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An Audit Tool to Assess Implementation of Standard 8 of the Children's National Service Framework: A Scoping Study

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1. Introduction

The Government is committed to improving the quality of care that public services, including the National Health Service (NHS), deliver to children and young people with disabilities. The National Service Framework (NSF) for Children and Young People and Maternity Services (DH, 2004) sets out the main vision for taking this commitment forward. The report, *Improving Life Chances for Disabled Children* (Cabinet Office et al., 2005)*,* the Social Care Green Paper, *Independence, Wellbeing and Choice* (DH, 2005), the White Paper, *Our Health, Our Care, Our Say* (DH 2006) and the Chancellor of the Exchequer's pre-budget review, *Support for Parents: The Best Start for Children* (HM Treasury, 2005) have reiterated this commitment. Ensuring services are designed to meet the additional needs of disabled children and families, better end of life care, extension of case-management for people with long-term conditions and increased investment in the expert patient programme are all included in this commitment. To take forward these commitments and to inform the 2007 Comprehensive Spending Review, the Chancellor announced a policy review of children and young people in the Budget 2006, including the objective to improve outcomes and life chances of disabled children through the development of effective and accessible services for disabled children and their families.

Standard 8 of the NSF relates to disabled children and young people, and those with complex health needs (DH, 2004). The Department for Health (DH) jointly with the Department for Education and Skills (DfES) is developing a delivery strategy to support local implementation of this Standard, which covers a range of topics including:

- access to and choice between services, covering both health services (primary health care, hospital care, CAMHS, rehabilitation/therapy services) and services provided by other agencies (social services, education, housing, equipment and assistive technology, transport and leisure);
- processes for early identification, integrated diagnosis and assessment and early intervention – including the role of Sure Start programmes, Children's Centres and extended schools in these processes;
- co-ordination of health care, and integrated continuing care;
- integrated palliative care and bereavement services;
- information and support to children and parents, and their involvement in planning services;
- safeguarding arrangements to prevent abuse of disabled children;
- planning and management of transition from child to adult services; and
- staff training and development.

To help service providers and commissioners obtain a clearer view of the services available to children in their area, including disabled children, a National Child Health Mapping exercise was conducted between November 2005 and January 2006 as part of the *Change for Children* Programme[1]. This annual data collection, the first of which is due to be published in the Autumn of 2006, is focusing initially on children's health services provided by Primary Care Trusts and secondary and tertiary care providers, although some information is asked of the voluntary and private sector

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[1] www.childhealthmapping.org.uk/

providers. This exercise has provided more information about the range of services available for disabled children and their uptake. However, in order to support NHS organisations, local authorities and other agencies in assessing how well they are implementing all the aspects of good practice outlined in Standard 8, including systems and processes, the DH is working with the Care Services Improvement Partnership to develop an audit tool for Standard 8. An audit tool would specifically support Primary Care Trusts in assessing their progress in relation to the requirement in *Our Health, Our Care, Our Say* (DH 2006) to audit services against Standard 8 and agree commissioning arrangements, service models and funding with their new Strategic Health Authorities (SHAs).

The Child Health and Maternity branch at DH asked the Thomas Coram Research Unit (TCRU) within their responsive programme of work to undertake background work to establish the resources likely to be needed to develop a tool to enable healthcare, local authorities and other organisations to audit their implementation of Standard 8. Although the work was commissioned by DH, there was agreement that the work should embrace the perspective of both DH and DfES in order to inform both Departments.

2.   The Study

This was a small scoping study undertaken between January and March 2006 to provide information for the DH and DfES to make decisions about the type of tool needed to audit Standard 8 of the NSF, including an estimate of the resources required for development. To meet this aim, the study employed the following methods: a review of published audit tools relevant to the areas covered by Standard 8, interviews with key informants and a seminar for commissioners and providers of services for disabled children and their families details of which are provided below.

2.1   A review of published audit tools relevant to Standard 8

The review aimed to identify examples of different approaches to auditing and, where possible, assess how tools had been developed and the extent to which they had been validated. The review focused on obtaining information about the *range* and *type* of tools available, rather than about their detailed content. It was not intended to be a comprehensive overview of all existing audit tools in this field. Rather, it served to provide concrete examples that could inform discussion about the kind of tool that was needed, and enable an assessment of the resources needed for development. Relevant material was identified through literature and internet searches and through interviews with key informants.

2.2   Interviews with key informants

Telephone or face-to-face interviews with key individuals provided an opportunity to examine the issues and costs involved in developing an audit tool and to explore informed views on the form it should take. Interviewees included those involved in developing relevant audit tools and representatives of national organisations, such as the Council for Disabled Children and Contact-a-Family, who have a good understanding of the perspectives of disabled children and families and what they

might hope an audit tool could achieve (See Appendix A). Altogether, 13 key informants were interviewed including the developers of seven of the 14 audit tools identified for the review. The interviews covered the following areas: awareness and experience of using audit tools, developing such tools and the resources involved, the need for an audit tool for Standard 8 of the NSF and the kind of the tool that would be most useful. Each interview took one hour on average.   From the interview notes written up after the interview, a summary was produced of the themes and issues arising across all the interviews.

2.3   Seminar for invited commissioners and service providers

A small, half-day seminar was convened in March 2006 primarily for those involved in providing and commissioning health, education and social care services for disabled children. The purpose of the seminar was to ascertain views as to what would be most useful in relation to auditing implementation of Standard 8. The DH and the key informants we interviewed nominated those invited to the seminar (see Appendix B). The participants were each given a set of materials including examples and summaries of the audit tools reviewed. To start the discussion, the research team gave a presentation highlighting the main issues from both the review and the interviews with key informants.   Following the seminar, a summary of the key points from the seminar was written and circulated to all participants.

