



Public – To be published on the Trust external website

Recordings by patients and carers for personal use (silent recording)

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Document type: Procedure

Overarching policy: [Confidentiality and Information Sharing Policy](#)

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1 Introduction

The Trust supports patients to make personal recordings. All Trust staff should convey a positive, welcoming attitude to personal recordings by patients.

This procedure has been written to explain to staff how to facilitate patients in recording sessions where they wish to and to remind staff that patients do not have to ask for permission to make audio recordings.

It is acknowledged that recordings made by patients have sometimes, in the past, been for a purpose that has not been about the patient's own therapeutic use. This procedure aims to raise awareness of the patient's right to record, so that, by fostering an open and transparent dialogue where recording is consensual, negative connotations relating to private recording are minimised. Whilst we would encourage patients to advise that they are recording their session, we understand that there is no obligation to do so for audio recording. This will be reviewed on an ongoing basis.

Information disclosed during a consultation is confidential to the patient, and a private recording is not therefore a breach of confidentiality. Clinical staff nonetheless have a reasonable expectation of privacy during a consultation. However, where a patient makes an audio recording of their clinical session without permission, staff have no legal redress as they are acting in a professional, not personal, capacity. However, we will support staff with any concerns and comply fully with the [Social Media Policy](#).

1.1 Strategic goal 1: We will co-create high quality care

Implementing this procedure provides assurance to patients, carers, families and staff that the Trust accepts the rights and freedoms of patients to be able to reflect on their consultations and may record their sessions in order to achieve this. This can be done both privately and openly.

Engaging patients in their own care can promote increased confidence and willingness to take control of their health, which ultimately can lead to healthier behaviours and improved outcomes. (Turakhia, P and Combs, B; 2017).

The Data Protection Act 2018 and Freedom of Information Act 2000, which underpin all aspects of confidentiality and information sharing, give transparency to all aspects of the way that information is processed within the Trust.

The British Medical Association (BMA) acknowledge the benefits of consensual recordings, confirming that "We believe there is significant benefit for both patients and doctors in supporting consensual recordings. We encourage doctors to do so, particularly where patients may have difficulty remembering information." (BMA, 2021). They go on to say that "Encouraging patients to make recordings means that they are less likely to make them covertly."

1.2 Maintaining good quality records has both immediate and long-term benefits for staff.

It can directly benefit them, for example in respect of safety. Records management promotes better communication as well as continuity, consistency, and efficiency, and reinforces professionalism (Wood, C; 2003). Information Governance (IG) ensures not only that all colleagues understand their role around the use and sharing of information that is created or used by them, but also that patients understand their rights to make a personal recording for their own record. When staff understand their roles they become confident in their decision making. Staff share the records that they make with their patients so that the record becomes a jointly-understood document at all times.

1.3 Trust values and behaviours

Embedding good Information Governance practice across all areas of the Trust enables us to evidence how we live our values of respect, compassion and responsibility in everything we do.

2 Purpose

The purpose of this procedure is to provide guidance to TEWV staff, patients, and carers on the use of personal recordings in healthcare settings.

Following this procedure will help the Trust to: -

- Promote understanding among staff and patients and carers of the benefits of personal recordings.
- Support and welcome patients and carers to record their interactions with staff.
- Ensure everyone understands when patients and carers may and may not record interactions.
- Ensure everyone knows how personal recordings can be used. Understand that patients and carers may record their sessions or conversations with staff and can do so without the consent or knowledge of staff. They do not have to ask permission to audio record.
- Consent is required to video record and/or capture images.
- Understand the legislation which underpins a patient's right to audio record their clinical session without permission.

This procedure does not include any recordings made by patients outside of clinical consultations. For any concerns regarding other recordings, refer to 5.4 below and [Social Media Policy](#).

If the clinical session involves conducting neuropsychological testing, recording by the patient should be discussed at the start of the session.

[Guidance on the recording of neuropsychological testing in medicolegal settings.pdf \(bps.org.uk\)](#)

3 Who this procedure applies to

All staff who come into contact with patients and carers for any reason.

It will also be of interest to patients and carers. Staff should refer them to this procedure. Recordings by Private Carers do not fall within the scope of this procedure and are not supported by the Trust.

