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North Lincolnshire Council
Home First Short Stay Centre
Statement of Purpose 2021

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On behalf of	
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Content

1. Quality and purpose of care

1.1. Introduction

This Statement of Purpose is written in accordance with Care Quality Commission (Registration) Regulations 2009.

The statement is produced by the Registered Manager on behalf of North Lincolnshire Council, Adults and Community Wellbeing.

Reference is also made within the document to a series of North Lincolnshire Council, Adult & Well-being Services policy documents, which can be read in conjunction with this statement. These documents are all available in full at www.northlincs.gov.uk

This document is created for submission to the Care Quality Commission as part of North Lincolnshire Adult & Well-being Services' legal responsibility to **produce a Statement of Purpose for any registered services it provides, in accordance with Care Quality Commission (Registration) Regulations 2009. The document is also available to**: -

- Each person who works at the Home First Short Stay Centre, Sir John Mason House (SJMH).
- People provided with support and services at the Home First Short Stay Centre.
- All carers or family members of people provided with support and services at Home First Rehabilitation Centre.

The Home First Short Stay Centre is a Care Quality Commission (CQC) registered Rehabilitation Service, providing time-limited rehabilitation therapies and support in a purpose built, 30 en-suite room, residential setting.

This document aims to provide a detailed account of the services provided at the Home First Short Stay Centre, in line with CQC (Registration) Regulations 2009.

This document will provide a clear picture as to the overall aims and objectives in terms of providing the optimum standards of care support to achieve a person's goals to live as independently as possible.

This document is available to people who use the service, and their families, and any other professional agency with a legitimate link or enquiry about the Centre. It is a requirement that every member of staff remains fully conversant and up to date with the contents and meaning of this document.

The Registered Manager regularly reviews the Statement of Purpose and associated policies in relation to the Home First Short Stay Centre.

1.2. Ethos and Philosophy

We strive to deliver support that puts people at the centre of services. We will ensure that we keep the person at the heart of our service and take their whole wellbeing into account. We aim to ensure that when a person returns home, they feel confident, safe and ready to return to independent living.

We will enable people to feel confident and supported when taking managed risks, enabling them to develop the strength and skills to maximise their ability to live independently.

We will treat everyone as an individual and encourage them to maximise their intellectual, social and physical potential.

We will strive to preserve and maintain dignity, individuality, privacy and remain sensitive to a person's ever-changing needs.

We will, at all times, treat people with care and compassion and respond to people in a courteous, caring and respectful way.

We will offer services that ensure everyone has equal access to care and support and equality is demonstrated in the behaviours of all staff working in the integrated service. Staff from across health, social care and other partner agencies, work together to promote and develop care and support that is personal, fair and diverse.

We will work with a person to identify and achieve their potential through identifying the outcomes and goals that are important to them to maximise their independence. This will form the basis of their care and support plan and will be reviewed with them on a regular basis, to assess and adjust the support they need to achieve their goals.

We identify a person's 'circle of support' as families, friends, carers, loved ones or others that provide care and support to an individual. We encourage a person to appropriately involve their Circle of Support in decisions made during their recovery process. We work inclusively to ensure all views, goals and circumstances are taken into account and they feel fully supported and empowered during their rehabilitation journey.

We believe that being part of a community and having a network of support can empower people to live healthy and fulfilling lives, thus supporting their health and emotional well-being. We work to ensure that when a person has reached their potential, and planning discharge from the Centre, that if they require ongoing support with the Home first community service that this is available.

They may also require some opportunities to develop links within the network further through the Community Wellbeing Hubs and other community activities and services, and where appropriate we will work with individuals and their Circle of Support to confidently access these services.

1.3. What is the Home First Short Stay Centre?

The Short Stay Centre, is part of North Lincolnshire Council's Adult and Community Wellbeing Social Care support offer, and is located within Sir John Mason House in Winterton. The Centre provides time-limited, rehabilitation and reablement support.

A person may need support after a stay in hospital, or a period of illness, to regain the physical strength and daily living skills needed to restore their independence, enabling them to remain living in their own home.

The service can also be accessed by individuals who are unwell and live in the community however would benefit from rehabilitative support in the Short Stay Centre.

