Mersey Care NHS
NHS Foundation Trust

Policy Number	SA41
Policy Name	Performance Indicator Kite Marking
Policy Type	Trust-wide Non-clinical
Accountable Director	Director of Informatics and Performance Improvement
Author	Head of Performance Improvement and Customer Relationship Management
Recommending Committee	Data quality steering group
Approving Committee	Acquisition Steering Group
Date Originally Approved	20 September 2015 (Reviewed July 2016)
Next Review Date	September 2018

This document is a valid document, however due to organisation change some references to organisations, organisational structures and roles have now been superseded. The table below provides a list of the terminology used in this document and what it has been replaced with. When reading this document please take account of the terminology changes on this front cover.

Terminology used in this document	**New terminology when reading this document**
Mersey Care NHS Trust	Mersey Care NHS Foundation Trust
Trust Board	Board of Directors
Lead executive director: Executive Director of Finance / Deputy Chief Executive	Lead director: Chief Information Officer / Director of Informatics and Performance Improvement
Lead Author(s): Chief Information Officer / Director of Informatics and Performance Improvement	Lead Author(s): Head of Performance Improvement and Customer Relationship Management
Author(s): Jim Hughes Chief Information Officer / Director of Informatics and Performance Improvement Contact(s) for further information about this document: Telephone: 0151 473 2786 Email: jim.hughes@merseycare.nhs.uk	Author(s): Wendy Copeland-Blair Head of Performance Improvement and Customer Relationship Management Contact(s) for further information about this document: Telephone: 0151 472 4051 Email: wendy.copeland-blair@merseycare.nhs.uk
Published by: Mersey Care NHS Trust 8 Princes Parade Princes Dock St Nicholas Place Liverpool	Published by: Mersey Care NHS Foundation Trust V7, Kings Business Park Prescot Liverpool L34 1PJ

Terminology used in this document	New terminology when reading this document
L3 1DL	
5.3 **Lead Executive Director** – the lead Executive Director for this policy (Executive Director of Finance / Deputy Chief Executive) has strategic responsibility for the management of data quality working through the Chief Information Officer / Director of Informatics and Performance Improvement on a day to day basis. The lead Executive Director is responsible for selecting the KPIs on which the trust needs to be assured using the kite-mark and for defining appropriate elements for inclusion in the kite-mark.	5.3 **Lead Director** – the lead Director for this policy (Director of Informatics and Performance Improvement) has strategic and operational responsibility for the management of data quality. The lead Director is responsible for selecting the KPIs on which the trust needs to be assured using the kite-mark and for defining appropriate elements for inclusion in the kite-mark. Policy Lead (Chief Information Officer / Director of Informatics and Performance Improvement
5.4 **Policy Lead** – the Policy Lead (Chief Information Officer / Director of Informatics and Performance Improvement) has operational responsibility for data quality in the trust. The Chief Information Officer / Director of Informatics and Performance Improvement will be responsible, together with their team, for putting measures in place such that data quality for the elements in the kite-mark can reliably be measured and reported to the Trust Board and its committees, where appropriate	5.4 **Policy Lead** – the Policy Lead (Head of Performance Improvement and Customer Relationship Management) will be responsible, together with their team, for putting measures in place such that data quality for the elements in the kite-mark can reliably be measured and reported to the Trust Board and its committees, where appropriate
6.2 The kite-mark will primarily be applied to KPIs that appear on the trust's Care at a Glance report to the board and within the two clinical division Care at a Glance report.	6.2 The kite-mark will primarily be applied to KPIs that appear on the trust's Care at a Glance report to the board and divisional Care at a Glance reports.
In the following sections replace Chief Information Officer / Director of Informatics and Performance Improvement: 6.8, 6.9, 6.10, 6.12, 8.1 and 9.1	Head of Performance Improvement and Customer Relationship Management.

Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

PERFORMANCE INDICATOR KITE-MARKING

Policy Number:	**SA41**
Scope of this Document:	**All staff involved in producing and reporting performance information to the trust board.** **Internal and external audit.**
Recommending Committee:	**Data Quality Steering Group**
Approving Committee:	**Executive Committee**
Date Ratified:	**20 September 2015**
Next Review Date (by):	**September 2018**
Version Number:	**2016 – Version 1.4**
Lead Executive Director:	**Executive Director of Finance / Deputy Chief Executive**
Lead Author(s):	**Chief Information Officer / Director of Informatics and Performance Improvement**

2016 – Version 1.4

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS Trust

TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

PERFORMANCE INDICATOR KITE-MARKING

Further information about this document:

Document name	**PERFORMANCE INDICATOR KITE-MARKING (SA41)**
Document summary	**The purpose of this policy is to provide a system for reporting assurance of key performance indicators (KPIs) to ensure that board information provides an accurate reflection of the trust's performance.** **This policy document summarises Mersey Care NHS Trust's Performance Indicator Kite-Marking system. It sets out rationale for implementation, description of the system and practical guidance on how the system is to be applied and the standards expected.**
Author(s) Contact(s) for further information about this document	**Jim Hughes** **Chief Information Officer / Director of Informatics and Performance Improvement** **Telephone: 0151 473 2786** **Email: jim.hughes@merseycare.nhs.uk**
Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside** **L34 1PJ** **Your Space Extranet: http://nww.portal.merseycare.nhs.uk** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**Health records (IT06)** **Corporate Data Quality (IT11)**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

Version History:		
Final draft 1.0	Original issue to corporate document review group.	August 2014
Final Version 1.1	Minor revisions to reflect feedback from corporate document review group. Ratified and uploaded to trust website.	August 2014
Version 1.2	Revised version for consideration by policy review group. Amendments made to version 1.1 to ensure adherence to new policy format and to reflect lessons learned during the first year of implementation of the policy.	August 2015
Version 1.3	Amended in line with policy group recommendations. For approval by executive committee in September 2015.	August 2015
Version 1.4	Acquisition Steering Group	June 2016

SUPPORTING STATEMENTS – this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

CONTENTS

1 PURPOSE AND RATIONALE

1.1 **Purpose** – The purpose of this policy is to provide a system for reporting assurance of key performance indicators (KPIs) to ensure that board information provides an accurate reflection of the trust's performance.

1.2 **Rationale** – This requirement is derived from Monitor's "Well-led framework for governance reviews: guidance for NHS foundation trusts" (Section 2.4, Question 10) (2015), which requires that "The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant." Acceptable data quality is crucial to operational and transactional processes and to the reliability of business analytics / business intelligence reporting. High quality information leads to better decision making to improve patient care and patient safety, and there are potentially serious consequences if information is not correct and up to date. Management information produced from patient data is essential for the efficient running of the trust and to maximise utilisation of resources for the benefit of patients and staff. Poor data quality puts organisations at significant risk of: damaging stakeholder trust; weakening frontline service delivery; incurring financial loss; and poor value for money.

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 For this Performance Indicator Kite-marking policy the aims and objectives are as follows.

a) Performance information considered by the trust board and its committees will provide an accurate reflection of trust's performance.

3 SCOPE

3.1 This is a trust wide non-clinical policy.

3.2 This policy applies to all those involved in producing and reporting performance information to the trust board.

3.3 The elements and criteria will be used by internal and external audit as the basis for providing assurance on the quality of performance information supplied to the board and committees of the board.

3.4 The only exception to this will be where external auditors are required to adopt an alternative approach in order to meet the requirements of those commissioning the work.

4 DEFINITIONS

4.1 The relevant terms and their definitions (within the context of this policy document) are outlined in Table 1.

Table 1: Definitions

Term	Definition
IT	Information Technology
KPI	Key performance indicator
KPI owner	The individual (executive director) responsible for setting standards and agreeing reporting methodologies in relation to key performance indicators. The individual holds operations to account for the delivery. The individual responsible for the sign off of "improvement plans" developed in respect of key performance indicators.
Data quality	Data are of high quality "if they are fit for their intended uses in operations, decision making and planning." Alternatively, data are deemed of high quality if they correctly represent the real-world construct to which they refer. Within an organisation, acceptable data quality is crucial to operational and transactional processes and to the reliability of business analytics / business intelligence reporting. Data quality is affected by the way the data is entered, stored, analysed, managed and reported. (J. M. Juran, 1951)
Accuracy	Data should be sufficiently accurate for its intended purposes and captured as close to the point of activity as possible. (Audit Commission, 2007)
Validity	Data will be recorded and used in compliance with relevant requirements, including the correct application of any rules or definitions. (Audit Commission, 2007)
Reliability	Data will reflect stable and consistent data collection processes across collection points and over time. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection methods. (Audit Commission, 2007)
Timeliness	Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions. (Audit Commission, 2007)
Relevance	Data captured will be relevant to the purposes for which it is used, capable of evolving to reflect changing needs. Quality assurance and feedback processes are needed to ensure the quality of such data. (Audit Commission, 2007)
Completeness	Data requirements will be clearly specified and based upon the information needs of the organisation and data collection processes matched to these requirements. (Audit Commission, 2007)

5 DUTIES

5.1 **Trust Board –** the Trust Board, through the Executive Team, is ultimately responsible for ensuring the quality of the performance data received by itself and its committees.

