

PQASSO Quality Mark

improvement action planning

What is an improvement action plan?

It is a plan that outlines what your organisation intends to do about any indicator or indicators of PQASSO that have not been met. You will only need to develop an *Improvement Action Plan* if the peer reviewers tell you that your organisation cannot be recommended for the PQASSO Quality Mark. In such circumstances the *On-site Report* given to you by the peer reviewers will clearly state which indicators have not been met and why this is the case.

What is the process for improvement action planning?

You have to provide the lead reviewer with an *Improvement Action Plan* within **2 weeks** of the site visit. The lead reviewer will review your *Improvement Action Plan* within **2 weeks** of receiving it, to check that the actions suggested are sufficient to ensure that the relevant indicators will be met in the future. The lead reviewer will then contact you either to approve the *Improvement Action Plan*, or to suggest changes that need to be made to it.

Once your *Improvement Action Plan* has been approved, you will have **8 weeks** to undertake the agreed improvements. By the end of these 8 weeks you must send the lead reviewer evidence of the agreed improvements having been made.

The lead reviewer will check your evidence within **2 weeks** of receiving it. This is to decide whether there is sufficient evidence to demonstrate that the improvement actions have been carried out satisfactorily and that the indicator(s) are now met. The lead reviewer will write a report on your improvement actions and send this to you and to CES.

There can be two outcomes at this stage:

EITHER

Your organisation meets all the requirements of the relevant level of PQASSO and the lead reviewer will recommend that CES awards your organisation the PQASSO Quality Mark.

OR

Your organisation does not meet the requirements of the relevant level of PQASSO because there are still gaps in the evidence, and therefore cannot be recommended to CES to be awarded the PQASSO Quality Mark.

If the lead reviewer does not receive evidence of your improvement actions within the 8 week period, he or she will contact you to tell you that you will not be recommended for the PQASSO Quality Mark.

Preparing an improvement action plan

To prepare an improvement action plan you must complete the template provided. You should clearly state:

1. **Indicator** – This is the PQASSO indicator which the peer reviewers deem your organisation to have not met.
2. **Peer reviewer findings** - These are the findings of the peer reviewer as they appear in the *On-site Report*.
3. **Improvement required** – This is the organisational improvement you intend to make so that you meet the indicator.

Once completed, the Improvement Action Plan should be signed and dated by the chief executive or chair and then sent by post to the lead reviewer.

Implementing improvement actions

The actions you implement depend on the requirements of the relevant indicators which you need to meet. Some issues that arise as a result of an un-met indicator will be relatively simple and easy to resolve, while others will be more complex and involve more detailed actions.

In the case of all improvement actions, you must make sure that you both deal with the present situation by taking remedial action, and then ensure that the problem does not arise again, by looking for the cause of the problem and dealing with it.

For example, it is reported that:

'Some staff do not receive annual appraisals.' (5.2.7)

Immediate action might involve staff who have not had an appraisal receiving one immediately. However, this does not prevent the situation arising again, so the appraisal process needs to be examined to determine why the relevant staff did not receive their appraisal. What was the cause? For example, was it due to communication failure, lack of planning or a defective procedure?

Once the cause is identified, it must be dealt with accordingly.

Recording improvement actions

Once you have implemented an identified action, this should be recorded in the final two columns of the *Improvement Action Plan*:

4. **Action undertaken** – This is the actual improvement action that has been undertaken.
5. **Evidence** – This is a list of the evidence that you will send to the lead reviewer to show that you have completed your improvement actions.

Submitting an improvement action plan

Once improvement actions have been completed, the *Improvement Action Plan* must be signed by your chief executive or chair. You must also collate and attach to the plan any relevant documents – such as new procedures or records of actions done – which help demonstrate that actions have been implemented as stated in the plan. The completed and signed-off *Improvement Action Plan*, together with the attached documents, will then be used as evidence that your organisation has carried out the agreed actions and that they will result in you meeting the requirements of the indicator(s).

You must send this to the lead reviewer within 8 weeks of receiving approval of your plan. The lead reviewer may ask you for any further details if anything is unclear. Once the lead reviewer is satisfied that the indicator(s) are met, he or she will confirm this to you and contact CES.

Example improvement action plan

The indicators used in this example are from PQASSO 3rd edition and are as follows:

3.1.4 Managers ensure that the organisation meets all legal, financial and contractual obligations, and that all insurance requirements are up to date.

4.2.7 Targets are set for the levels of user satisfaction.

Indicator	Peer reviewer findings	Improvement required	Action undertaken	Evidence
3.1.4	Employers' liability insurance out of date.	Examine our present system for identifying legal requirements and set up a process to ensure these legal requirements are met.	Previously unmet legal requirements have been put into place. Relevant people have been informed. Ongoing process has been established to ensure legal requirements are up-to-date.	Copy of employers' liability certificate.
4.2.7	There is no documented complaints procedure.	Develop a complaints procedure.	Complaints procedure developed and communicated to staff.	Documented complaints procedure.

Signed	<i>J Smith</i>	<i>J Smith</i>
Position	Chief Executive	Chief Executive
Date	30/04/2009	30/07/2009