The Home First Short Stay Centre is an integrated social care and health service, where a team of professionals within Adult and Community Wellbeing Services and the Health Service, provide programmes of intensive therapy and care in a purpose built, 30 room, residential setting.

The team includes social care staff, occupational therapists, physiotherapists, nurses and general practitioners from social care and health. By working in an integrated way we are able to:

- deliver support plans that bring together services to achieve the outcomes important to each individual
- improve transition between health and social care services
- communicate effectively to people accessing support services
- ensure effective, timely and inclusive decision making between social care and health

1.4. Core Functions

We work with people and their circle of support to develop a programme of support to improve mobility, meet health needs, help with daily living activities, practical tasks and develop the confidence, strength and skills to carry out these activities independently to enable people to continue to live at home.

We work in partnership with other social care and health professionals to prevent avoidable admission to hospital and facilitate appropriate early discharge.

1.5. Aims and objectives

Our goal is to provide a service that is fully person-centred, supporting people's physical, emotional and social needs to improve and develop their whole wellbeing.

We ensure that everyone has equitable opportunities to live the best lives they can with the fewest restrictions, irrespective of their individual backgrounds or circumstances. We embrace our values, influence and responsibility to engender high ambitions for vulnerable adults across our partner agencies - ensuring that all adults achieve

excellent outcomes. We aim to ensure that all adults have the opportunity to reach their maximum independence after a period of illness or injury.

We are striving to ensure that at every stage of the journey individuals:

- recognise and achieve their potential
- have the confidence to live at home
- feel safe and be safe
- enjoy good health and emotional wellbeing

The Home First Short Stay Centre is a multi-disciplinary service that focuses on maximising long-term independence, choice and quality of life, simultaneously attempting to minimise on-going support.

We aim to:

- improve health and well-being outcomes
- promote independence
- increase and sustain daily living skills
- support carers to continue to care

We aim to enable independence, ensuring individuals are supported actively to take managed risks to build confidence and increase independence. We want individuals to live and thrive within their communities and will support them to regain the skills and support networks they need to live at home.

Home First Vision:

Acting in line with our vision for good practice underpinned by the 6 Cs:

Care, Compassion, Competence, Communication, Courage and Commitment.

1.6. Service Description

Private Facilities

- The Centre is modern care facility equipped to support and enable our guests to return to independent living.

- We have 30 rooms all with en-suite bathrooms, TV and furnished to a high standard to ensure comfort and safety.

- Each room has a lockable cupboard for personal items and medication.

- Each guest can have a key to their own room (unless a risk assessment states otherwise).

- Toilets are fitted with grab rails and raised toilet seats are available to enable people to use the facilities independently. Commodes are available if people are assessed as requiring one.

Communal Facilities

- We have a communal lounge with TV, radio, CD player, books and board games.

- There is a private garden to sit and relax in.

- There is a large dining room where our team offer home cooked meals with flexible dining options.

- A smaller dining room where people can take their meals in a quieter environment.

- A kitchen where a person and/or their visitors can make their own snacks and refreshments and where kitchen assessments will take place.

- There are cordless phones for people to receive calls.

- We provide domestic laundry facilities and guests are encouraged to do their own laundry or allow family or friends to help them.

- We have a supply of library books, talking CDs and mp3 players that are refreshed by the council's library service every few months.

- There is a free Wi-Fi service available for all to use.

- We have several IPads and IPods that can be used to listen to music, entertainment, emails and access the internet.

- We have a laptop computer that can be used to access emails, the internet and Skype family and friends.

- There is a mobile scooter for guests to try to see if this might be the type of equipment that could help them when they return home, or for them to get out and about in whilst they undertake their period of rehabilitation.

- Guests can take part in a variety of recreational and physical activities. The activities may include book clubs, 'knit and natter' groups, dominoes, music sessions, concerts and plays put on by visiting schools and colleges and other theatre groups, various talks and presentations.

Services

- We complete a 'proportionate assessment' in partnership with individuals and their families, to plan what services would help a person retain or regain their physical health and social care needs. Assessments ensure they are responsive to people's preferences, aspirations and choices and keep them at the centre of everything we do.