4 Related documents

This procedure should be read alongside the [Use of Visual and Audio recording in clinical procedures procedure](#) and [Social Media Policy](#).

See also:

[Consent for Images and Recordings procedure](#)
[Mobile technology policy for patients and visitors](#)

5 Recording

5.1 What is a personal recording?

The Trust welcomes and supports personal recordings. A personal recording is an audio or video recording made by a patient (and/or carer – see Section 5.7 below) of their interactions with Trust staff. This may include consultations, care review meetings, formulation meetings etc..

Personal recordings include private recordings. Private recordings are sometimes referred to as 'covert' recordings. "Private recordings" is the Trust's preferred term for recordings made without staff knowledge. Patients have the right to audio record privately, and the Trust encourages staff to demonstrate a positive attitude in this regard. Patients do not have the right to video record privately. Video recording does require consent as video contains a person's image and is therefore easily personally identifiable.

Any recording made by the patient becomes their confidential information and can be disclosed by them as they see fit for their own personal use.

A personal recording by a patient differs to recordings made by staff in the course of their work. Considerable legislation applies to recordings made by staff and staff recordings usually require informed consent. (Please see the [Consent for Images and Recordings](#) procedure and the [Use of Visual and Audio Recordings in Clinical Procedures](#) procedure.) This legislation does not apply to patients making personal recordings as stated in recital 18 of the Data Protection Act 2018.



Recital 18 states the following:

This Regulation does not apply to the processing of personal data by a natural person during a purely personal or household activity and thus with no connection to a professional or commercial activity

There is case law that would suggest that if a person uploads recordings onto social media it could mean that the reason for processing is no longer for purely personal/household reasons. If that were the case the posting would fall under the DPA regulations as the individual would be deemed to have become a Data Controller within the meaning of the Act. This enables the Trust to act should recordings be uploaded to social media – see [Social Media Policy](#).

5.2 Benefits of Personal Recordings

Personal recordings by patients and carers have numerous benefits for everyone:

- A welcoming attitude to recordings from a clinician can build trust for all concerned and strengthen the therapeutic relationship.
- Recordings can act as a memory aid of what was said and what action should result from it – as such, they reduce the distracting need to take notes during a meeting.
- Recordings can act as source of information and discussion for carers and other concerned people who were unable to attend a meeting.
- If staff encourage patients and carers to record meetings, it can help patients to reflect on discussions about their own health and wellbeing, leading to restorative benefits for them.
- If recordings are shared, staff can also enjoy the opportunity for reflection, thus furthering their own learning and development.
- Recordings can help resolve factual disputes, thus eliminating the need for a formal complaint.
- Recordings can help patients with previous bad experience to feel safer.
- Recordings can provide evidence of poor standards of care.

NB The encouragement of patients and carers to make recordings openly means that covert recordings are less likely [BMA, 2021].

5.3 How should staff respond to personal recordings?

The Trust supports patients to make personal recordings. All Trust staff should convey a positive, welcoming attitude to personal recordings by patients.

Trust staff should:

- Recognise that patients have a right to record, and that, by fostering an open and transparent dialogue where recording is consensual, negative connotations relating to private recording are minimised.
- Reassure the patient that they have the right to audio record without the knowledge or permission of staff.
- Reassure the patient that staff are happy for them to record.
- The start of important meetings, is an opportunity for staff to remind patients that they may record. This includes discharge meetings and care review meetings.
- Announce the date and time of the meeting, and the people present
- Be mindful that some patients have experienced negative reactions from staff when they make personal recordings and, consequently, may be afraid of staff reactions.



Staff should be careful to avoid communicating in a way that may be perceived as pressurising the patient to say whether they are recording.

The Trust is aware some staff have difficulty adjusting to patients and carers making personal recordings. Staff who are struggling with their feelings about patients making personal recordings should seek supervision and support.

The Trust expects all professional staff to uphold their professional code of conduct and the Trust values in relation to personal recordings by patients, including awareness of the legal framework.

5.4 Privacy of other patients and carers



This procedure does not remove anyone's rights to whistle-blow or bring attention to other concerns such as safeguarding or abuse of another person's Human Rights. This may include recording harm or mistreatment of or by other patients.

The Trust has two posters that describe the critical issues to be aware of when recording in communal settings. These can be viewed at appendix 3 and should be posted in all communal settings including waiting rooms.

