# Policy:

## IMST 010 - Recording Policy

| | |
|---|---|
| **Executive Director lead** | Executive Director of Finance & SIRO |
| **Policy Owner** | Data Protection Officer |
| **Policy Author** | Data Protection Officer |

| | |
|---|---|
| **Document type** | Policy |
| **Document version number** | v1.2 |
| **Date of approval** | 16/01/2020 |
| **Approved by** | Executive Directors' Group |
| **Date of issue** | 12/02/2020 |
| **Date for review** | 31 January 2023 |


**Summary of policy**

This policy governs the use of audio and video recordings within the Trust by staff, volunteers, service users and carers.


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|---|---|
| **Target audience** | SHSC staff, volunteers, service users and carers |

| | |
|---|---|
| **Keywords** | Audio, video, recording, surveillance |

**Storage**

Version 1.2 of this policy is stored and available through the SHSC intranet/internet.

**Contents**

**Flowchart**
*Not applicable*

## 1 Introduction

As the capability to make audio and video recordings becomes cheaper and more widespread there have been more instances of service users, carers and staff making electronic recordings. This policy sets out principles to control such recordings to ensure that they meet national guidance and legal requirements.

## 2 Scope

This policy applies to all Trust staff, volunteers, service users, carers and others involved with Trust business.

## 3 Purpose

This policy regulates the use of audio and video recordings within the Trust.

## 4 Definitions

**Covert recordings:** Audio or video recordings made without the knowledge of the people being recorded.

**Data Protection Impact Assessment (DPIA):** An assessment made before any significant new processing of person-identifiable information or change to existing processing to ensure it complies with data protection regulations and to identify any risks the processing presents. A template for DPIAs is available from the Data Protection Officer.

**Skype:** Skype is a proprietary telecommunications application which can be used for both voice and video communication.

**Surveillance cameras:** Video cameras used to monitor areas within the Trust including wards, corridors, server rooms, car parks or other places used by staff, service users, visitors or members of the public. Surveillance cameras may be used for live video or the images may be recorded. Surveillance cameras include cameras mounted in fixed positions and cameras worn or carried by members of staff.

## 5 Duties

| Role | | Responsibility | Description |
|---|---|---|---|
| Chief Information Officer | CIO | Director IMST | Responsible for the Information Technology that supports the overarching strategies of the Trust |
| Senior Information Risk Owner | SIRO | Director Finance | Owns the Trust's information risk policy and risk assessment process |
| Caldicott Guardian | CG | Deputy Chief Executive | Responsible for protecting the confidentiality of patient and service user information and enabling the |

| | | | |
|---|---|---|---|
| | | | appropriate level of information sharing |
| Data Protection Officer | DPO | | Supporting Trust wide Data & Information governance in accordance to GDPR, NHS Digital & England and Data Security & Protection Toolkit. |
| Data & Information Asset Owners | DIAO | Directorate | Senior representatives of the directorates closely aligned to major stores of organisational data, information and systems |
| Data & Information Asset Managers | DIAM | Service Managers | Primary administrative and management responsibilities for segments of data primarily associated with their functional area |
| All SHSC Staff and Volunteers | | | Responsible for compliance with Trust policy and reporting of any incidents |

## 6 Procedure

### 6.1 Covert Recordings by Staff

The Trust does not usually authorise or undertake covert recordings, whether audio or video, of service users or members of staff. If such recordings were felt to be necessary for the investigation of suspected serious malpractice or a criminal offence this would need to be approved by the Senior Information Risk Officer or Caldicott Guardian in conjunction with NHS Counter Fraud and would be subject to the Regulation of Investigatory Powers Act 2000. Any such recording would be for a specific, documented purpose and limited to a specified timeframe.

Staff should not undertake covert recordings of colleagues or service users without being specifically authorised to do so by the Trust. If staff have concerns which they believe need to be investigated they should raise them with their line manager or other appropriate manager in accordance with the Speaking Up – Freedom to speak up: Raising concerns (whistleblowing) policy.

Members of staff are not permitted to make covert recordings of colleagues or service users for their own purposes whilst at work. Anyone making such recordings in contravention of this policy would be personally responsible for any breach of Data Protection legislation.