3.   Distinguishing Features of Existing Audit Tools

Many audit tools already exist covering specific aspects of healthcare and social care for disabled children. The review identified 14 audit tools representing a range of approaches from simple checklists to detailed quality improvement programmes, and including a care pathway. For each, we produced a one-page summary in a standard format (see Appendix C) with the intention of providing a useful resource for any future development of an audit tool for Standard 8 of the NSF. In general, there was little published information about how such tools were validated, or the process by which they had been developed. Much of the information obtained about these tools came from interviews with their developers (see Appendix B) although within the scope of the study we were unable to interview the developers of all the tools identified. Interviews were supplemented with information from the tools themselves and material downloaded from the internet.

In the rest of this section, we analyse the diversity of existing tools in terms of how they were developed and by whom, their focus, purpose and the level of guidance given on how to assess performance against a set of standards.

3.1   Development

Those developing audit tools ranged from national bodies, such as the Department of Health and the Healthcare Commission to local Primary Care Trusts and service providers. The motivation for developing an audit tool was often because at the time there was little available that was suitable. Interviewees commented that there were many more audit tools now in circulation than was the case when they started their development work.

Development work for the audit tools varied from large to small-scale projects and took between six months and four years to complete, often depending on the resources available as well as the scope of the tool. For example, the Association of Children's Hospices Quality Assurance Scheme, *Are We Getting it Right?* (Appendix C number 5[2]), took approximately four years to develop, but employed one person working part-time. Development work usually followed a similar course of reviewing relevant literature and existing audit tools, setting up steering groups and/or consultation groups to develop the structure and content of the tool, piloting and revising drafts, and publication of the final version. However, the amount of work involved in each phase depended upon the purpose of the tool, the timescales involved and the resources available.

The *Early Support Service Audit Tool* (Appendix C number 3) evolved from the development work for the Early Support Programme aimed at providing families of disabled children with better information and coordination across services. This is a large programme providing a range of training and support materials, of which the audit tool is one part. Development of the tool involved extensive consultation and piloting. At the other end of the spectrum is the *Self-Assessment Tool for Child Protection for Clinical Teams* (Appendix C number 10), which took six months to complete and, because it was a pressured time-scale, built on pre-existing self-assessment tools. Although development work did include consultation and some piloting, it was by no means on the same scale as for the *Early Support Service Audit Tool*.

Very few projects involved any evaluation of the tool's effectiveness. Often, the success of the tool was assessed anecdotally through feedback from users[3]. The success of the *CAMHS Matrix* (Appendix C number 4), for example, a tool that is completed annually on a voluntary basis, was attributed to the fact that Partnerships reported that they found it useful, which would seem to be borne out by the very high completion rates. In a summary report on the progress of the 45 Pathfinder areas working with the Early Support Programme since July 2004, it was reported that the *Service Audit Tool*, which is also voluntary, 'has patchy use, but [is] creatively and effectively used where it is in place' (DfES, 2005:6). The universities of Manchester and Salford are currently evaluating the impact, effectiveness and outcomes of the Early Support Programme.

3.2 Scope

None of the tools reviewed for this study covered the full age range and all the topics in Standard 8. Instead, they focused on particular groups of children, particular processes or aspects of the system, or specific age ranges. Thus, the *National Healthy Care Standard Audit Tool* (Appendix C number 6) considers the health of looked-after children. The *Self-Assessment Tool for Child Protection for Clinical Teams* focuses on child protection but covers all children, while the *Early Support Service Audit Tool*, although covering a comprehensive range of topics currently focuses on disabled children aged from birth to three.

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[2] The appendix reference is given for a tool when it is first mentioned in each section, but not thereafter.
[3] 'User' refers to the user of the audit tool, usually the service provider. To avoid confusion with service users, we have used 'service user' when referring to this group of users.

3.3 Purpose

Not only do the tools vary in scope, but also they have different purposes. Some audit tools are intended primarily for monitoring performance, whilst others aim to improve services through a quality improvement process involving an audit of strengths and weaknesses, action planning, implementation and review. Such tools enable users to identify how services are currently performing, where they need to get to, what needs to be done and what action should be taken to bring about change. The purpose of a tool, whether for performance monitoring or service improvement, affects design and leads to tools ranging from yes/no checklists to those with more sensitive rating scales, detailed guidance and all the components of a quality improvement programme.

3.4 Quality improvement programmes

There are a number of essential components of a quality improvement programme including:

- clearly defined standards exemplified with good practice examples,
- a means for reviewing or auditing strengths and weaknesses and summarising results,
- action planning and implementation,
- a review of progress against agreed objectives and,
- support systems.

Some of the audit tools under review, such as the *Early Support Service Audit Tool*, are quality improvement programmes with all of these elements, whilst others have some but not all of them. The *Learning Difficulties and Ethnicity Audit Tool* (Appendix C number 7)*, for example, lacks clear standards and does not provide a means for the user to summarise information in order to identify strengths and weaknesses of the service.

3.5 Standards and guidance

Whether a checklist or a more detailed set of materials, most audit tools require users to assess their service or practice against a set of standards or statements. Each standard usually has a set of supporting indicators or criteria illustrating how attainment of the standard would look in practice, although the indicators are examples and by no means exhaustive. The indicators guide the user in their rating of the standards, helping to reduce different interpretations and ensure greater accuracy and reliability. These indicators also serve to alert users to the areas they may need to work on to reach the required standard. However, considerable variability in the level of guidance provided is evident across the tools reviewed as demonstrated by the following examples.