The Trust has a duty to protect the confidentiality of all patients in their care. Therefore, the Trust does not allow patients and carers to record other patients and carers whether this is on Trust premises or within the community.

- If the Trust finds out that recordings have been made of other patients and carers within a hospital setting, refer to the Trust's Mobile Phone Policy - patients and Visitors.
- If this occurs within a community-based waiting area, this should be discussed within the Multi-Disciplinary Team (MDT) and appropriate action taken. The patient should be fully involved in this discussion.
- Patients may be asked to delete images if they are found to have misused their device to record or take photographic images of other patients or carers on Trust premises. All decisions will be made on a case-by-case basis with full collaboration at all points.
- Depending on the suspected images, photos or recordings taken, staff may need to seek advice from a manager. If a potential crime has been committed or there are potential concerns regarding Safeguarding, ward or community staff should contact the Police or Trusts Safeguarding Team and record this on the Trust's incident reporting system. Any consideration given to removing a mobile device must be made, recorded and managed in accordance with the Trust's [Mobile technology policy for patients and visitors](#).

Where possible, alternative means should be provided for the patient's to safely record their personal interactions with clinicians.

It is the Trust's responsibility to ensure that patient's care is provided in a way that maintains their privacy as far as reasonably possible. Staff can assist with this by holding conversations about patient's care in private rooms. This should include closing the door when dispensing medicine to a patient's so the queue of waiting patients cannot over-hear the conversation. Maintaining privacy in this way will help avoid patient's inadvertently recording other patients.

5.5 Requesting that a patient or carer session be recorded

It is acceptable for a patient, carer, or member of staff to request that an interview/clinical session be recorded.

The process to be followed will be as described within this procedure and the justification and outcome must be recorded.

Recording sessions with patients can be a useful tool for both clinicians and patients, whether it is for the patient to use later or as part of the therapeutic journey.

If the individual takes the recording away, they must be made aware of the risk of losing the information and that the Trust will not be held responsible for any subsequent loss.

There can be many reasons why a patient may wish to record a session or conversation. The clinician should make sure that all patients are reminded of their right to record as this will help them to remember what was discussed and can make their therapeutic relationships with staff stronger. It may be part of their care plan.



At the moment it is not possible for staff to record person to person sessions or conversations.

Remote sessions (individual or family sessions up to 6 people or MS Teams for Groups of 6 or more) can be recorded.

Staff should make themselves aware of the methods that can be used to record sessions and conversations with patients and carers. Refer to the [Use of Audio/Visual Recordings in Clinical Procedures procedure](#).



The recording does not replace the making of clinical records and does not form part of the clinical record. Recordings may be used to provide an accurate case note in some situations.

If a patient requests a recording in a person to person setting, they should be encouraged to use their own recording device and time given to set this up.

The beginning of any session is an opportunity for staff to have a conversation with the patient about their needs for the session(s) by asking if they would like to have their session recorded if staff have prepared and have the software available.

Staff should make a note in the clinical record that such a recording has taken place. Staff should discuss and make the record with the patient.

A patient may not wish to have a recording made by staff. They will have their own reasons for doing this and should be respected in their choices.

5.6 Use of personal recordings in the complaints process or as evidence in court

The Trust is committed to providing good care and investigating concerns. Where a recording is relevant to a complaint by a patient the Trust is likely to be willing to consider a transcript of a recording.

Patients may also use transcripts of their recordings in complaints processes external to the Trust, such as the Parliamentary Health Service Ombudsman, or when taking legal action. In these situations, it is likely the recordings will need to be an unmodified, full recording of the encounter. Therefore, patients should be aware that voice activated recordings are less likely to be useful evidence in any complaint.

It is good practice at the start of any meeting to name the attendees and state the date and time. Whilst staff may not be aware that a recording is taking place this approach to a meeting at its start will help to orientate any future enquiries into the recording as to time and place.

A private recording can be submitted as evidence in legal proceedings, but with some conditions:

- A recording may be relied on in evidence if the court gives permission
- An application for permission should be made on form C2 (obtained via the court)
- The recording should be made available to other parties before any hearing to consider its admissibility.