- Proportionate assessments are carried out with the purpose of exploring support which will enable people to remain independent using the The Care and Support (Eligibility Criteria) Regulations 2014 - The Care Act 2014.

- We arrange emergency placements to support early discharge from hospital and to ensure the discharge is safe to take place. Following emergency placements an assessment is completed to ensure rehabilitation placement is appropriate.

- Documentation provided to individuals, e.g. Residency Contract and Welcome Guide, is discussed and manages the person's expectations of the service provided and how they will contribute to their rehabilitation.

- Individual support plans, which include programmes of care and therapy plans are completed in partnership with individuals and their family / carers (circle of support) to ensure the support and therapies we provide are personalised, effective at an individual level to achieve good outcomes and maximise independence.

- We monitor and review support regularly throughout the period of rehabilitation, this can be daily, weekly as circumstances and achievements change. We work in partnership with our multidisciplinary team, the individual and their circle of support, reducing services as appropriate to enable an individual to regain maximum independence.

- Upon discharge or transfer, we provide advice and information to enable people to have choice and control over their own lives and to make good decisions about care and support.

- Where necessary we make referrals to other health and social care services, enabling individuals to regain/ maintain independence. We introduce people to well-being hubs to access activities in their local community, reducing social isolation.

- The Liaison Officer shares information about alternative private and voluntary services and support organisations that may also meet people's needs, and which could prevent them from becoming more dependent on services and delay the need for longer term support.

- Where further eligible social care needs are identified, we refer to the appropriate network for full assessment of needs.

2. Care planning

2.1. Admission criteria

This service is available to people who are:

- Over 18 and live in North Lincolnshire or are registered with a North Lincolnshire GP
- Are willing and able to take part in a social care programme of support to improve daily living skills
- Are willing and able to take part in a therapy care programme to improve mobility and physical health
- Are in hospital and medically fit for discharge
- Are able to be supported in the Rehabilitation Centre and could therefore avoid an admission to hospital
- Meet the Care and Support (Eligibility Criteria) Regulations 2014 (see below).

The Care and Support (Eligibility Criteria) Regulations 2014 within the Care Act 2014 states the eligibility criteria for adults who need care and support are:

An adult's needs meet the eligibility criteria if:

- The adult's needs arise from or are related to a physical or mental impairment or illness
- As a result of the adult's needs the adult is unable to achieve two or more of the outcomes specified outcomes as a consequence, there is, or is likely to be, a significant impact on the adult's well-being.

The specified outcomes are:

- Managing and maintaining nutrition
- Maintaining personal hygiene
- Managing toilet needs
- Being appropriately clothed
- Being able to make use of the adult's home safely
- Maintaining a habitable home environment

- developing and maintaining family or other personal relationships.

For the purposes of this regulation an adult is to be regarded as being unable to achieve an outcome if the adult:

- Is unable to achieve it without assistance
- Is able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety
- Is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult, or of others
- Is able to achieve it without assistance but takes significantly longer than would normally be expected.

2.2. Proportionate Assessment

Requests for support by the Home First Service are assessed using a multi-agency approach. This approach brings together both the social care and health needs of a person allowing a proportionate assessment to consider the whole of a person's needs and ability to benefit from rehabilitation support. As shown in the Care and Support (Eligibility Criteria) Regulations 2014, a need for rehabilitation may not always arise from a medical condition. Therefore, the final decision to offer services at the Centre remains with Adult Social Care to ensure support is given to all who meet the regulations and would benefit from a period of rehabilitation.

The person is fully involved in their ongoing assessment, family, circle of support and carers are also included to allow all views, goals and circumstances to assist the assessment process.

2.3. Care and support plan

Individual support plans are co-produced with each person to ensure their views, personal goals and desired outcomes are included and implemented. The plan will include how they wish to be spoken to, how cultural needs can be met and their preferences and dislikes. This empowers people to have choice and control over the support they receive and enables staff to work with empathy and compassion, have a deeper understanding of the people they support and provide a service that is caring, person-centred and culturally appropriate.

We appreciate the valuable input families, friends and carers can provide in a person's recovery, and always encourage their opinions and support when developing a support plan and reviewing a person's individual needs. The plan will remain person-led.