The *Early Support Service Audit Tool* has quite detailed indicators for each of its 27 standards. Indicators are provided from the perspective of what the standard means for work with families and from the perspective of the service provider. Thus, within the theme of referral, identification and initial assessment there are six standards, which are rated on a seven point scale. For the first standard, which considers referral

polices and practices to ensure families are not left in need, users are presented with 18 indicators.

The *Quality Self-Assessment Tool* (Appendix C number 9) has eight headings some of which are written as standards. Under each heading is a list of questions or indicators, but with little guidance about good practice. Likewise, the *Valuing People Audit Tool for Social and Health Care Agencies* (Appendix C number 13) gives little guidance to help users determine if their practice is good enough to reach the standard.

4.   Developing an Audit Tool for Standard 8: Issues to Consider

Drawing upon summaries of the interviews with key informants and the seminar discussion, the following key issues arose for consideration when developing an audit tool for Standard 8 of the NSF.

4.1   The purpose of auditing

The overwhelming view of all those consulted was that the purpose of an audit tool should be to improve service quality. Services are often unaware that what they are doing is not good enough and serious case reviews (where a child has been seriously harmed or killed) illustrate that there is often no systematic approach to identifying where a service is not working well. Quality improvement is about identifying where the service is failing and implementing action to put it right. This means going beyond monitoring and performance indicators. As one interviewee remarked in stressing the importance of measures that lead to improvement, "there is no point in having measures if [users] are not learning and improving - too many audits don't do that".

However, if the purpose of auditing is to improve the service, using the word 'audit' may be unhelpful, since it tends to imply monitoring rather than reflection, learning and change. There was a suggestion that the audit tool could be called something else, perhaps an improvement or planning and improvement tool.

If the audit tool is for quality improvement rather than simply monitoring how the service is currently performing, the question arises of how to balance quality and quantity. A point frequently made was that services are so overstretched that they need a tool that is manageable and not so detailed as to become overwhelming and thus deter use. The challenge is to develop a tool that is both meaningful and promotes improvement whilst at the same time being manageable.

Yet, quality improvement is not something that can be undertaken quickly it was pointed out, and use of a tool needs to be seen as an ongoing process. Improvement tools such as the *Early Support Service Audit Tool* (Appendix C number 3) and *Are We Getting it Right?* (Appendix C number 5) take time and resources to work through, though developers of these tools stressed the tool's flexibility. Users can focus on one standard or even one indicator of a standard, or different teams can work on different areas. Nevertheless, resources and time do need to be set aside for this work. For example, it was estimated by the project manager from the Association of Children's Hospices that it takes one day a month of staff time to keep the quality

assurance system, *Are We Getting it Right?* running smoothly and it would take approximately two years for a service to work through all six themes, whilst the *Early Support Service Audit Tool* 'can be used as a framework against which to plan for development within standard three or five year cycles' (DfES, 2004:15). It should be remembered of course that these tools are quality improvement programmes and involve not only an audit, but action planning, change implementation and review.

One suggestion made by seminar participants was that there may be a need for different types of tools fulfilling different functions. For example, a tool that takes less time to complete for the purpose of monitoring and one designed as part of a quality improvement programme, which will therefore involve more time.

Whatever the tool's function, with the development of a mixed economy of commissioning and providing services involving health, education and social care, the importance of establishing whom the tool is for and which services are covered becomes essential. This mixed economy suggests that the tool should be for both commissioners and providers, particularly if it is for auditing standards and benchmarking.

4.2   A tool for integrated services

With the drive towards integrated services and multi-agency working, an important feature of any new tool is that it should be suitable for multi-agency use. This means that the tool's key standards or the key indicators of each standard should not be exclusive to education, health or social care, but be easily identified across all sectors and therefore owned by all.

A tool where people physically come together to work on it is particularly desirable because there was a strong view that this process facilitates communication, promotes integration and begins to break down the barriers between health, education and social care, all of which are especially important when services are not already working together.

A number of Welsh Partnerships[4] piloting the *Self-Assessment Audit Tool* (Appendix C number 2) had organised meetings of representatives from different departments and agencies to agree responses to the key actions, and reported that the greatest value of the tool lay in the dialogue it fostered between them. However, bringing people from across different departments or agencies together in one place had been time-consuming and difficult to achieve. It was felt that senior managers with their strategic overview needed to be involved since they could provide the full picture, but this group could be particularly hard to bring together. Bringing senior management on board is also important to ensure that they too take responsibility for audit findings by agreeing priorities for action planning, an important factor in promoting improvement.

Developing a multi-agency tool is not without its challenges. Different agencies may have difficulty agreeing a rating, for example, where one is doing well in meeting a particular standard and another is not. The approach taken in the *Self-Assessment*

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[4] Children and Young People's Framework Partnerships

Audit Tool is to use the lowest rating for the joint assessment, based on the principle that a service is only as good as its weakest link. This inevitably leads to a 'flattening' of scores when one part of the service is working well, but another part is not. An example was given of a children's information service deserving a 'gold star', but getting a poorer rating because it was not being used by therapists and therefore was not accessible to every eligible family.

Finally, health, education and social care do not necessarily 'speak the same language', yet for a multi-agency tool to be successful, it requires a common language between disciplines and agencies. Involving all stakeholders in development and piloting can help to achieve this.

