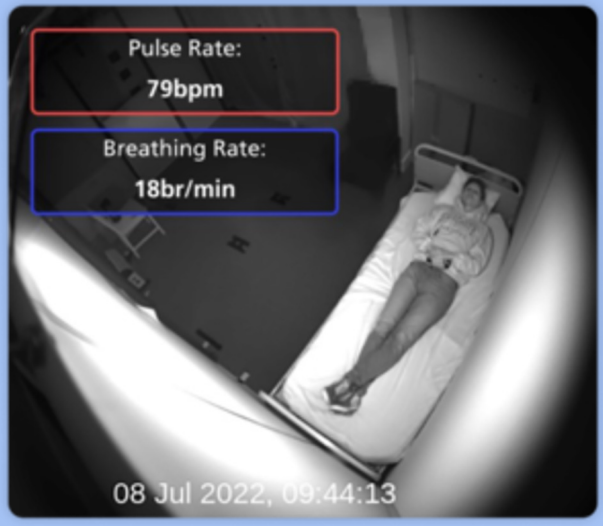
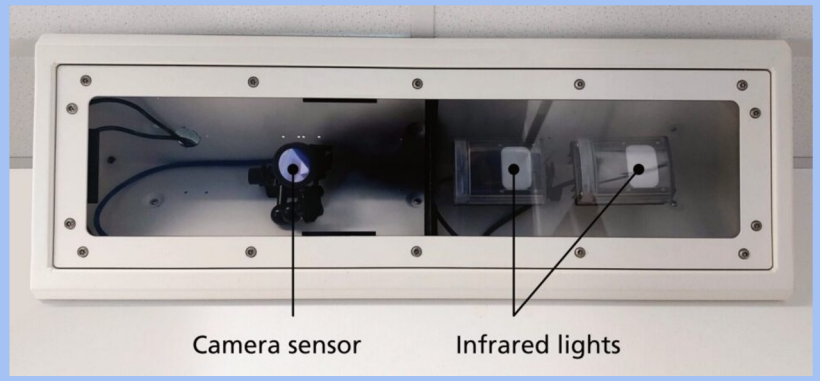
The use of vision based monitoring systems in observations

- The ‘evidence’/academic literature base

- Insights from survivor research:
- Rights concerns
- Safety concerns
- Lived Experiences
- Issues for relational care



What is Oxevision?



- **Contains:**

- A camera, that is recording 24/7 - footage can be ‘clipped’ and saved at the discretion of staff
- Vital signs monitoring (heart rate, breathing rate)

- Located above the bed in bedrooms
- Not ‘intended’ to replace observations (but it often *is*)
- Alerts to patients being in bathroom for more than a certain amount of time
- No alert for deterioration in vital signs

The evidence* (*From a review on all surveillance tech on MH wards)

- Academic literature claims ‘cost savings’, reduction in aggression and self harm, increased safety on the ward

- Review (on all surveillance tech) found this to be poor quality (Griffiths et al 2024)
  - Methodological issues (eg in quantitative data)
  - Financial conflicts of interest

- The literature that claimed cost savings had discrepancies (ie not accounting for wear and tear, upgrade costs etc, alongside other methodological limitations)

- The high quality literature found surveillance technologies (specifically BWCs) do not reduce ‘aggression’ or self harm

The evidence cont…

- Very little literature comprehensively investigates the potential negative effects of these technologies (ie iatrogenic harms)

- Some of the literature (specifically regarding CCTV) indicated that where policies for use are implemented, these are often not followed

The evidence cont…

"*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*"

- Griffiths et al 2024

\+ A call for more independent research

Factors affecting the evidence

- The changing nature of academia and academic work
  - ‘Collaborative’ working (industry-academia-NHS)

- A need for a critical eye when reviewing evidence
  - What claims is it making and why?
  - Who is making these claims? Who might be benefiting from it?
  - Are these claims in the best interest of the patient/support relational care?