Our multiagency approach allows people's health and social care needs to be fully supported. Our integrated staff team work to ensure people's physical needs and emotional wellbeing are fully considered and supported during their recovery.

Support plans are continually assessed in full partnership with the individual and their circle of support. A multiagency meeting once a week, or more frequently if required,

gives time to reflect on the goals and outcomes set and consider if they are being achieved and any adjustments made.

If the service is unable to meet an individual's needs, a multidisciplinary meeting will be held with the individual and their circle of support to find an alternative solution.

There is currently no charge for rehabilitation up to a maximum of six weeks. A programme may be provided partly from the Centre or, for a proportion of those six weeks, provided at home by the Home First Community Services. Together they cannot exceed six weeks. After this period, if further support is required, we will discuss with the individual and their circle of support, fees payable and carry out an assessment of contribution to the cost of support. Our aim is to ensure we maximise a person's potential for rehabilitation within a 2-3 week period, with a possibility of continuing their recovery at home with Home First Community Services. To achieve this we must continually assess if a person can receive the rehabilitation support they may need in their own home – 'Why not home, why not today?

2.4. Return to independent living

The purpose of the Centre is to support people to regain the physical strength and daily living skills needed to return to independent living.

We work as a multidisciplinary team with the individual and their circle of support, adjusting support as appropriate to enable an individual to regain maximum independence.

Upon discharge, we provide advice and information to enable people to make informed decisions about care and support and help prevent them from becoming more dependent on services or delay the need for longer term support.

We make referrals to other social care and health services which can assist a person remain independent. We introduce people to community wellbeing hubs to access activities in their local community, promoting inclusion and reducing social isolation.

Home visits are arranged to support safe transition home and links established with universal services, to ensure people remain safe and risks are minimised in and around the home.

3. Views and wishes

3.1. Involvement of individual, family and carers (Circle of Support)

We encourage the complete involvement of a person throughout their care and support at the Centre. This involvement starts with their first assessment of care needs.

Involvement continues when a person first arrives at their 'welcome meeting' which helps them, and their circle of support, understand the services, environment and care objectives of the Centre in more depth. A plan for returning home, and what needs to be in place for this to happen, is first discussed at the 'welcome meeting' and this topic is returned to throughout a person's stay. This ensures independent living remains a core goal. This meeting also helps us to develop our understanding of each person as an individual, and their wishes and goals for regaining their independence.

We develop the support plan in partnership with the individual and their circle of support to ensure they are fully involved in identifying the outcomes required and adjustments needed to enable them to get back to health and therefore back home as quickly and safely as possible.

Records and support plans are available to the person receiving support, and are always open to scrutiny and comment.

3.2. Reviews

As part of our quality assurance we request residents and their circle of support complete a questionnaire this enables us to understand what their experience of the service is like for them, if their outcomes and goals are being achieved and if they have suggestions for changes or improvements to the service.

We use these views and comments to evaluate the service to ensure it is achieving its aims and objectives. They inform and influence any improvements and development of services to enhance our offer to the people of North Lincolnshire.

Weekly manager walkabouts will also give residents and their circle of support an opportunity to share ideas, thoughts and feeling on good practise/ways to improve.

3.3 Feedback

Feedback and comments help inform and develop the service we deliver. Each person is informed of the formal complaints process at the welcome meeting. People are encouraged to make comments, suggestions, and complaints through a variety of means.

- They can raise a concern with a member of staff verbally as the issue arises.
- Use a feedback form placed in their room at any point in their stay.
- Complete a complaints / compliments form either after or during their stay.
- Complete the surveys and questionnaires that are sent to a person and their family / circle of support after they have left the Centre.
- Discuss with managers at weekly walkabout.

4. Health

4.1. Physical health

The Home First Short Stay Centre is an integrated service of health and social care professionals. Our **multi-agency approach provides both social care support and health therapies to support a person to return to physical independence.**

Our social and health care professionals support people to regain skills they may have lost through illness. They will provide a mixture of health therapies and social care support to help them achieve their goals to live as independently as possible. These may include:

- Support to improve mobility and health needs.
- Help with daily living activities and practical tasks.
- Building confidence to carry out these activities.
- Working with health professionals to maximise therapy plans.