### 6.2 Recording of Consultations by Service Users or Carers

Service users and/or carers are not encouraged to record consultations with professionals but there may be instances where they wish to make recordings to which they can refer back and so may record consultations unless to do so would be detrimental to staff or service user safety, or detrimental to the care and treatment of the service user.

If service users or carers make recordings they are responsible for maintaining the confidentiality of their own information.

Where the professional is aware that a recording is being made, the service user or carer should be reminded of the private and confidential nature of the recording and that it is their responsibility to keep it safe and secure. The professional should clarify that any recording is only made for personal use and that the misuse of a recording may result in criminal or civil proceedings.

The professional may request that they are not visible in any video recording.

If the professional believes that the recording could be detrimental to the treatment of the service user or that it could pose a risk to the safety of the service user or the professional (for instance if it was posted online) then they may terminate the consultation unless the recording is stopped.

### 6.3 Recordings of Staff or Service Users on Wards

Service users are not permitted to make audio or video recordings of other service users, visitors or staff performing their duties on inpatient wards. They should be informed of this on admission to the ward or as soon as practical thereafter.

Similarly, visitors to wards are not permitted to make recordings on the ward.

If staff become aware of service users making any such recordings they will ask the service user to delete the recording from their device and staff will witness the deletion.

If the service user persists in making recordings the device being used may be confiscated for the duration of their stay on the ward.

If visitors are found to be making recordings on the ward they will be asked to stop and to delete the recordings. If they refuse they will be asked to leave the ward.

Unauthorised recordings by service users will be recorded as incidents via the SHSC incident recording process.

### 6.4 Use of Surveillance Cameras

The Trust may use surveillance cameras to record on Trust premises where it is deemed necessary to protect the safety of service users and staff, or to deter violence or investigate serious incidents.

Surveillance cameras will only be used when less-intrusive methods would not be sufficient to achieve the stated aim(s) of the cameras.

Any proposed installation of surveillance cameras must be subject to a Data Protection Impact Assessment and must be approved by the Data and Information Governance Board before it may commence.

Where surveillance cameras are used, information will be provided to staff, service users and visitors informing them about the use of cameras, their purpose, the identity of the data controller and data subjects' rights including the process for making subject access requests for recordings.

Information recorded by surveillance cameras does not form part of the care record. Any information from the recording which is relevant to the care record of service users must be transcribed separately into the care record.

### 6.5 Recording of Telephone Conversations

The Trust may record telephone conversations in case they are needed for the completion of records or the investigation of incidents.

Where telephone conversations are routinely recorded the caller will be informed of this fact by a standard announcement before being connected.

Recordings of telephone calls do not form part of the care record – any information which is relevant to the care record must be transcribed into the care record promptly.

Where there is a need to record telephone conversations covertly for the investigation of a suspected offence this must be approved by the Senior Information Risk Officer or Caldicott Guardian in conjunction with NHS Counter Fraud and would be subject to the Regulation of Investigatory Powers Act 2000.

**6.6 Recording of Skype telemedicine sessions/consultations**

Remote consultations by Skype or similar services, whether video or audio only, will be treated in the same way as telephone conversations – recordings of them will not be retained as part of the care record so any relevant information from them must be documented in the care record. Recordings of remote consultations may be stored for a limited time for the completion of records or the investigation of incidents.

If sessions are recorded the service user will be informed of this fact.

**6.7 Recordings of staff and/or service users for training or publicity**

Where audio or video recordings or photos of service users or staff are required to be used for training or publicity this must be with the explicit, informed consent of the subject – contact the Communications department for details of the necessary consent forms.

**6.8 Recording of sessions by trainees for assessment by supervisors**

Recordings may be made as part of professional training subject to the explicit consent of the service user and subject to the service user being provided with information as to the uses of the recordings, their storage, how long they will be kept for and who will be able to access them. The service user will also be given the right to withdraw their consent at any time and provided with information on how to do this. Any such recordings must be transferred to the assessor or supervisor by means of a secure process approved by the SHSC IT Department.

**6.9 Recording of Meetings**

Recording may be of use for lengthy meetings and hearings to aid the accuracy of minute or note taking over a long period. It may also be useful for evidential purposes during official Trust hearings (such as appeals or employment hearings). Such recordings do not replace the formal record of any meeting, but may assist with the accuracy of the formal record or if there is dispute over what was said. It is also advisable to have a minute or note taker in attendance in the event of a technology failure.