4.3   Coverage and scope

The developers of the *Self-Assessment Audit Tool* argued that a national tool covering the whole NSF, as this tool does, is a more powerful and useful tool than one designed for local use or which only covers parts of the NSF. The *Self-Assessment Audit Tool* enables aggregation of data, which can be compared across authorities. A benchmarking capability such as this can be a strong motivator both to use the audit tool and to stimulate change.

It was thought by informants that the tool should not be restricted to implementation of Standard 8 alone since the universal core standards 1 to 5 of the NSF were just as relevant, if not more so, to disabled children.   It was therefore the general feeling that the tool needs to address other NSF Standards that were equally applicable to disabled children and their families.

As the majority of disabled children are expected to be accessing mainstream services it was felt that the tool should be applicable to both specialist and mainstream services. A tool that can be used by both mainstream and specialist services would help to ensure that all services are able to respond to the needs of disabled children and their families.

Some informants questioned whether one tool could feasibly cover the range of disabilities, special needs and complex needs that Standard 8 embraces. The view expressed was that unless it was specified which indicators applied to which groups more than one tool would be necessary. It was the general opinion that more than one Care Pathway, described below, would be needed for implementation of Standard 8 if this approach were adopted.

4.4   Service users' perspective

An essential principle of a good audit tool is the involvement of all stakeholders, particularly disabled children and their families, in the development process. The *Early Support Service Audit Tool*, the *National Healthy Care Standard Audit Tool* (Appendix C number 6) and *Are We Getting it Right?* all involved extensive consultation both with practitioners and with disabled children and their families. This ensures that what is important to each stakeholder group - service users, practitioners, providers and commissioners – is given due consideration. Furthermore, consultation

can give stakeholders ownership of the tool, which is more likely to increase its credibility and its use.

Another feature of a good tool is inclusion of service users' evaluation of the service, since their experience can be a measure of how well a service is working. *Are We Getting it Right?* and the *Early Support Service Audit Tool* provide good examples of including service users' views. However, it was acknowledged by seminar participants that engaging service users in evaluation is not always easy, particularly as their priority may be to get on with 'ordinary' lives, and can be a lengthy process.

4.5   Standards and measurement

Key informants and seminar participants alike raised a number of issues relevant to the design of an audit tool. These issues included:

- determining what is measured,
- the unit of measurement,
- where the standard is set and
- ensuring the data collected is accurate and reliable.

Determining what is measured is usually achieved through a process of consultation with all stakeholders, including service users, and identifying effective practice through a review of the evidence base. Ideally, structure, process and outcomes are measured. Indicators of structure reflect the environment in which care is provided such as the physical facilities, characteristics of the organisation and qualifications of staff; indicators of process reflect the way in which care or the service is provided; and outcome indicators reflect the desired change, effect or results that are achieved by the care or service. In practice, it is difficult to find good or indeed any kind of outcome measures. The *Self-Assessment Audit Tool* for example measures process and not structure or outcomes.

Several respondents mentioned the importance of designing a tool with a developmental element not least because the NSF is a ten-year strategy and many services are a long way off implementation. As one interviewee said, "[services] are on a journey and need help in how to get there". Not only does this emphasise the need for a quality improvement tool, but also a rating scale that is sufficiently sensitive to recognise both current and emerging good practice. The *Early Support Service Audit Tool* the design of which 'positively encourages services to move toward a 'gold standard', while acknowledging, valuing and documenting emerging and improving practice' (DfES, 2004:4), has a seven point rating scale. The *Self-Assessment Audit Tool* reflects the long-term strategy of the NSF in Wales in that the key actions are divided into core and developmental. Developmental actions with achievement over a 10 year period are given a six point rating system whilst core actions with early delivery have a three point scale of 'yes', 'no' and 'partially met'.

Designers also have to make decisions about the level at which attainment of the standard is set. How good does practice have to be? Setting the standard too high may lead to many services failing 'at the first hurdle', but a tool with a developmental approach that rewards current and emerging good practice to some extent overcomes this dilemma.

The view that although standards need to be specific and measurable they should not be so detailed that the tool becomes overwhelming was contrasted with the view that it was necessary to 'drill down' and provide detailed guidance in the form of indicators or examples of good practice for at least two good reasons. First, clear indicators enable users to identify what practice should look like and, where it is failing, the sort of practices that need to be in place. Second, these examples help to ensure greater reliability in self-assessment, reducing different interpretations of the standard and narrowing the measurement yardstick. Without these indicators, as with the *Quality Protects Audit Tool* (Appendix C number 9) where there is no guidance provided as to how to interpret the scale nor indicators of practice to illustrate the questions that are asked, what may be considered excellent practice in one authority may be seen as less than excellent by another.

Whereas some audit tools, such as the *Self-Assessment Audit Tool* and the *Early Support Service Audit Tool* require users to provide evidence that the indicators of the standard have been met others such as the *CAMHS Matrix* (Appendix C number 4) do not. How users of the tool arrive at their assessment of the service is important information, not only to the those involved in the assessment process, but also those who may be external to the process, but with an interest in the results such as senior managers and inspectors. One interviewee recounted her experience of asking a senior manager why a standard had been 'ticked' as met to be told that it was because it was on their agenda. This in turn raises questions about what counts towards attainment of the standard and reinforces the need for exemplification in the form of indicators and examples of good practice.

As we have seen, the scale upon which to assess attainment of the standards or indicators can vary from a two point yes/no checklist to a three, four, five or seven point scale. Just as exemplification of the standard is important so too is exemplification of the scale to reduce the scope for individual interpretation and increase reliability across service users. Thus, the six point rating scale for the *Self-Assessment Tool for Child Protection for Clinical Teams* (Appendix C number 10) describes what 'scarcely', 'slightly', 'somewhat', 'substantially', 'strongly' and 'fully' mean in practice.