We have a contract with a general health practitioner service to provide support for general health needs of people staying with us.

We support people to make arrangements to see specialist practitioners, such as a dentist, chiropodist, optician or audiologist.

4.2. Social and wellbeing

All support plans consider the social and wellbeing health of a person. Views and suggestions given by an individual's Circle of Support are always valued.

Whilst a person is at the Centre they are encouraged to participate in the available social and wellbeing activities and opportunities.

People are encouraged to take their meals in one of the two dining rooms, giving opportunity to interact with other people who are receiving support at the Centre.

There are group activities to encourage physical exercise and social interaction, for example, chair-based exercises, concerts and craft activities to build independence and improve wellbeing.

We encourage people to join in the activities that are taking place in the adjoining Community Wellbeing Hub and will support a person to do this.

When a person leaves the Centre, we provide information and advice on community activities within their area and will link with other services that can support them to feel confident accessing these services.

We discuss the person's Circles of Support and explore how these networks might help to keep people healthy and included in their community.
Where a person has no personal network of support we will work with them to put in place a support network, which may include support to attend their local Community Wellbeing Hub, reducing social isolation.

4.3. Medication

Our Medication policy ensures everyone is fully informed and takes responsibility for the safe administration of medicines in the centre. The policy ensures audits are carried out regularly and in the event that an error occurs a learning review is quickly undertaken to immediately record and rectify the situation.

Controlled drug audits are also completed and our Medication Champion liaises with the local Clinical Commissioning Group Intelligence Officers.

Risk assessments are completed and establish whether someone's medication status is administer, assist or can self-medicate. This is reviewed regularly, and adjustments made if necessary.

5. Safe Safeguarding Champion

5.1. Managed risks

We work to ensure people feel safe and are safe and are supported in taking managed risks and building confidence to return safely home.

We achieve this through our person-centred approach to a person's recovery, ensuring they are completely involved and consulted on their Support Plan, they have choice and control over what goals they would like to set and achieve, and are continually encouraged to take up new opportunities that will improve outcomes and general wellbeing.

5.2. Safer Recruitment

The service is well supported by the council's Human Resources Department. The Council's Safer Recruitment policies and processes ensure all staff have DBS clearances, which are reviewed and updated every three years. References for all employees are taken and any gaps in employment thoroughly explored.

The Adult Services Workforce Team provides mandatory and statutory training and all staff are trained in adult protection as well as child protections awareness.

5.3. Adult Protection

Safeguarding is embedded in the policies and procedures of the Centre. Our policies reflect the local Safeguarding Adults policies and procedures. This is a multi-agency document endorsed by the North Lincolnshire Safeguarding Adults Board.

It describes how all partners work together to safeguard vulnerable adults in North Lincolnshire.

The Safeguarding Adults Board promotes and audits effective partnership working across North Lincolnshire and is made up of representatives from key partners who are responsible for the health and wellbeing of the public, for example, health, police and social care organisations.

We have implemented the principles of 'Making Safeguarding Personal', which enables adults at risk of harm to be encouraged to identify desired outcomes and what steps they can take to change their situation and to be safe and involved throughout the safeguarding process.

The centre is a 'space of safety' for anyone to feels unsafe to call and seek help or advice.

The Herbert protocol is used to capture personal details for all our guests in the event anyone gets lost in the area. The protocol includes a photograph being taken within four hours of arrival and staff are trained in its importance in helping to keep people safe. The protocol is shared with individuals and loved ones at the welcome meeting.

5.4. Health and Safety

We are well supported by the Council's Health and Safety Team and Procedures for building and personal awareness. Training is given and updated regularly for all members of staff. Accident recording systems are in place for guests, visitors and staff members.

Individuals, visitors and staff have a responsibility to keep themselves and others safe when using the facilities provided.

Infection control procedures are in place and regularly reviewed. The service accesses specialist support if necessary.

Business continuity plans are in place and mandatory exercises occur every three years.