Those attending meetings or hearings must be informed in advance of the intention to record the proceedings. This advance notification is helpful in avoiding any issues on the day. Any objections to the recording must be considered by the Chair who will ultimately decide whether the recording is appropriate in light of any objection. At the meeting, the Chair must also notify all attendees that recording will take place prior to the commencement of the recording. The recording must stop at the formal close of

the meeting or hearing. Attendees who were not present at the start of the meeting must also be notified that recording is taking place. Covert recordings must not be taken and to do so will be considered a disciplinary offence.

### 6.10 Retention of Recordings

Recordings containing personal-identifiable information will be subject to the same requirements as other person-identifiable records.

They must be stored securely, including any held on mobile devices.

Retention periods are set out in the Information Governance Alliance Records Management Code of Practice although recordings will not generally form part of the care record.

### 6.11 Access to Recordings

Recordings containing personal-identifiable information are covered by Subject Access rights provided by Data Protection legislation.

Subject Access requests are processed and monitored by Corporate Affairs. Forms are provided to expedite the processing of requests but data subjects can make verbal requests to the organisation if the prefer. There is no fee for requests and they should be answered within one month of receipt unless the request is complex, so staff should contact Corporate Affairs promptly if they receive a request.

## 7 Development, consultation and approval

This policy was developed at the request of the Data & Information Governance Board (DIGB).

It was submitted to the Clinical Operations Meeting for comment in April 2019.

It was further revised in light of comments from Data & Information Governance Board members in December 2019.

## 8 Audit, monitoring and review

*This section should describe how the implementation and impact of the policy will be monitored and audited. It should include timescales and frequency of audits.*

*If the policy is required to meet a particular standard, it must say how and when compliance with the standard will be audited.*

| **Monitoring Compliance Template** | | | | | | |
|---|---|---|---|---|---|---|
| Minimum Requirement | Process for Monitoring | Responsible Individual/ group/committee | Frequency of Monitoring | Review of Results process (e.g. who does this?) | Responsible Individual/group/ committee for action plan development | Responsible Individual/group/ committee for action plan monitoring and implementation |
| Compliance with this policy | Review as part of the Data Security & Protection Toolkit assessment | Data & Information Governance Board | Annual | Data & Information Governance Board | Data & Information Governance Board | Data & Information Governance Board |

This policy will be reviewed three years after approval and implementation or sooner is national guidance or legislation requires.

## 9 Implementation plan

| **Action / Task** | **Responsible Person** | **Deadline** | **Progress update** |
|---|---|---|---|
| Upload new policy onto intranet | Director of Corporate Governance | | 12/02/2020 |
| Ensure staff are aware of this policy | SHSC team managers | Ongoing | |

## 10 Dissemination, storage and archiving (Control)

| Version | Date on website (intranet and internet) | Date of "all SHSC staff" email | Any other promotion/ dissemination (include dates) |
|---|---|---|---|
| 1.2 | 12/02/2020 | Feb 2020 | |
| | | | |
| | | | |
| | | | |

## 11 Training and other resource implications

Departmental managers are responsible for ensuring that their staff are aware of and comply with this policy.

## 12 Links to other policies, standards (associated documents)

Data & Information Security Policy
Remote Working and Mobile Devices Policy
Data & Information Acceptable Use Policy
Records Management Policy
Mobile Phones, Communication Devices and Internet Access for Service Users
Confidentiality Code of Conduct
Data Protection Act 2018/General Data Protection Regulation
Regulation of Investigatory Powers Act 2000
Information Governance Alliance - Records Management Code of Practice for Health and Social Care 2016

## 13 Contact details

*The document should give names, job titles and contact details for any staff who may need to be contacted in the course of using the policy (sample table layout below). This should also be a list of staff who could advice regarding policy implementation.*

| ***Title*** | ***Name*** | ***Phone*** | ***Email*** |
|---|---|---|---|
| Data Protection Officer | John Wolstenholme | 3050749 | john.wolstenholme@shsc.nhs.uk |
| | | | |

## Appendix A – Version Control and Amendment Log

| Version No. | Type of Change | Date | Description of change(s) |
|---|---|---|---|
| 1 | Draft policy created | 02/2019 | New policy commissioned on approval of a Case for Need |
| 1.1 | Draft policy amended | 07/2019 | Amended in light of comments |
| 1.2 | Draft policy amended | 12/2019 | Further amendments and formatting. Addition of section or recording meetings. |
| 1.2 | Approved by Data & Information Governance Board | 01/2020 | |