In relation to children and according to section 13(4) of the Children and Families Act 2014:

“Where in contravention of subsection (3) a child is medically or psychiatrically examined or otherwise assessed, evidence resulting from the examination or other assessment is inadmissible in children proceedings unless the court rules that it is admissible.”

5.7 Recordings made by carers

Carers can make recordings if they fall into the criteria of being purely for personal/household reasons. However, it should always be paramount in a carers mind that their duty is to the patient. This means that if they are aware that the patient would not wish them to make a recording they should not do so. The Trust would not support a Carer in making a recording that they knew the patient did not or would not agree to.

The most helpful approach to carers involvement with patients and their care is to have a discussion at a suitable time where all the conditions for carer involvement are discussed and incorporated into the care plan. This is especially important where the patient may have fluctuating capacity.

The duty of confidentiality remains in place and Carers should always be mindful that they are holding confidential information that is not about them and should consequently not share the information with third parties.

6 Definitions

Term	Definition
Personal/household use	The application of the household exemption means that any data processing falling within the scope of 'a purely personal or household activity' would not be subject to any restrictions imposed by the GDPR. This means that the processing of personal data done for exclusively personal, or household purposes is exempt from the DPA 2018.
Personal recording/private recording	As defined within the DPA 2018 the recording should be for the use of the person making the recording or their carer if the individual has requested that the recording be made on their behalf. A private recording is a personal audio recording made without the knowledge of staff.
Carer	A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person (definition from oxford languages dictionary)
Care Giver	A caregiver is a paid or unpaid member of a person's social network who helps them with activities of daily living. Since they have no specific professional training, they are often described as informal caregivers (definition taken from Wikipedia)
Advocate	A person who puts a case on someone else's behalf a person who puts a case on someone else's behalf (definition from oxford languages dictionary)
Third Party	A third party would be any individual or organisation mentioned in records or present at a meeting that was not the patient, or the healthcare staff involved with their care
Data Protection Act 2018 (DPA 2018)	The Data Protection Act 2018 controls how your personal information is used by organisations, businesses, or the government. (definition taken from Data protection - GOV.UK (www.gov.uk)). The Data Protection Act 2018 is the UK's implementation of the General Data Protection Regulation (GDPR)
General Data Protection Regulation (GDPR)	The General Data Protection Regulation (GDPR) is a legal framework that sets guidelines for the collection and

	processing of personal information from individuals who live in the European Union (EU) .
Professional Code of Practice	<p>A code of practice is a written guideline that is set out by a professional association to guide its members toward compliance with the appropriate ethical standards (definition taken from What is Code of Practice? - Definition from Safeopedia)</p> <p>For example, the Nursing & Midwifery Council (NMC) state that:</p> <p>“The Code presents the professional standards that nurses, midwives and nursing associates must uphold in order to be registered to practise in the UK.”</p>
Natural Person	An identifiable natural person is one who can be identified, directly or indirectly, by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural, or social identity of that natural person.
Information Commissioners Office	The Information Commissioner's Office (ICO) upholds information rights in the public interest , promoting openness by public bodies and data privacy for individuals. The ICO is an executive non-departmental public body, sponsored by the Department for Digital, Culture, Media & Sport.
Private Carer	A private care organisation or agency outside of the patient’s normal carer arrangements, e.g. a representative of a care home who has brought the patient to their appointment.

7 How this procedure will be implemented

- This procedure will be published on the Trust’s intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.
- Posters will be placed in prominent places on wards and in community settings in line with the implementation plan.
- Short meaningfully co-produced online training courses will be developed and available to all staff, patients, and carers within the initial 12 month implementation of this procedure. This training will be reviewed after 6 months, then annually thereafter.
- Procedure will be included in ward welcome packs in line with the implementation plan.

7.1 Implementation action plan

To reiterate the right to record applies and is supported in all areas subject to the criteria set out in this procedure. This is a new procedure and may be unfamiliar to a number of staff therefore a staged roll out plan to support implementation has been designed as in below table.