6. **Leadership and management**

Registered Provider
North Lincolnshire Council Church Square House 30-40 High Street Scunthorpe North Lincolnshire DN15 6NL
Responsible Individual
Marian Davison Church Square House 30-40 High Street Scunthorpe North Lincolnshire DN15 6NL
Registered Manager
June Elvin Home First Short Stay Centre Sir John Mason House De Lacy Way Winterton North Lincolnshire DN15 9XS

6.1. Staffing of the Home First Short Stay Centre

The number of staff required on duty by day is determined by the occupancy of the building, any assessed risks and the time of day.

Number of Adult Social Care staff required on duty during the day and evenings	
Team Manager	1 Monday to Friday.
Senior Rehabilitation Officer	1/2 officers, AM and PM
Number of care staff on duty during the day am and pm shifts	8 care staff
Number of care staff on duty during Night	5 care staff
Number of ancillary staff 8am – 6pm	3/4 staff members
Number of catering staff	2/4 staff members
Operational Support Staff	2 staff members, Monday to Friday
Gardener/Handy Person	1 Monday to Friday

The table above shows the number of Adult Social Care staff on duty. In addition to this a number of health care professionals are present at the Centre delivering health therapies. This staff group will consist of:

- Physiotherapists
- District Nurses
- Occupational Therapists
- General Practitioners – contracted to the Centre 'as needs arise'

6.2. Supervision

North Lincolnshire Adult & Well-being Services requires the regular and meaningful supervision of all staff. Regular supervisions give the opportunity to address issues, promote a positive culture and improve the overall quality of service delivery. Staff receive regular reflective supervision. The performance review model encompasses how an individual can have an impact on the priorities of the service and wider council by demonstrating working towards the following priorities:

- ENABLE communities to thrive and live active and healthy lives
- SUPPORT safeguard and protect the vulnerable
- SHAPE the area into a prosperous place to live, work, invest and play
- COMMISSION to improve outcomes for individuals and communities
- TRANSFORM and refocus, ensuring we remain a dynamic and innovative council

The Council's Code of Conduct on employment is given to, and discussed with, all members of staff.

Supervision and Whistle Blowing procedures ensure staff can raise any concerns.

6.3. Induction and training

Staff receive an initial induction including safety training:

- Adult protection responsibilities
- Safeguarding awareness
- Mental Capacity Act and Deprivation of Liberty basic awareness
- Health and Safety Awareness

Annual training plans include:

- Health & safety risk assessments/IOSH training
- Safeguarding
- Medication
- MCA DoLs
- Moving and handling
- Diversity
- Data protection

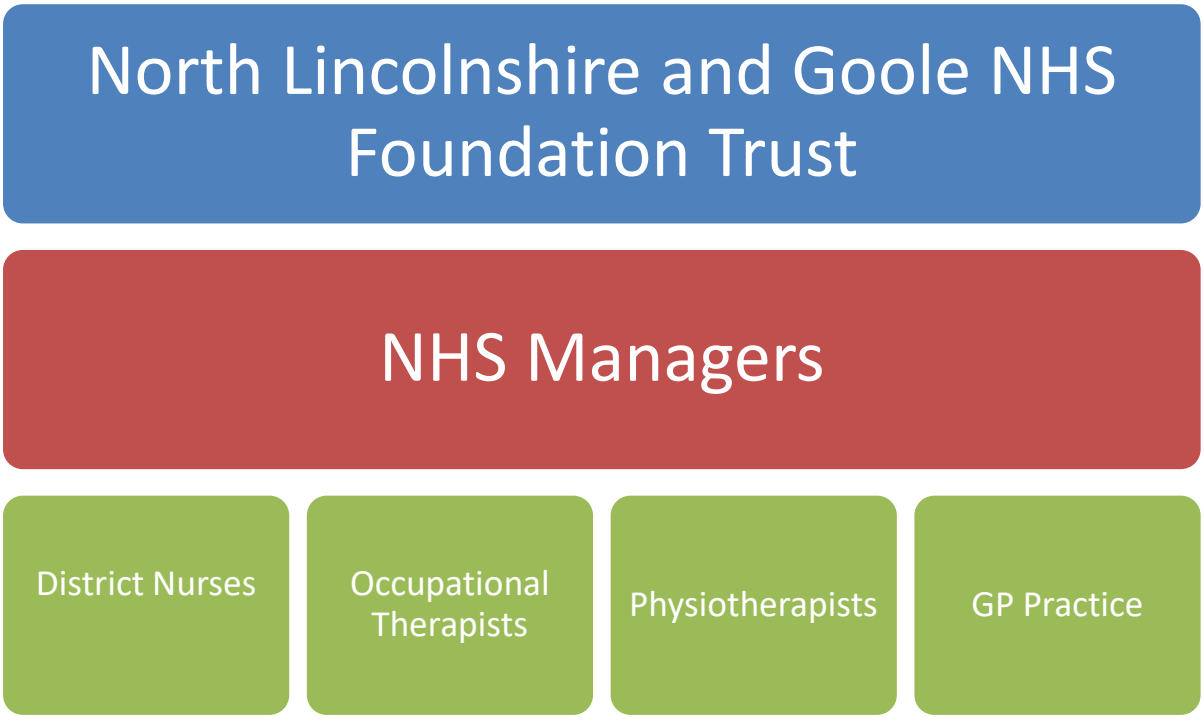
Mandatory medication training is provided for staff with annual updates. A Medication Champion advises staff members, monitors training attendance and identifies areas for training.