- Power dynamics: Exists in the context of NHS England’s strategy ambition to “*speed up and scale up the adoption of innovation in the NHS and to improve the NHS’s global competitiveness in life sciences and MedTech*”

- Technology posed to ‘fix’ broader structural issues such as issues with staffing and time for care

Surveillance is not safety:

STOP oxevision

Insights from survivor research

- A note on knowledge politics
- Rights concerns
- Safety concerns
- Psychological safety
- Lived Experiences
- Observations

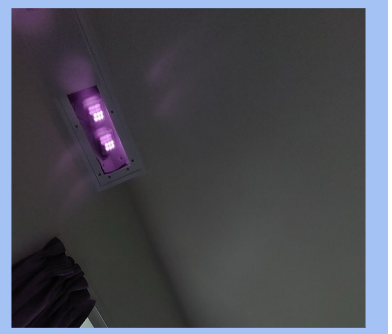
Rights concerns

- **Consent**
- Many instances of a lack of informed consent about camera
- Should not be used in a ‘blanket way’ according to NHS principles but some Trusts still have ‘opt out’ policies
- Issue of coercive ‘consent’

- **Privacy and dignity**
- Complete removal of privacy when in bedrooms
- Potential for video footage to be used in a court of law - distress becomes criminalised
- Betrayal of trust in caregiving relationship

- **Surveillance is a restrictive practice**
- Restraint reduction network has identified surveillance as a restrictive practice
- Has the potential to result in harm for some groups even more than others (ie religion, ethnicity)

Psychological ‘safety’



- **Can exacerbate pre-existing paranoia**
- No way of knowing which member of staff is watching you through the camera and when (exacerbated for some people)
- Infra-red light cannot be switched off, no way of knowing for sure if turned off or on
- We still do not know the long-term psychological implications of being filmed 24/7

- **Can be (re)traumatizing for those with experience of camera-based and/or coercive abuse**
- Potential for malicious staff misuse

Observations

- **Replacing in person care**
- ‘Not intended to be used instead of in-person observations’ *vs* proposed cost savings and claims to allow uninterrupted sleep
- Lived experience accounts of being left alone without in person care (see next slide)

- **Reduced opportunity for relational care**
- Observations as opportunities for relationship and trust building in care relationships

STORIES FROM THE WARD | ACUTE

Patricia: Saving valuable time

As told by Jane Biner, Charge Nurse

“I used Oxevision to take an observation of Patricia in her room, and I saw that **she had a plastic bag tied around her head**. I immediately went to her bedroom and removed the plastic bag and she appeared to **start having a seizure**. When she came around, **she said she couldn’t see or hear anything**.

Previously, Patricia has **exaggerated how ill she had been**. We decided to continue observing her in her bedroom, using Oxevision. We took pulse and breathing rate measurements which were in the normal range, and **her presentation wasn’t consistent with having had a seizure**.

Being able to observe Patricia and collect objective data using Oxevision meant that we could be **confident that she was ok**. This allowed us to **save valuable time for the doctor and the A&E staff**."

Above: Previous Oxehealth marketing material

A lived experience

There was **no discussion upon admission explaining Oxevision**. My first time with Oxevision I was told it didn't have a camera. There were no posters or information leaflets available on the ward I was on, even when I asked the MDT [multi- disciplinary team] I didn't receive one.

Most staff were not educated properly on how oxevision works and what it does, as a patient **I was receiving conflicting information from different sources and it was confusing.**

There were nights where I was **frozen with terror in bed lying underneath the camera**. There is no way of knowing when a staff member is watching you through Oxevision, I felt very unsafe and frightened. I begged the MDT to turn it off and they said it was impossible as there were no procedures in place to turn it off. **I felt powerless**.
It didn't improve my care, none of the activity or vitals that it recorded were ever mentioned to the clinician. Staff spent even less time engaging with patients.

The whole experience felt deceitful. **It has had a lasting impact, the experience left me with more trauma.** I am angry about the treatment I was subject to. Blanket surveillance has been implemented on such a large scale without consideration of patient consent, privacy or the psychological effects. I suffered unnecessarily and unlawfully.

- Anon via Stop Oxevision 2023

Safety concerns

- **Potential for misunderstandings of how the technology works**
- There is **no alert** for deterioration in vital signs
- Potential for over reliance on the technology at times of physical risk

- **Limited range for vital signs monitoring**
- Designed to measure heart rate between ranges of 50-130 (± 3) BPM*
- Breathing between 8 and 39 (± 2)*
- Patient must be completely still

*According to https://uploads-ssl.webflow.com/5f46bcde21c863c871c74a23/62e91d4940b23046163d79e5_Vital%20Signs-IFU-Instructions%20For%20Use-EN-UK-64.0.pdf

What now?

- **This is a camera in people's bedrooms that records 24/7. This is unchangeable, even if consent procedures and policies are changed.**

- In the wake of the Lampard Inquiry, Stop Oxevision and National Survivor and User Network (NSUN) have called for **"*all mental health trusts using Oxevision to immediately suspend its use on the basis of safety and legality concerns*".**

- **Concern about similar technologies**

- Importance of looking at context - ask 'is this technology claiming to fix structural issues?'