5.2 **Board Committees** – the committees of the Trust Board provide oversight of the implementation of this policy and procedure and the results of the kite-mark system. The committees of the Trust Board can request the application of the kite-mark to any performance indicator reported to the Trust Board and / or one of its committees.

5.3 **Lead Executive Director** – the lead Executive Director for this policy (Executive Director of Finance / Deputy Chief Executive) has strategic responsibility for the management of data quality working through the Chief Information Officer / Director of Informatics and Performance Improvement on a day to day basis. The lead Executive Director is responsible for selecting the KPIs on which the trust needs to be assured using the kite-mark and for defining appropriate elements for inclusion in the kite-mark.

5.4 **Policy Lead –** the Policy Lead (Chief Information Officer / Director of Informatics and Performance Improvement) has operational responsibility for data quality in the trust. The Chief Information Officer / Director of Informatics and Performance Improvement will be responsible, together with their team, for putting measures in place such that data quality for the elements in the kite-mark can reliably be measured and reported to the Trust Board and its committees, where appropriate

5.5 **KPI owners** – KPI owners are responsible for ensuring that indicators are appropriately designed and that actions required to address any non-compliance with the criteria detailed within this document are promptly taken.

5.6 **External and internal audit** – to provide independent assurance of the quality of performance information reported to the board in line with the framework and criteria detailed in this policy.

6 PROCESS / PROCEDURE

6.1 The kite-mark is designed to appear next to KPIs included on a dashboard to provide visual assurance on quality of a performance indicator (see Figure 1).

6.2 The kite-mark will primarily be applied to KPIs that appear on the trust's Care at a Glance report to the board and within the two clinical division Care at a Glance report.

6.3 The Executive Team can request that the kite-mark be applied to any other indicator within the trust's performance assurance framework in addition to those reported through Care at a Glance.

6.4 The kite-mark is a visual indicator that acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based.

6.5 Each measure is assessed as ‘sufficient’, ‘insufficient’ or ‘not yet assessed’ on seven distinct elements. For each element a colour code shows the strength of assurance. Each measure has an equal weighting.