The sensitivity of the scale is another important factor. A yes/no checklist may seem straightforward, but if the standard is met fully in one part of the service, but not another the user must decide whether to respond with a 'yes' or a 'no' neither of which represents the true picture. Three point rating scales such as the traffic light system widely used in health service audits may be marginally better, but can be insufficiently sensitive to assess accurately the situation 'on the ground'. There is a danger too that users fall into a set response mode where the middle rating is repeatedly used. The *CAMHS Matrix* moved from a three to a four point rating scale to address these issues.

Not all the tools reviewed required users to make a judgement about their service using a rating scale. The *Healthy Care Standard Audit Tool* is one example. The developers of this tool wanted to encourage practice improvement and did not want a tool that was too prescriptive and difficult for practitioners to manage. During consultation and piloting, practitioners expressed their wish for a tool that was

flexible and one that could accommodate local differences and it was decided not to include a rating scale.

4.6 Integrated Care Pathways

There was strong support from seminar participants and from some interviewees for using an Integrated Care Pathway (ICP) approach as a means to improve services. ICPs are not audit tools, but frameworks for looking at systems from the perspective of a particular client group, e.g. children with life-threatening and life- limiting conditions. Their starting point is therefore about the needs of the client group rather than the availability and functioning of current services:

'An Integrated Care Pathway determines locally-agreed, multi-disciplinary practice based on guidelines and evidence, where available, for a specific client group. It forms all or part of the clinical record, documents care given and facilitates the evaluation of outcomes for continuous quality improvement' (Sue Overill, *Journal of Integrated Care* (1998) 2, 93-98 quoted in *Integrated Care Pathways Guide 1: Definitions and Concepts*, Effective Interventions Unit, Edinburgh 2003).
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Integrated Care Pathways are part of a continuous quality improvement cycle as illustrated in the diagram below, taken from *Integrated Care Pathways Guide 1* cited above.

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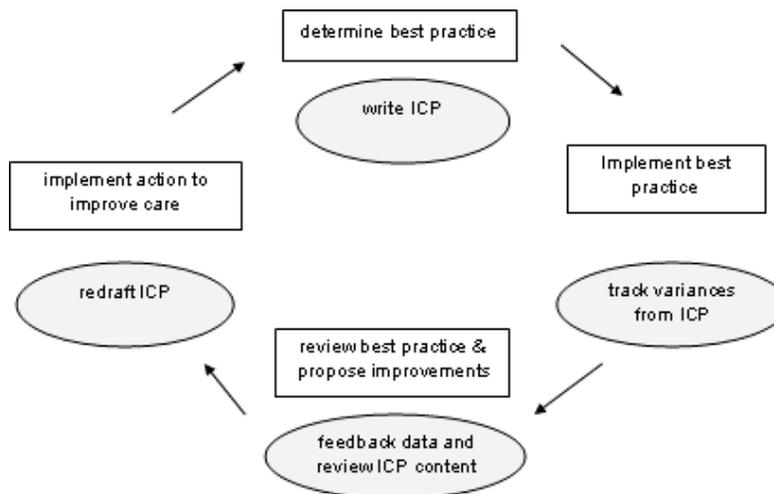
Care Pathways are flexible because they can be adapted to suit local situations, considered an important component of a good audit tool, but they provide standards and sentinel points for measurement and auditing. By assessing deviance from the pathway, practitioners are able to identify the gaps in the care provided and what action to take.

Historically, care pathways have been developed in health settings although interest has grown in their development across different treatment and social care settings. Nevertheless, the pathway concept is more familiar to health professionals than to other agencies. If a care pathway option were adopted to take forward

implementation of Standard 8, seminar participants stressed the need to develop an integrated rather than a medical model, and for appropriate training to be provided.

4.7   **Motivation and engagement to use an audit tool**

A common theme raised in both interview responses and the seminar was that a tool that is not useful and does not provide information that can improve services is unlikely to be used, either by commissioners or by providers of services for disabled children and their families. It may be that the National Child Health Service mapping exercise could provide useful experience on which to build, since it has managed the difficult task of engaging stakeholders at different levels.

Making sure that a tool is used is vital, especially if its completion is voluntary. Experience from study participants suggests a number of ways in which to encourage and engage potential users, which include providing comparative data, avoiding duplication in recording information, linking with inspections, and providing funding and support.

Comparative data: An audit tool that provides comparative data, such as the *Self-Assessment Audit Tool*, serves a number of valuable purposes. Having such data is a powerful motivator to use the tool because services want to see how well they are doing and demonstrate good practice. Aggregating and comparing data across authorities acts as a motivator for learning and change since for those doing less well it provides an impetus to improve. If the data shows, for example, that the service is performing poorly compared to other areas, this could be used as a lever or justification for improvements, particularly by those working directly with disabled children and their families who may have less power in the agency's management structure.

Avoid duplication: Having to record the same information in several different places is likely to deter use. However, avoiding this sort of duplication requires good information technology and communication systems.

Role of inspections: Another means of ensuring an audit tool is useful and encouraging its use is to link it with inspection frameworks, so that evidence from the audit can be used to assess standards. Inspectors undertaking the Joint Area Reviews already use results from the *CAMHS Matrix* when making their assessment, and likewise the Care Standards Commission, which inspects children's hospices, has accepted the quality improvement tool *Are We Getting it Right?* as contributing to evidence on quality.