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
Educational plan to be developed and shared with pilot teams that includes this procedure in a wider session linked to rights. Procedure to be trialed in 4 inpatient areas and 4 community teams initially	Evaluation of trial to determine plan for roll out	3 months (development) and delivered before roll out in pilot areas	Deputy Chief Nurse, DTVF Director of Lived Experience	Evidence of delivery of educational package. Feedback from staff and service users.
Develop roll out plan	Trust wide roll out based on learning from pilot	6 months after pilot completed	Deputy Chief Nurse, DTVF Director of Lived Experience	TBC once plan devised

7.2 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All staff that are involved with patients	In line with the implementation plan focus groups will be arranged for all staff to attend to discuss the procedure and responsibilities, along with staff anxieties and feelings around personal recordings	One hour	Once
All staff	Induction training	Included in corporate induction	On commencement of employment

8 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented
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	Performance Indicators		and monitored; (this will usually be via the relevant Governance Group).
1	Posters displayed	In line with the implementation plan peer reviews will check for evidence of posters. Care Group Director of Nursing and Quality	Integrated Care Group Governance Meeting Co-Creation Board
2	Information (standard text to be provided) added to appointment letters (outpatient / community) and ward welcome pack (inpatients)	In line with the implementation plan: <ul style="list-style-type: none"> • Service Manager • Assurance from ward/team manager of delivery at point of implementation. • Inpatient - welcome pack • Non-inpatient - spot check of 10 sample invite letters per team 	Integrated Care Group Governance Meeting

9 References

- ✓ [https://www.whatdotheyknow.com/request/379944/response/916674/attach/html/3/Patients recording NHS staff in health and social care settings guidance May 2016.pdf.html](https://www.whatdotheyknow.com/request/379944/response/916674/attach/html/3/Patients%20recording%20NHS%20staff%20in%20health%20and%20social%20care%20settings%20guidance%20May%202016.pdf.html)
- ✓ Article 2 Material Scope 2. This regulation does not apply to the processing of personal data (C) by a natural person during a purely personal or household activity. Suitable recital 18 not applicable to personal or household activities
- ✓ Recital 18: <https://gdpr-info.eu/recitals/no-18/>
- ✓ Patients Recording Consultations, BMA (2021) [Online] Available at: [Patients recording consultations \(bma.org.uk\)](https://www.bma.org.uk/patients-recording-consultations)
- ✓ Professional standards of practice and behaviour for nurses, midwives and nursing associates, NMC (2024) [Online] Available at: [The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council \(nmc.org.uk\)](https://www.nmc.org.uk/standards-of-practice-and-behaviour-for-nurses-midwives-and-nursing-associates)
- ✓ [Guidance on the recording of neuropsychological testing in medicolegal settings.pdf \(bps.org.uk\)](https://www.bps.org.uk/guidance-on-the-recording-of-neuropsychological-testing-in-medico-legal-settings.pdf)

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	03 March 2026
Next review date	03 March 2029
This document replaces	n/a – new document
This document was approved	Executive Clinical Leaders Sub-group 21 January 2026
This document was approved	Information Governance Group 28 January 2026
This document was ratified by	Executive Directors Group (EDG)
This document was ratified	03 March 2026
An equality analysis was completed on this policy on	16 January 2026
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
v1	03 Mar 2026	New document	Ratified

Appendix 1 - Equality Analysis Screening Form

Please note: [The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet](#)

Section 1	Scope
Name of service area/directorate/department	Trustwide
Title	Recordings by patients and carers for personal use
Type	Procedure
Geographical area covered	Trustwide
Aims and objectives	<ul style="list-style-type: none"> • Support and welcome patients to record their interactions with staff • Ensure staff and patients and carers understand when patients and carers may and may not record interactions. • Ensure staff and patients and carers know how personal recordings can be used. • Promote understanding among staff and patients and carers of the benefits of personal recordings. • Understand that patients and carers may record their sessions or conversations and can do so without the consent or knowledge of staff. They do not have to ask permission to do so • Understand that carers may record sessions or conversations on behalf of patients and can do so without the consent or knowledge of staff, but carers must have the permission of the patient to do so.
Start date of Equality Analysis Screening	September 2025
End date of Equality Analysis Screening	October 2025