## Appendix B – Dissemination Record

| Version | Date on website (intranet and internet) | Date of "all SHSC staff" email | Any other promotion/ dissemination (include dates) |
|---|---|---|---|
| 1.2 | 12/02/2020 | | |

# Appendix C – Stage One Equality Impact Assessment Form

## Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

**Stage 1** – Complete draft policy

**Stage 2** – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date) Yes. J Wolstenholme, 13 January 2020

**Stage 3** – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

| | **Does any aspect of this policy actually or potentially discriminate against this group?** | **Can equality of opportunity for this group be improved through this policy or changes to this policy?** | **Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?** |
|---|---|---|---|
| **AGE** | **No** | **No** | **No** |
| **DISABILITY** | **No** | **No** | **No** |
| **GENDER REASSIGNMENT** | **No** | **No** | **No** |
| **PREGNANCY AND MATERNITY** | **No** | **No** | **No** |
| **RACE** | **No** | **No** | **No** |
| **RELIGION OR BELIEF** | **No** | **No** | **No** |
| **SEX** | **No** | **No** | **No** |
| **SEXUAL ORIENTATION** | **No** | **No** | **No** |

**Stage 4** – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: no changes made.

Impact Assessment Completed by J Wolstenholme. 13 January 2020

# Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

**1. Is your policy based on and in line with the current law (including case law) or policy?**

✓ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

**2. On completion of flow diagram – is further action needed?**

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

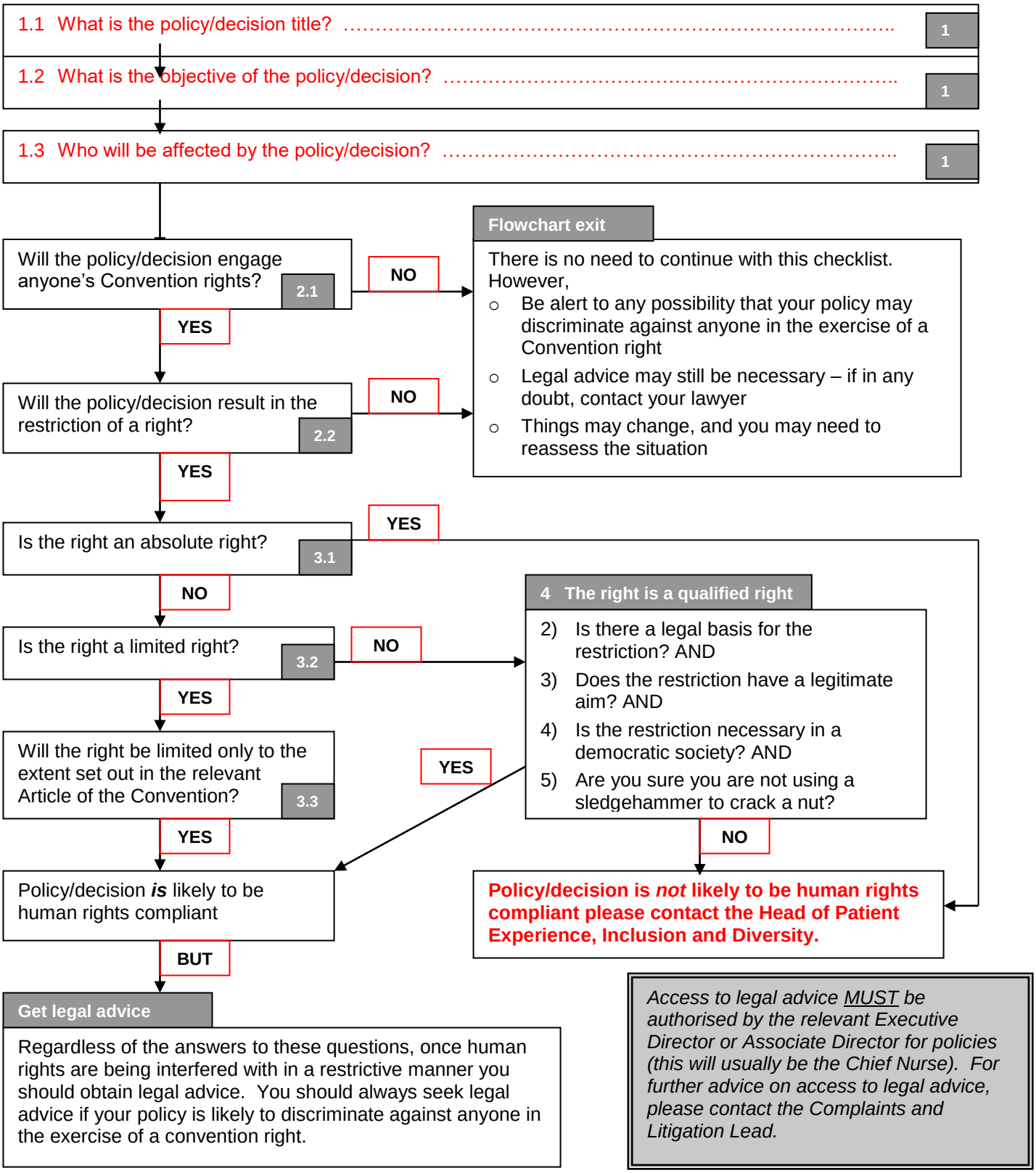
**3. Complete the table below to provide details of the actions required**