Joint Area Reviews are one way in which audits are currently implemented, but it was suggested that responsibility for the monitoring of standards could be devolved to practitioners and agencies, a more far-reaching development. The inspector's role would then be to ensure quality assurance processes were in place and that improvement had taken place. Such a move, it was argued, would serve to both shift responsibility for quality assurance to the organisation, thus helping to make it a part of its culture, and give practitioners greater ownership of the process.

Funding: When use of an audit tool is optional, making funding contingent upon auditing or audit results can encourage its use. There are international examples within early years settings (e.g. in Australia and New Zealand) where participation in a quality improvement programme has been linked to funding (Mooney et al., 2003).

Support: A system of support for those using the audit tool can be important. The Early Support Programme has an extensive support package including training and support for the audit tool. The online *Self-Assessment Audit Tool* for the NSF in Wales provided accessible central support during the development stage, which was valued highly by the pilot authorities, but this was reduced once the audit tool programme was rolled out. The developer of the *CAMHS Matrix* explained how users can be too hard or lenient when rating themselves, and how the availability of a 'critical friend' who supports users through the process is especially helpful. Indeed, one essential component of quality improvement programmes is providing support to users during the quality improvement process.

5.   Is There a Need for an Audit Tool for Standard 8?

There was consensus among interviewees and seminar participants that an audit tool to assess implementation of Standard 8 is needed. Existing tools are either for single agency use or unsuitable because they do not address the full age range or all the areas covered by Standard 8. According to one interviewee, there are no national performance indicators and no public sector agreements for disabled children and thus no real impetus to improve services. However, there are performance indicators for local authorities, which do cover disabled children such as the take up of direct payments and the number of disabled children receiving services and JARs consider how well local authorities and their partners are meeting the needs of disabled children in terms of the five Every Child Matters outcomes. A tool would therefore send out the right message and increase pressure on implementation of Standard 8.

Most of the audit tool developers interviewed were of the opinion that the tool they had been involved with could be adapted or the principles applied to a tool for Standard 8 and were keen to be involved in developing such a tool. Making a decision about whether an existing tool could be adapted would necessitate establishing the tool's purpose, who it was for, and mapping the content of existing tools against Standard 8 to identify gaps.

It was suggested that at this stage it might be preferable to audit a small number of nationally agreed indicators of good practice, which related to both the Every Child Matters agenda and the National Service Framework. Initially it was thought the priority may be looking at change management, perhaps starting with joint commissioning and joint training indicators.

6.   The Cost of Developing an Audit Tool

It is difficult to provide figures for the cost of developing an audit tool for Standard 8, because this will depend on the purpose of the tool, for example whether it is to be a simple checklist or a quality improvement tool, and on the extent of consultation

deemed appropriate. Costs will also vary depending on whether it is decided to extend an existing tool or to develop a new one; whether the proposed tool is to be made available online, in printed format or both; and the amount of support for users that is provided.

Very little information was available in the published literature on the resources needed to develop the audit tools listed in Appendix C. Although we enquired in interviews about development costs, the development of an audit tool had often been part of a wider programme of work and it was difficult to isolate the costs specific to the tool. The *Early Support Service Audit Tool* (Appendix C, number 3), for example, emerged from a two year programme of work which included funding to 45 pathfinder projects. The programme director estimated that the development of the tool itself might have cost around £150,000, with much of this spent on consultation, and gave a 'ballpark figure' of £250,000 to extend the tool from its focus on disabled children aged from birth to three to the full age range, including support materials and areas of Standard 8 not currently covered by the tool such as transition to adult services.

In Wales, the online *Self-Assessment Audit Tool* (Appendix C, number 4) was developed over a period of 18 months by a senior project manager employed by the National Public Health Service, and, as we have seen, covers the whole of the children's National Service Framework not just the standards for disabled children. Much of the first year was spent engaging with all stakeholders, dealing with differences between agencies and getting them on board, which was described as the most difficult but essential part. It then took just seven months to develop the tool itself: designing the software, training, piloting, making revisions, more testing and organizing feedback days. Development of the software was done by a small local company for the remarkably low figure of £20,000.

One tool focusing on child protection (Appendix C, number 10) had been developed in six months by one full-time worker, who described this timescale as 'very pressured' with little opportunity for real consultation. More commonly, tools were developed over a three or four year period, in a process of testing and refining early drafts. A consistent theme in many of the interviews was that quality improvement was an ongoing process and that tools needed to develop and adapt too. At the other end of the spectrum from a one-off checklist approach, one interviewee argued that the only way to improve quality in services for disabled children was to take a whole systems approach, developing integrated care pathways for different conditions plus a range of measures to audit progress at key ('sentinel') points along these pathways. Applying pathway thinking to Standard 8 and developing measures to use at sentinel points would, he argued, require £500,000 annually for ten years, involving a new improvement unit with lead investigator and several projects developing pathways and measures to evaluate their impact.

7. Relevant Developments

Work on this scoping study has identified other ongoing developments which need to inform work on an audit tool for the NSF standard for disabled children. The National

Minimum Dataset for Child Health Services[5] could provide useful data relevant to Standard 8, which would therefore not need to be included in an audit tool. Two seminar participants (David Widass and Sheila Davies) drew our attention to the potential this dataset could offer. They have undertaken an exercise looking at each section of Standard 8 and considering what information could be gathered by the Child Health Minimum Dataset and what would remain to be covered by an audit tool.