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All Trust staff, carers, patients
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	<ul style="list-style-type: none"> • Race (including Gypsy and Traveller) NO • Disability (includes physical, learning, mental health, sensory and medical disabilities) NO • Sex (Men, women and gender neutral etc.) NO • Gender reassignment (Transgender and gender identity) NO • Sexual Orientation (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) NO • Age (includes, young people, older people – people of all ages) NO • Religion or Belief (includes faith groups, atheism and philosophical beliefs) NO • Pregnancy and Maternity (includes pregnancy, women who are breastfeeding and women on maternity leave) NO • Marriage and Civil Partnership (includes opposite and same sex couples who are married or civil partners) NO • Armed Forces (includes serving armed forces personnel, reservists, veterans and their families) NO
Describe any negative impacts	<p>If this procedure is followed, it will prevent any potential for negative impact as there is mitigation included in the procedure to ensure that any negative impact is reduced or removed completely.</p> <p>If the procedure however is not adhered to, it has been identified that there could be potential negative impact for the following reasons:</p>

	<ul style="list-style-type: none"> - If carers record on behalf of patients, there is an acknowledgement that staff may not be aware if carers have recorded sessions without the permission of the patient. - A recording of a patients' session by a carer should still be the property of the patient. As staff are unable to ensure that this will occur in all instances and that the deletion of recordings take place on the request of patients, there is potential for negative impact. - Patients in CAMHS services accompanied by their carers / parents may be unaware of recordings being made without their permission as children over the age of 12 years old may not be aware of their rights around recordings being made without their consent. - Patients across a range of services including CAMHS, LD, AMH and MHSOP may be unaware of recordings being made without their permission as some patients may lack capacity. - TEWV will only be able to act on matters reported to them and it is anticipated that not all matters relating to recording by carers on behalf of patients will be known to TEWV or to the patient for them to report the issue. - There is therefore potential for negative impact on the protected characteristic of 'Disability' and 'Age' if the procedure is not followed. This is, however, not a consequence of the procedure but a potential consequence of the current legal position. - The procedure explicitly highlights that the Trust position protects against these potential impacts and therefore the procedure itself is not anticipated to have any negative impact but rather provide clear guidance to staff and patients.
Describe any positive impacts	<ul style="list-style-type: none"> • Assist people, especially those with memory problems or physical disability affecting their ability to take notes, to remember clinical information.

	<ul style="list-style-type: none"> • Provide protection from harm and mistreatment which will particularly benefit the most vulnerable patients and any groups that face increased risk of discrimination. • Prevent inappropriate responses from staff to patients recording thereby supporting better clinical relationships and enhancing accessible healthcare for vulnerable groups. • Promote choice and dignity which will improve wellbeing of patients/ people with MH disabilities.
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Section 3	Research and involvement
<p>What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)</p>	<p>The procedure is new to the Trust and it is difficult to know the impact it will have and any future guidance that may be necessary.</p> <p>Business Plan: Goal 1 of the strategic framework “create a better experience for patients” also, ambition of the safety and quality strategy. upholding Trust values (promoting trust/respect/patient centred)</p> <p>Guidance: medical defence union – is not co-produced or sends negative message (possibly)</p> <p>Codes of Practice: upholding patients’ rights, knowledge of legal framework surrounding practice</p>
<p>Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?</p>	<p>Yes</p>

<p>If you answered Yes above, describe the engagement and involvement that has taken place</p>	<p>Yes – Please describe the engagement and involvement that has taken place</p> <p>Consultation has taken place with a patient and carer group since September 2020. It has also involved the Triangle of care group and will be consulted on via the Trustwide feedback system for policies and procedures. It will also go out to further consultation with patients and carers via routes such as the involvement mailing list (Dec 2022). Further wider consultation Oct 2023 across patients, carers, families, staff, and other groups. (completed 2024)</p> <p>There will be further meetings and co-production with patients following consultation on the procedure. The procedure will be regularly reviewed in consultation and co-production with different groups. There is also a service evaluation planned which will explore the implementation of the procedure in various settings and patient groups.</p>
<p>If you answered No above, describe future plans that you may have to engage and involve people from different groups</p>	

Section 4	Training needs
<p>As part of this equality analysis have any training needs/service needs been identified?</p>	<p>Yes</p>
<p>Describe any training needs for Trust staff</p>	<p>Yes – Trust staff - e-learning needs updating</p>
<p>Describe any training needs for patients</p>	<p>No</p>
<p>Describe any training needs for contractors or other outside agencies</p>	<p>Yes - if they have patient contact</p>

