacted] [I/S]; JENNINGS, Sarah (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S] >; HOLLOWAY, Sarah (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S] >; KEHOE, Jemma (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S] >; Sophie Davies [redacted] [I/S] >
Cc: FARROW, Christina (NHS ENGLAND & NHS IMPROVEMENT - X24) [redacted] [I/S]
Subject: Feedback on concerns about Oxevision

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Hi Charlotte, Sophie,

Please see below – I think some considered reflections. You might not agree with them all as critiques of the technology, as opposed to how it is being used. As discussed, I said I would share the unredacted feedback (aside from names of some patient reps) as it's helpful to be open to give best chance to understand where different people are coming from.

To note that some of this is based on people's impressions from implementation either in one or two places, or what they have read in the media etc. You will obviously have seen the other concerns relating to Camden & Islington – which was raised with us via the media route.

I should add that I have also had feedback from other places that it has resulted in staff have had more meaningful time to spend with patients, and not less as per concerns below. Also they have really gone through robust processes of adjusting its use during implementation.

I was encouraged by the discussion yesterday to hear from you guys that you share the wish to improve understanding of how it should and shouldn't be applied, and in particular to hear your concerns about ethics of using it to support people who have been through certain traumas and abuse.

Look forward to learning more!

XXX is obviously very anti this tech as it is about as incompatible with Trauma informed care as it is possible to be, however, she has joined the trust implementation group as she wanted to understand whether it is useful for some patients and/or if there are ways to make it less invasive. These were her findings:

- She raised the point about how vital it is that patients consent to being filmed in their bedroom in an informed way; she was told by the trust that most patients do not have capacity to consent and therefore the decision to use it is made in their best interest
- She attended a ward where it is used and asked how patients are informed of the tech and was told they receive a leaflet in their welcome pack, but when asked to share said leaflet the ward couldn't find any
- When in the staff office she was shown what the staff could see which included recorded footage of patients in their bedrooms
- The main "success" story the trust spoke of was a situation where a member of staff conducted observations on a patient and left, then a few minutes later the patient attempted to hang themselves. Oxevision identified this and staff were able to stop the patient. To me this reads that the staff conducting observations absolutely failed in the key purpose of observations and it is very concerning that staff needed the CCTV footage to be able to assess that the patient was feeling so unsafe.

I thought these reflections might be helpful in thinking through how we may be able to mitigate the key issues with the way in which this tech is being used. I thought it might be helpful for me to summarise my main concerns (but please feel free to ignore as usual I am just sharing my views which are biased towards women in hospital who are trauma survivors, but also based on my experience of managing many hospitals over the years):

1. It is absolutely the role of healthcare staff to use relational security to help keep people they are caring for safe – the use of tech to provide the "checking" on patients in the name of safety has the potential to erode the relational element – which we know is the most important to people's recovery. I really worry that relying on tech to identify if a patient has self harmed or made an attempt on their life will give a false sense of security to staff and reduce the clinical skill/focus on understanding how safe a patient feels, when they are at risk and how to help. (I think there is a case for some research in this area, its not my area of expertise but the Safewards model was built on evidence base of what helps to keep patients safe – which found that procedural and physical security are not the answer)
2. For trauma survivors, being filmed without consent (or even with it as many trauma survivors will feel they have to agree to being filmed as it replays the dynamic experienced when being abused) is incredibly re-traumatising and thus should be understood as patient harm
3. I believe being filmed without informed (and really, properly informed) consent is a breach of people's human rights and I think needs to be weighed very carefully against what is perceived as increasing safety
4. I think at the very least, we should push for the use of CCTV to be understood as a restrictive practice and recorded as such and then we will at least have sight of this worrying practice and be able to support systems to reduce it

1. There is a place for tools that help nurses to respond quickly or decide on appropriate frequency of checks to patients who are physically unwell/vulnerable for example: monitoring someone with unstable epilepsy, sleep apnoea or post rapid tranquilisation and (with all the usual consent caveats) advances in this area are generally welcomed by patients & staff (as evidenced by the long history of the use of things like seizure sensors).

2. I note that the NIA goes beyond this and purports to monitor 'high risk activity' capturing 'behavioural trends' etc. My experience in services tells me that once you start introducing 'behaviour surveillance' by electronic tools it requires a lot of effort, safeguards, training, policies, etc etc. to make sure it doesn't turn into a slippery slope situation.

3. Whilst some patients may find CCTV useful and in some circumstances it can be Let's not forget that many of those currently in long term segregation (including recent high profile patients) have had their every move constantly monitored by CCTV cameras and often all it seems to achieve is the patient has very limited or no 'human contact' and their distressed behaviour, self-harm, aggression escalates etc. until they are fed through a hatch, don't even get out for fresh air and, in some cases, die. <https://www.irwinmitchell.com/news-and-insights/newsandmedia/2014/november/inquest-into-death-of-stephanie-bincliffe-while-detained-under-mental-health-act-jq-684260>

Bottom line consent is critical, shouldn't replace well trained staff in sufficient numbers and each applicability should be robustly tested etc.

I am aware that there is a lot of service user concern about this approach, how it has been implemented in wards with no advanced warning for patients, how it breaches human rights and how retraumatising it can be for particularly survivors of Sexual violence to be filmed. I am personally aware of wards where the approach has been implemented with patients having no right to decline it. The concern has also been flagged by the chair of the restraint Reduction Network, who has written openly to Claire and CQC via the campaign group Rightful Lives. It is also worth noting that many of the survivors objecting to this tech are those involved in the Stop SIM campaign.

I am not sure what is and isn't our role in terms of advising/supporting or not but in case helpful my concerns are as follows:

1. The whole point of Observations is that they are therapeutic (they are mostly not) but they are meant to be about building a therapeutic relationship with service users and having a more robust opportunity to assess safety and risk – the best hope we have of knowing if someone is at risk of harm is talking to them and our best hope for keeping them safe is having a therapeutic conversation with the person. I cannot understand how this technology enables/supports this and would say it actively detracts from it.

2. I think tech such as this along with other approaches to making ward environment 'safe' completely miss the point that the only way to help patients stay safe is to build a trusting therapeutic relationship, help the person to feel psychologically safe and to have a care plan which supports the person to increase their safety – I worry that approaches

like this lead staff to missing the point – they are about managing risk as staff see it, not focussing on the patient feeling safe.

3. The use of CCTV is absolutely an infringement on people’s human right to privacy, but as you say, there may be some patients for whom it is helpful. There will be many patients for whom it is traumatising and psychologically harmful and I am certainly aware of a number of trusts not giving patients the choice to refuse being filmed.

Bobby Pratap
Deputy Head of Mental Health
Programme Lead for Adult Crisis and Acute Care
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