Chris Bush, another seminar participant, alerted us to a meeting hosted by the Council for Disabled Children on 9th May 2006, which he considered may be relevant. The purpose of the meeting was to develop an outcomes framework to support the improvement of better outcomes for disabled children in relation to the Every Child Matters agenda. The specific objectives of the meeting were to determine:

- What the five outcomes (being healthy, staying safe, enjoying and achieving, making a contribution, and achieving economic well being and quality of life) mean for disabled children, moving beyond broad statements to a specific understanding of how the outcomes apply to this group.
- How success is measured. What will it look like when better outcomes have improved for an individual child, when better outcomes have been achieved locally and when better outcomes have been achieved nationally? What will tell us that this is the case?

8.   Conclusions

In the interviews with key informants and the seminar for commissioners and service providers, the need for an audit tool to assess implementation of Standard 8 was overwhelmingly endorsed. There was consensus among both informants and seminar participants on a number of points, particularly that the tool should be for multi-agency use, and that it should achieve improvements in the quality of the services for disabled children and their families. The tool should therefore go beyond performance monitoring and be a quality improvement programme.

The study has identified the principles that should underpin the development of a good audit tool and the challenges that developers may face, which are summarised in the text boxes (8.1 and 8.2) on the following page. However, whether the tool is for performance monitoring or a quality improvement programme, some of the same principles for development apply including ensuring that users do not have scope for individual interpretation of the standards and rating scale.

Although we have provided illustrative examples of the resources used to develop some existing audit tools, it is difficult to be precise about costs because the tool's function will influence its structure, which in turn will affect cost. What this scoping study and report does provide is a good resource for the next stage in developing a tool to encourage implementation of Standard 8.

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[5] http://www.icservices.nhs.uk/datasets/pages/children.asp

The study has established that there is goodwill and enthusiasm among those working with disabled children and their families for taking this work forward and highlighted the issues that need to be considered. It has brought together a reference group of experts that might be invited to oversee and advise on future development work, and assembled a set of summaries of existing tools that provides a good starting point for such work.

As far as we are aware, there currently exists no one tool that covers the whole of Standard 8, but there is a wealth of experience on which to build, and considerable potential to extend existing tools such as the *Early Support Service Audit Tool* or to develop integrated care pathways along the lines of the *Integrated Multi-Agency Care Pathways for Children with Life-threatening and Life-limiting Conditions*.

Box 8.1: Principles of a good audit tool for Standard 8

- Owned by all stakeholders including senior managers
- For multi-agency use across all services
- Is evidence based
- Addresses all NSF Standards applicable to disabled children, those with complex health needs, and their families
- Flexibility to accommodate local situations
- Seen as an aid not a chore for the user
- Motivates learning and change
- Specific and measurable standards
- Clear indicators and examples of good practice
- Requirement to justify ratings
- Acknowledges current and emerging good practice
- Physically brings people together for completion
- Avoids duplication of information recording
- Addresses users' perspectives
- Explicit links with inspection and other frameworks
- Provides comparative data
- Support provided for users after development

Box 8.2: Challenges in developing an audit tool

- Defining the tool's purpose
- Including all disabilities covered by Standard 8 in one tool
- Balancing quantity and quality
- Ensuring users are rating reliably and accurately
- Where to set the bar for the standards
- Dealing with cross-agency rating discrepancies
- Getting people across departments/agencies in one place
- Lack of a common language
- Engaging service users
- Motivating use if optional
- Providing support after development phase

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Appendix A: List of interviewees

Francine Bates
Chief Executive, Contact a Family

Helen Chambers
Project Manager for Healthy Care Audit Tool, National Children's Bureau

Lizzie Chambers
Project Manager for Integrated Care Pathway developed by the Association for
Children with Life Threatening or Terminal Conditions (ACT)

Jean Christensen
Project Manager for the Self-Assessment Audit Tool, Welsh Assembly Government

John Ford
Director of Early Support Programme, DfES

Fiona Gale
Project Manager for the CAMHS Matrix

Eve Herd
Project Manager for Quality Assurance Tool developed by the Association of
Children's Hospices

Christine Lenehan
Chief Executive, Council for Disabled Children

Simon Lenton
Vice President of Royal College of Paediatrics and Child Health

Susan Lewis
Project Manager for Early Support Service Audit Tool

Alison Loftus-Hills
Project Manager for Self-Assessment Audit Tool for Child Protection for Clinical
Teams, Healthcare Commission

Tricia Sloper
Professor of Child Health, Social Policy Research Unit, University of York

Peter Smith
Advisor to the Department of Health

Appendix B: Invited seminar participants

Susan Aitkenhead	Nurse Advisor Child Health and Maternity	Department of Health
Chris Bush	Service Manager, Integrated Disabled Children's Service	Leicester Federation
Hilary Cass*	Director of PGME & Deputy Medical Director	Great Ormond Street Hospital
Rachel Cooke	Community Matron	Newham Primary Care Trust
Sheila Davies	Paediatrics Project Officer	Contact-a-Family
Christine Lenehan*	Chief Executive	Council for Disabled Children
Mary Lewis	Senior Children's Nurse & Research Associate	University of the West of England
Ann Mooney	Senior Research Officer	Thomas Coram Research Unit
Amy Nicholas	Deputy Branch Head, Child Health and Maternity	Department of Health
Jane Ryder Richardson	Principal Educational Psychologist	Essex County Council
Fiona Smith	Adviser in Children's and Young People's Nursing	Royal College of Nursing
June Statham	Reader in Education and Family Support	Thomas Coram Research Unit
Jacqueline Shurlock*	Disabled Children's Team Leader	Department for Education and Skills
Valerie Wigfall	Research Officer	Thomas Coram Research Unit
Mark Whiting	Consultant Nurse, Children with Complex Needs	Hertfordshire Partnership Trust
David Widdas	Consultant Nurse, Children with Complex Needs	North Warwickshire PCT South Warwickshire PCT Coventry PCT, Rugby PCT
Sandra Williams	Chief Research Officer, Child and Maternal Health, Sexual Health Research & Development	Department of Health