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	Title		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	Rationale		
	Are reasons for development of the document stated?	Yes	
3.	Development Process		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	No	Related documents will be reviewed soon as part of policy review calendar
4.	Content		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	Training		
	Have training needs been considered?	Yes	Workshops to be set up

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Are training needs included in the document?	Yes	
7.	Implementation and monitoring		
	Does the document identify how it will be implemented and monitored?	Yes	Monitored via feedback and survey process
8.	Equality analysis		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9.	Approval		
	Does the document identify which committee/group will approve it?	Yes	
10.	Publication		
	Has the document been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

Appendix 3 – Posters

List of posters: -

Use of mobile phones & devices

Audio & visual recording

Audio recording

Use of mobile phones and devices

You are welcome to use your mobile device whilst visiting or staying on our wards, however we want to respect the privacy and dignity of others in order to keep everyone safe.



Please do:

- ✓ Keep the mobile phone in 'silent' mode.
- ✓ Discuss phone charging with staff.
- ✓ Only record your own consultations.

Please do not:

- ✗ Take photographs of anyone without permission.
- ✗ Make audio or visual recordings of other patients and carers or visitors.
- ✗ Loan your mobile phone to other patients or carers.
- ✗ Record or photograph in communal areas.

Staff will be happy to explain anything you are unsure about.

Poster co-created with patients and carers, 9th March 2021

Audio and visual recording

If you wish to make an audio or visual recording (e.g. on your mobile phone) of discussions with staff involved in your care, we welcome you to do this. If you need any help, please ask staff who will be very happy to support you.

Please do:

- ✓ Respect the privacy and dignity of others especially in communal areas.
- ✓ Only record your own clinical consultations.
- ✓ Keep the recording for your own personal use.

Please do not:

- ✗ Make a recording during a mental health tribunal.
- ✗ Video record or take images of staff without consent
- ✗ Make a recording of discussions with 'experts by experience' or peer support workers if they are sharing their own lived experiences.



Please note:

Staff will not ask you to stop recording for your own personal use unless it affects the privacy of others. You may audio record your clinical consultations staff without their consent or knowledge.

Poster co-created with patients and carers, 9th March 2021

Audio recording

Our Trust supports patients and carers to make personal recordings of their interactions with staff

You do not have to ask staff permission to make recordings. If you are a carer, you may record sessions or conversations on behalf of patients, but you must have the permission of the patient to do so.

Our procedure, '**Recordings by patients and carers for personal use**', sets out in more detail what a personal recording is and what you may and may not record. You can access this procedure on our website.



Appendix 4 – Questions and Scenarios

Audio and/or Audio-visual Recordings of TEWV Consultations*

KEY POINTS

1. Everything must be done with the aim of supporting the care and recovery of the patient.
2. Patients do not require permission from staff to make audio recordings of their own consultations for their own subsequent personal use.
3. Carers **may** require the permission of 'their' patient to make recordings of the patient's consultations for their own or the patient's own subsequent personal use.
4. The communication between the carer and patient should inform the overall approach to planning of care.

KEY QUESTIONS

1. Are members of staff responsible for facilitating patients'/carers' recordings, if requested?

The ability to facilitate recording can be difficult for staff as recording equipment may not easily be available. If a session is held virtually then a recording can be made available and can therefore be offered.

If a patient or carer has difficulty setting up a recording using their own equipment staff will help where they can. If staff are unable to help and the patient/carer really needs or wants the recording it may be necessary to make another appointment. The options will always be discussed fully with the patient/carer at the time.

2. Are members of staff responsible for facilitating the charging of patients'/carers' recording devices, if requested?

If staff have a charger available, they may be able to offer to charge a patient's recording device whilst they are attending the site. If the patient is an in-patient, it is likely that the charger will be kept in the ward office and equipment charged as requested.

3. Are members of staff responsible for seeking/confirming the permission of patients for carers to make recordings or for otherwise authorising/preventing carers' recordings?

If a carer makes it clear that they are recording a session, then a discussion should be held about this at the start of the meeting. If the patient is clearly not happy to have the recording take place, then the carer should be asked not to record the session.

If private recording is taking place, then no one will know it is happening.

4. Can carers make recordings for their own personal use as a memory aid to help them care for their patient?

Recording should always be done with the knowledge of the patient if this is possible.