6.6 The elements of the kite-mark are detailed in Table 2.

Figure 1: The kite-mark

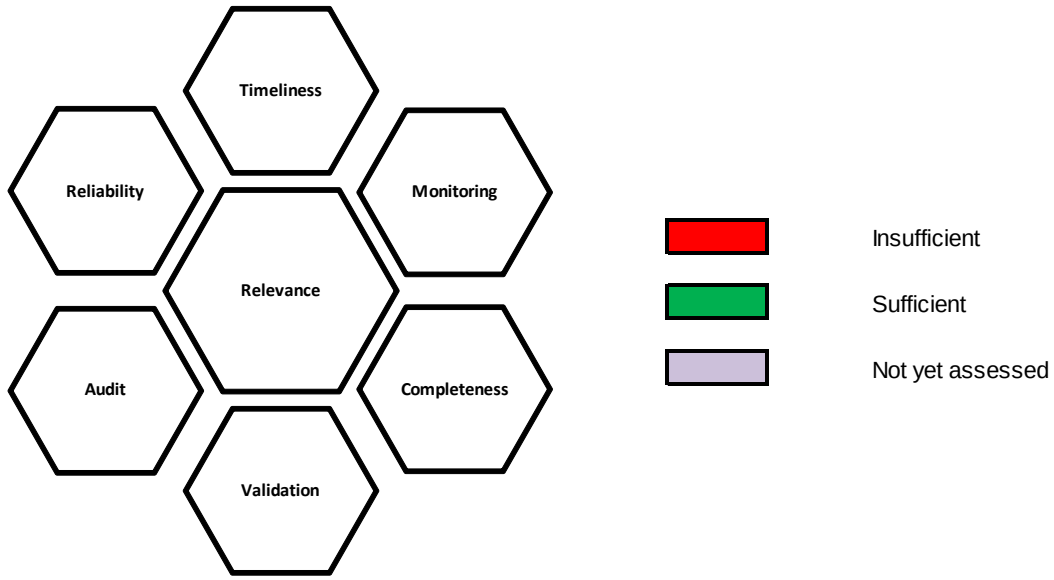

Table 2: Elements of the kite-mark

Element	Definition
Timeliness	This is the time taken between the end of the data period and when the information can be produced and reviewed. The acceptable data lag will be different for different performance indicators. Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
Monitoring	This is the degree to which the trust can drill down into data in order to review and understand operational performance. The level to which the trust needs to drill down into the data will vary for different performance indicators. Some information should always be available at patient level for performance monitoring purposes. Whereas some information may be sufficient if it is available at speciality level for all specialties or even trust level for performance monitoring purposes.
Completeness	There are two aspects to completeness. This is the extent to which all of the expected attributes of the data are populated but also the extent to which all of the records for the relevant population are provided.

Element	Definition
Validation	This is the extent to which the data has been validated to ensure it is accurate and in compliance with relevant requirements. For example, correct application of rules and definitions. The level of validation required will vary from indicator-to-indicator and will depend on the level of data quality risk. Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.
Audit	This is the extent to which the integrity of data (completeness, accuracy, validity, reliability, relevance, and timeliness) has been audited by someone independent of the KPI owner (for example, Internal Audit, External Audit, Clinical Audit or Peer Review) and the extent to which the assurance provided from the audit is positive.
Reliability	This is the extent to which the data is generated by a computerised system, with automated IT controls, or a manual process. It also relates to the degree of documentation outlining the data flow, i.e. documented process with controls and data flows mapped. Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.
Relevance	This is the extent to which the data is captured for the purposes for which it is used. This entails periodic review of the selection of key performance indicators to reflect changing needs, such as new strategic objectives. For example, is this indicator the right indicator by which to measure performance against a strategic objective?

6.7 Each indicator should be assessed as 'sufficient' 'insufficient' or 'not yet assessed'. The assessment is based on a positive response to the criteria in Table 3. Where an attribute is marked as 'insufficient' or 'not yet assessed,' the KPI owner should explain the issue, why it exists and the remedial action to be taken including the time frame in which the action will be completed.

Table 3: Assessment Criteria

Element	Sufficient	Insufficient
Timeliness	Where data is available daily for an indicator, up-to-date data can be produced, reviewed and reported upon the next day. Where data is only available monthly, up-to-date data can be produced, reviewed and reported upon within one month.	Where data is available daily for an indicator, there is a data lag of more than one day. Where data is only available monthly, there is a data lag of more than one month.

Element	Sufficient	Insufficient
	Where the data is only available quarterly, up-to-date data can be produced, reviewed and reported upon within three months. Where data is only available annually, data being produced, reviewed and reported upon is no more than 12 months old.	Where data is only available quarterly, there is a data lag of more than one quarter. Where data is only available annually, there is a data lag of more than 12 months.
Monitoring	Where relevant, the trust is able to drill down into the data down to the right level (for example, speciality or patient level) to inform decision making on operational performance. Additionally, where the trust is able to drill down into the data to the right level, the KPI owner is able to provide assurance that this information is reviewed on a regular basis at that level (i.e. board, sub-committees, divisions, service lines, consultants)	The trust is either: 1.Not able to drill down into the data down to speciality or patient level where required; or 2. able to drill down into the data but the KPI owner cannot provide assurance that this information is appropriately reviewed at different levels.
Completeness	Fewer than 3% blank or invalid fields in expected data set. This standard applies unless a different standard is explicitly stated for a KPI within commissioner contracts or through national requirements. Additionally, the KPI owner can provide assurance that effective controls are in place to ensure that 100% of records are included in population. In other words, no individual records are omitted from the population due to fraud or error.	More than 3% blank or invalid fields in expected data set Inadequate assurance or no assurance that effective controls are in place to ensure that 100% of records are included within the total population.
Validation	The trust has agreed upon procedures in place for the validation of data for the KPI. A sufficient amount of the data, proportionate to the risk, has been validated by the trust to ensure data is:	Either: 1. No validation has taken place; or 2. an insufficient amount of data has been validated as determined by the KPI owner; or