Moving & Handling Champions carry out risk assessments advise staff and monitor training. They receive and disseminate updates.

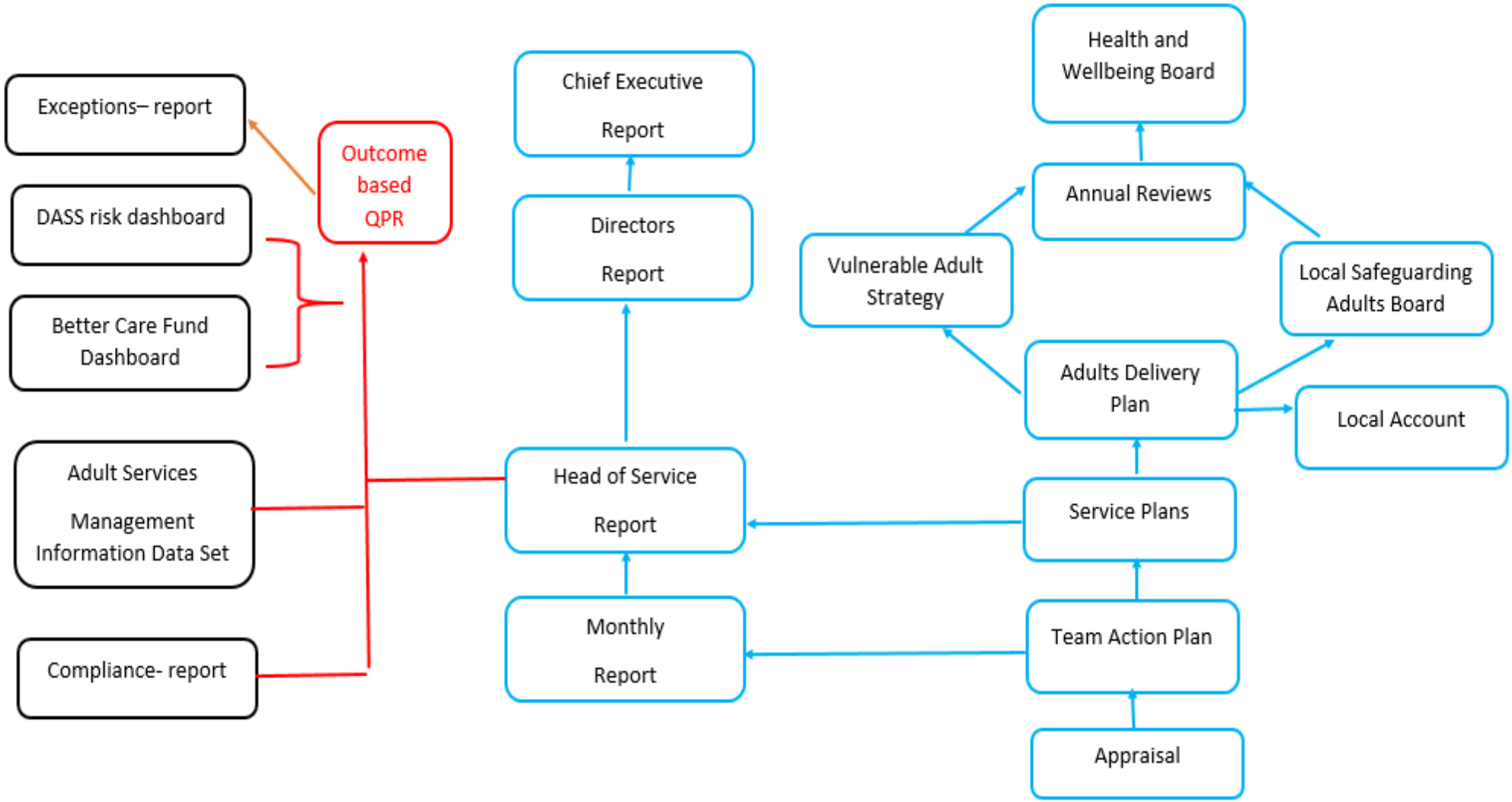
6.4. Resources

£1.4m budget

6.5. Organisational Structures


North Lincolnshire and Goole NHS Foundation Trust
NHS Managers
District Nurses
Occupational Therapists
Physiotherapists
GP Practice

6.6 Internal Governance Framework



6.7 Performance and Compliance Measures

Compliance Measures	Best Practice Timescales	Statutory or Best Practice	Performance Target	Reporting Timelines
Completion of controlled drugs Audit	Quarterly	Statutory	100%	Quarterly
Number of people remaining at home 91 days after discharge from hospital into R and R services	Quarterly	Statutory	Actuals	Monthly
Notification of service user death (CQC)	24 hours	Statutory	100%	Weekly
Home First Assessment (screening)	Same Day	Statutory	100%	Monthly
DBS Clearance	3 Yearly	Statutory	100%	Monthly
Number of Complaints	Quarterly	Statutory	actuals	Monthly
How many responded to within timescale	20 working days	Statutory	95%	Monthly
Mandatory Training requirements	12 months	Statutory	100%	Monthly

ACTIVITY

Activity Measures	Best Practice Timescales	Statutory or Best Practice	Performance Target	Reporting Timelines
Case reviews/Progress	Weekly	Best Practice	Actuals	Weekly
Update Care first records	Daily	Best Practice	Actuals	Weekly
MAR sheet Audits	Monthly	Best Practice	Actuals	Monthly
Service Users discharged	monthly	Best Practice	Actuals	Monthly