5. Could a blanket agreement be made between the patient and their carer for a given care period to allow the carer to record a consultation, for the subsequent personal benefit of the patient or the carer, without necessarily negotiating consent each time?

This could happen but the staff and carer would always need to be aware that the patient could change their mind.

SCENARIOS

1. Despite obvious displeasure from (a) staff member(s), a patient wishes to record a consultation and does so.
2. Regardless of the attitude of (a) staff member(s), a patient wishes their carer to record a consultation and the carer does so.

Staff should support patients to record their own sessions. The Trust position is that staff should welcome patients making their own recordings and not behave in ways that would discourage this. Where a carer is recording a session and the staff member becomes aware of this, they should seek clarification from the patient that this can go ahead.

Trust will support patients to complain if they are affected by negative attitudes of staff to their personal recordings and such attitudes may result in a referral to the ICO or further training.

3. A carer wishes to record a consultation for the patient's subsequent personal benefit and obtains consent from the patient to do so.
4. A carer wishes to record a consultation for their own subsequent personal benefit in caring for the patient and obtains consent from the patient to do so.

The care team should document this provision in the care documents and care plan and thereafter make sure that the carer is able to do this.

5. A carer wishes to record a consultation for their own or the patient's subsequent personal benefit, but the patient refuses to consent to this.

The Trust position is that the recording should not go ahead.

6. A carer wishes to record a consultation for their own or the patient's subsequent personal benefit but the patient refuses to consent to this. As the carer is very worried about their own ability to remember the exact details of the consultation, and this may be vital for the subsequent care of the patient, they try, possibly at some length, to persuade the patient to agree to it.

Staff should facilitate a conversation between the patient and carer as to why the recording is felt to be necessary and what the objections are. There may be ways that the carer can be

helped without the need for recording. Ultimately if the patient does not want the session to be recorded it should not be.

7. A carer wishes to record a consultation for their own or the patient's subsequent personal benefit, but the patient refuses to consent to this. The carer privately makes a recording anyway – should a member of staff intervene if they become aware of this at the time?

If staff become aware that the carer is recording sessions and the patient does not want this to happen the staff should speak with the carer to establish why they are doing this and whether another route can be considered. The Trust position is that carers should not record without patients consent.

8. If a carer has recorded a consultation without the patient's consent and staff become aware of this later, should the staff take action, e.g., report this?

It would not be usual for a carer to record a session without the patients consent. However, circumstances do vary so prior to recording the carer should discuss their preference with the care team to develop a solution. All decisions should be documented in the patient record.

9. A patient has a history of erratically giving or withdrawing consent for their carer to record a consultation. After the consultation, immediately or later, the patient often/usually regrets their decision.

If this is known to be a course of action that the patient takes then a plan should be developed, preferably when the patient is well, so that everyone knows what has been agreed to happen when the patient is unwell.

10. A carer wishes to record a consultation for their own or the patient's subsequent personal benefit, but the patient refuses to consent to this. As a result, no recording is made, and this then causes a serious problem in the patient's care.

This matter would need to be dealt with on a case-by-case basis. The patient records should show what has happened at a meeting and the key decisions taken and should support the patient and carer in this situation.

11. A carer may feel it necessary, without patient consent, to record (within the procedure guidelines), a meeting involving their patient with fluid capacity to consent. E.g., A patient U having an episode due to symptom of a diagnosed mental illness.

Scenario: Recording made by a carer of a meeting with ward staff and an in-patient (Patient) on a Mental Health Ward for the elderly (MHSOP).

The ward has both Organic and Functional patients.

Mrs Smith is a regular visitor to her husband who is the in-patient. He has varying degrees of capacity and at times his behaviour can be challenging and upsetting and intrusive to the other

patients. He has an I-phone, but ward staff found it best that he only has use of this under observation by them or his carer.

At this meeting Mrs Smith and the member of staff felt that it would be helpful if the dialogue were recorded so that they could reflect on what was said. Particularly so, her husband's input, so they could use the recording later when her husband was more able to comprehend. Mr Smith was insistent that he wanted to use his phone as he felt that they might 'conspire to alter' what was said by him. They agreed that both he and Mrs Smith would make a recording of the meeting.