Element	Sufficient	Insufficient
	• accurate; and • in compliance with relevant rules and definitions for the KPI. The KPI owner is responsible for determining what a 'sufficient' amount of data validation is.	3. Validation has found that the KPI is not accurate or does not comply with relevant rules and definitions. Commentary should be available to indicate which of the above is the case
Audit	The data quality of the KPI has been audited in the last 3 years and either: • positive assurance was received; or • recommendations have been completed and successfully followed up by audit.	1. The data quality of the KPI has not been reviewed by audit in the last 3 years; or 2. the data quality of the KPI has been reviewed by audit in the last 3 years but: • negative assurance was received; and • recommendations have not yet been followed up by audit. Commentary should be available to indicate which of the above is the case
Reliability	Mostly a computerised system, with IT automated controls, and therefore less prone to human error. Automated controls may include field validation, system interface reconciliations and system configuration. Process is fully documented with controls and data flows mapped. Process is stable and consistent over the last 12 months unless the change in reporting was necessary to reflect a change in operational / statutory requirement. Where data is processed by a third party, the trust has received assurance over the processes and controls in place at the third party to ensure data quality.	Mostly a manual system, with no IT automated controls, and therefore more prone to human error. Process is not documented and / or, for manual data production, does not adequately detail controls and validation procedures. Process has changed during the last 12 months therefore there is an increased risk that data is not consistent between reporting periods. Any change in reporting methodology cannot be linked back to an operational / statutory

Element	Sufficient	Insufficient
	Where a manual process exists, this is fully documented with controls and validation procedures detailed.	requirement. Where data is processed by a third party, the trust has not received assurance over the processes and controls in place at the third party to ensure data quality. Commentary should be available to indicate which of the above is the case.
Relevance	This indicator is relevant to the measurement of performance against the: • Performance area • Performance question • Strategic objective	This indicator is no longer relevant to the measurement of performance against the: • Performance area • Performance question • Strategic objective

6.8 The Chief Information Officer / Director of Informatics and Performance Improvement should add blank kite-marks to appropriate performance reports containing the KPIs to be assured.

6.9 The KPI owner, working with the Chief Information Officer / Director of Informatics and Performance Improvement, should clarify the sources of assurance required to enable a rating for each attribute of the kite-mark to be assessed.

6.10 The Chief Information Officer / Director of Informatics and Performance Improvement will work with the KPI owner to populate the kite-mark and identify whether each element should be assessed as “sufficient” or “insufficient”. The outcome of the kite-mark process for each indicator will be reported to the Executive Committee at least annually or as required e.g. when new indicators are added to the Care at a Glance report or are amended significantly.

6.11 Actions to address any element assessed as “insufficient” will be developed by the KPI owner. Progress in delivering the actions will be reported to the Executive Committee on a quarterly basis through the Care at a Glance report. Once all actions have been completed in relation to an element, the kite-mark will be updated to show that element is now assessed as “sufficient”.

6.12 A schedule of indicator testing by internal and external audit will be developed by the Chief Information Officer / Director of Informatics and Performance

Improvement each year in relation to the current Care at a Glance indicators. Each indicator subject to the kite-mark will require independent audit on a three yearly basis. The prioritization process is as follows.

a) Priority 1 (High) – The indicator has been introduced by a national body e.g. NHS Trust Development Authority or Monitor.

b) Priority 2 (Medium) – The indicator has been introduced by commissioners.

c) Priority (Low) – The indicator has been introduced locally.

6.13 Where an indicator subject to the kite-mark is not identified as requiring audit through the schedule, this will be clearly identified within the audit schedule document and the reason detailed.

6.14 The Audit Committee will receive the agreed schedule of audits on an annual basis and receive updates on progress against this on a quarterly basis.

7 CONSULTATION

7.1 A desktop review was performed of similar data quality kite-marking systems used by other NHS organisations in their Board reporting which highlighted examples of good practice.

7.2 External advice was sought, including a presentation to the trust officers covering the kite-mark, key attributes and examples of dashboards where it has been used.

7.3 Distribution of the external presentation by the Head of Performance to key individuals, including non-executive directors of the trust, and incorporation of their feedback into this policy.

7.4 A presentation to the Performance and Investment Committee on the appropriateness of attributes that make up the kite-mark and the criteria that would mark each as sufficient or insufficient.

7.5 The completed Equality, Diversity and Human Rights analysis for this policy is included in Appendix A.

8 TRAINING AND SUPPORT

8.1 No formal training is required to support the implementation of this policy. Advice on application of the policy will be provided by the Chief Information Officer / Director of Informatics and Performance Improvement.

