**Supported Improvement Plan**

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| **Name** |  |
| **Ward** |  |
| **Position** |  |
| **Line Manager** |  |
| **Date** |  |

This Supported Improvement Plan (SIP) should be used as a tool to help support an employee to address aspects of their work role where they are not working to the standard/ level of their role. This plan could be to attend training course, produce a piece of work, meet certain target, or achieve a competency.

The Supported Improvement Plan will be devised in collaboration with the individual, their line manager and with the practice development/clinical education team if required. It is the responsibility of the line manager to meet regularly with the individual and review the plan.

All objectives set should be **SMART** achieving:

**S:** Specific – Target a specific area of improvement

**M:** Measurable – Quantify or at least suggest an indicator of progress

**A:** Achievable – Attainable and not impossible to achieve

**R:** Realistic – State the result which can realistically be achieved given available resources

**T:** Timely – Specify when the results can be achieved

**Section 1.a**

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| **Learning need/area for development**  *This section should clearly identify the development need/objective* | **Support plan/interventions**  *Clearly state the actions required to achieve the objective; this can be split into* *a number of actions with varying dates for completion* | **Outcome measures**  *This section should clearly identify the measures used to demonstrate achievement of the objective- please specify with the date* | **Date to be achieved by?** | **Achieved / Not Achieved**  *Please see* ***section 1.b*** *of this document for additional comments* | **Signature**  *Practice Assessor or Ward Manager* |
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**The objectives and interventions documented within this plan have been agreed by the individual, their line manager, the clinical educator and the SIP recorded on the Clinical Education Learner’s Tracker. The outcome measures were agreed by the individual and failure to achieve the measures identified will lead to a further investigation on a formal basis at a formal capability hearing.**

Employee Name: Signature: Date:

Line Manager Name: Signature: Date:

PDN Name (if needed): Signature Date:

**Section 1.b**

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| Mid-Point Review Date: | Final Review Date: |
| Comments: | Comments: |
| Employee Signature:    Line manager/PDN Signature: | Employee Signature:    Line manager/PDN Signature: |