Number of people signposted to universal services	Monthly	Best Practice	Actuals	Monthly
Quality Assurance Surveys sent and returned	Quarterly	Best Practice	Actuals	Monthly
Case File Audits – Grade 10 x2 per month	Monthly	Best Practice	100%	Monthly
Home First Welcome Meeting	Same Day	Best Practice	Actuals	Monthly
Number of admissions into Home first residential	Monthly	Best Practice	Actuals	Monthly
Number of referrals from HFR to Localities for full assessment or further social work interventions	Monthly	Best Practice	Actuals	Monthly
Sickness recorded on system	Monthly	Best Practice	100%	Monthly
Sickness managers checklists recorded	Monthly	Best Practice	100%	Monthly
Sickness return to work interviews recorded	Monthly	Best Practice	100%	Monthly
Appraisals	Annual	Best Practice	100%	Monthly
Appraisal audits completed	Annual	Best Practice	Actuals	Monthly
6 monthly appraisal reviews (new starters)	6 months	Best Practice	100%	Monthly
Supervisions	4 weekly - min 10 per year / 4 a year (Regulated Services)	Best Practice	90%	Monthly

Activity Measures	Best Practice Timescales	Statutory or Best Practice	Performance Target	Reporting Timelines
Number of Compliments	Monthly	Best Practice	Actuals	Monthly
Fitness to practice - driving licence	Annual	Best Practice	100%	Annual
Fitness to Practice - Risk assessments, VDU etc.	Annual	Best Practice	100%	Annual
National Minimum Data Set (NMDS)	Monthly report (internally)	Best Practice	100%	Monthly