9 MONITORING

9.1 The Chief Information Officer / Director of Informatics and Performance Improvement should review the effectiveness of the kite-marking system and

this policy once a year. This may involve internal audit periodically to provide independent assurance.

9.2 The outcome of the review of the effectiveness of the system and compliance with this policy will be reported to the performance and investment committee by the Chief Information Officer / Director of Informatics and Performance Improvement.

10 SUPPORTING DOCUMENTS AND REFERENCES

10.1 Table 4 provides details of the supporting documents that should be considered alongside of this policy.

Table 4: List of Supporting Documents

Reference	Name
IT06	Health records
IT11	Corporate Data Quality

10.2 Table 5 provides details of the reference documents and bibliography used in the development of this policy.

Table 5: List of References and Bibliography

Name
Well-led framework for governance reviews: guidance for NHS foundation trusts, Monitor, London, April 2015
Improving Information to Support Decision Making: Standards for Better Data Quality, the Audit Commission, Audit Commission Publishing Team, 2007
Quality Control Handbook, J M Juran, New York, NY: McGraw-Hill, 1951

Mersey Care NHS
NHS Trust

Equality and Human Rights Analysis

Title:	Performance Indicator Kite-marking Policy
Area covered:	The purpose of this policy is to provide a system for reporting assurance on the of key performance indicators (KPIs) to ensure that board information provides an accurate reflection of the trust's performance.

What are the intended outcomes of this work?
REVIEW AUGUST 2015
To ensure that board information provides an accurate reflection of the trust's performance.

Who will be affected?
Board members

Evidence

What evidence have you considered?
Quality Governance Framework, Monitor, London, 2010

Improving Information to Support Decision Making: Standards for Better Data Quality, the Audit Commission, Audit Commission Publishing Team, 2007

Quality Control Handbook, J M Juran, New York, NY: McGraw-Hill, 1951

Outcome of a review of the policy by equality analysis group.

Disability including learning disability
Nil - Reviewed 2015

Sex
Nil- Reviewed 2015

Race
Nil- Reviewed 2015

Age
Nil- Reviewed 2015

Gender reassignment (including transgender)
Nil- Reviewed 2015

Sexual orientation Nil- Reviewed 2015
Religion or belief Nil- Reviewed 2015
Pregnancy and maternity Nil- Reviewed 2015
Carers Nil- Reviewed 2015
Other identified groups Nil- Reviewed 2015

Human Rights	Is there an impact? How this right could be protected?
Right to life (Article 2)	No - Reviewed 2015
Right of freedom from inhuman **and degrading treatment (Article 3)**	No- Reviewed 2015
Right to liberty (Article 5)	No- Reviewed 2015
Right to a fair trial (Article 6)	No- Reviewed 2015
Right to private and family life **(Article 8)**	No- Reviewed 2015
Right of freedom of religion or belief **(Article 9)**	No- Reviewed 2015
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	No- Reviewed 2015
Right to freedom from discrimination **(Article 14)**	No- Reviewed 2015

Engagement and involvement

External advice sought including a presentation to trust officers.
Circulation of the presentation to key individuals including non-executive directors
Sharing of proposed attributes with the performance and investment committee

Summary of analysis - Reviewed 2015

No specific equality or human rights significant within this policy

Eliminate discrimination, harassment and victimisation

The improvement of data quality and scrutiny will support the Trust to identify and indicate relevant action to support the elimination of discrimination, harassment and victimisation.

Advance equality of opportunity

The improvement of data quality and scrutiny will support the Trust to identify and indicate relevant action to support the advancement of opportunity

Promote good relations between groups

The improvement of data quality and scrutiny will support the Trust to identify and indicate relevant action to support the promotion of good relations between groups.

What is the overall impact?

Nil

Addressing the impact on equalities

No issues identified

Action planning for improvement

No issues identified for action

For the record

Name of persons who carried out this assessment:

Wendy Copeland-Blair (Chair) (August 2014)
Joyce Williamson (August 2014)
Kate Greenwood (August 2014)
Meryl Cuzak (August 2015)
Kate Greenwood (August 2015)

Date assessment completed:

11 August 2014 / Reviewed 10 August 2015

Name of responsible Director/Director General:

Neil Smith, Executive Director of Finance / Deputy Chief Executive

Date assessment was signed:

11 August 2014 / 10 August 2015