| Action required | By what date | Responsible Person |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Human Rights Assessment Flow Chart**

**Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red** (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

**Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.**



## Appendix E – Development, Consultation and Verification

This policy was developed to meet an identified need within the Trust due to the wider availability and use of recording devices amongst service users, staff and others and the introduction of surveillance cameras within the Trust to enhance the safety of staff and service users.

Different versions of the draft policy were presented to the Data & Information Governance Board and amendments made.

The draft policy was presented to the Clinical Operations Group for comment in April 2019. Policy elements relating to surveillance cameras were discussed at the Body Warn Cameras and CCTV project groups.

## Appendix F –Policies Checklist

***Please use this as a checklist for policy completion. The style and format of policies should follow the Policy template which can be downloaded on the intranet (also shown at Appendix G within the Policy).***

**1. Cover sheet** ☒

All policies must have a cover sheet which includes:

- The Trust name and logo ☒
- The title of the policy (in large font size as detailed in the template) ☒
- Executive or Associate Director lead for the policy ☒
- The policy author and lead ☒
- The implementation lead (to receive feedback on the implementation) ☒
- Date of initial draft policy ☒
- Date of consultation ☒
- Date of verification ☒
- Date of ratification ☒
- Date of issue ☒
- Ratifying body ☒
- Date for review ☒
- Target audience ☒
- Document type ☒
- Document status ☒
- Keywords ☒
- Policy version and advice on availability and storage ☒

**2. Contents page**

**3. Flowchart** ☒

**4. Introduction** ☒

**5. Scope** ☒

**6. Definitions** ☒

**7. Purpose** ☒

**8. Duties** ☒

**9. Process** ☒

**10. Dissemination, storage and archiving (control)** ☒

**11. Training and other resource implications** ☒

**12. Audit, monitoring and review** ☒

This section should describe how the implementation and impact of the policy

will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

| **Monitoring Compliance Template** | | | | | | |
|---|---|---|---|---|---|---|
| Minimum Require-ment | Process for Monitoring | Responsible Individual/ group/ committee | Frequency of Monitoring | Review of Results process (e.g. who does this?) | Responsible Individual/group/ committee for action plan development | Responsible Individual/group/ committee for action plan monitoring and implementation |
| A) Describe which aspect this is monitoring? | e.g. Review, audit | e.g. Education & Training Steering Group | e.g. Annual | e.g. Quality Assurance Committee | e.g. Education & Training Steering Group | e.g. Quality Assurance Committee |

☒

**13. Implementation plan**

**14. Links to other policies (associated documents)** ☒

**15. Contact details** ☒

**16. References** ☒

**17. Version control and amendment log (Appendix A)** ☒

**18. Dissemination Record (Appendix B)** ☒

**19. Equality Impact Assessment Form (Appendix C)** ☒

**20. Human Rights Act Assessment Checklist (Appendix D)** ☒

**21. Policy development and consultation process (Appendix E)** ☒

**22. Policy Checklist (Appendix F)** ☒