* Apologies sent

Appendix C: Audit tool summaries

1.   Let Me Be Me: Improvement Handbook (Audit Commission)

2.   Self-Assessment Audit Tool (SAAT) (Welsh Assembly)

3.   Early Support Service Audit Tool (DfES/DH)

4.   CAMHS Partnerships Self-Assessment Matrix (NCSS/HSCAS)

5.   Are We Getting it Right? (ACH)

6.   National Healthy Care Standard Audit tool (NCB)

7.   Learning Difficulties and Ethnicity Audit Tool (DH)

8.   Healthy Equity Audit (DH)

9.   Quality Protects Quality Self-Assessment Tool (DH)

10.   Self-Assessment tool for Child Protection for Clinical Teams (Healthcare Commission)

11.   Children's National Service Frameworks Audit Tool (GOS Hospital)

12.   Integrated Multi-Agency Care Pathways for Children with Life-threatening and Life-limiting Conditions (ACT)

13.   Valuing People: An Audit Tool for Social and Health Care Agencies (North West Training and Development Team based in Accrington)

14.   Taking Part Toolkit: Promoting the real participation of children and young people (Barnardo's)

AUDIT TOOL SUMMARY No.1

Publication details

Ref No:	ISBN 186240 459 3
Name:	**Let Me Be Me: An Improvement Handbook**
Author:	Audit Commission
Date:	2003 (April)
Copy from:	www.audit-commission.gov.uk/disabledchildren/handbook.asp
Cost:	£30

Type of Tool

Online/paper:	Handbook for improvement
Pages:	194
Focus:	Disabled children and their families
Topics/org	Four themes: 1. planning services to meet needs; 2. the workforce; 3. children grow and move on; 4.inclusion in everyday life. Each has a number of sub-themes organised under 6 sections which includes a self-evaluation checklist. Eg. Theme 1 has 5 sub-themes of which 1.1 (understanding the local population and their needs) has a 28 item checklist. 16 sub-themes in total. Handbook incorporates components of good QA system – evidence base (findings from their research) features of good practice; signposting to other resources and self-evaluation
Rating system:	√ (yes/no) checklist for each item under the 16 sub-themes
Purpose:	Review, develop and improve services
Audience:	Cross-agency – managers/staff in LA and NHS working with this group Providers and commissioners Each checklist indicates which groups it is most appropriate for

Development

Developers:	Audit Commission
Year:	2001-2002?
How:	Part of Audit Commission study on disabled children, which includes a national report and factsheets. Based on research with 240 including disabled children and parents + Interviews with 60 service managers in 5 localities in Eng and Wales Including wide range of services and agencies
Resources:	Unknown

Coverage	Would require mapping against NSF, but clearly covers many of the topics e.g. access, consultation, coordination and integration of care, transition to adulthood; staff development. Includes leisure, equipment, housing, transport.

AUDIT TOOL SUMMARY No.2

Publication details

Name: **National Service Framework for Children, Young People and Maternity Services in Wales: Self-Assessment Audit Tool (SAAT)**

Author: National Public Health Service for Welsh Assembly Government

Date: 2005

Copy from: Online Audit Tool but training site and guidance notes accessible: http://www.wales.nhs.uk/childrensnsftraining/
Briefing paper www.wales.nhs.uk/sites/documents/368/SAAT.doc

Type of Tool

Online/paper: Online and described as user friendly, which appears the case

Focus: Broad - all 7 chapters of NSF for Wales (Chapter 5 is disabled children)

Topics/org 21 standards with 203 key actions. For 5 (disabled children) there are 4 standards with a total of 37 key actions – number varies depending on standard. 4 standards are 1: child and family centred services; 2. access to services; 3. quality of services; 4. transitions.

Rating system: Key actions divided into core (for early delivery) and developmental (achievement over 10 year period) 1-6 point rating system with a descriptor for each rating for developmental actions and 1-3 (yes, no and partially met) for core actions. Requirement to provide qualitative evidence to justify ratings. Further guidance is provided to enable greater accuracy in scoring key actions – e.g. what a score of 6 would look like in practice
Organisations cannot enter data against key actions which are not relevant to them

Purpose: Review, planning, improvement, benchmarking at local and national level within and across agencies. Opportunity to share best practice.   Measure of process, not structure or outcomes

Audience: Multi-agency including NHS and LAs. Providers and commissioners.

Development

Developers: Welsh Assembly Government. Standards and key actions developed by 7 external working groups representing key stakeholders covered by NSF.

Year: 2003-2005

How: Steering group set up to advise f/t project manager. First year engaging stakeholders, 7 months developing tool itself including training, piloting in 6 LAs, more testing, feedback days. Software developed by small local firm.

Validation: External validation of data through existing inspection processes

Resources: Manager's salary, training and consultation costs plus £20K software development

Coverage Appears to cover most of Standard 8

Contact Jean Christensen, Project Manager, Welsh Assembly Government

AUDIT TOOL SUMMARY No. 3

Publication details

Ref No:	ESPP34
Name:	**Early Support Service Audit Tool** (part of Early Support Programme ESP)
Author:	DfES
Date:	2004
Copy from:	DfES or www.earlysupport.org.uk

Type of Tool

Online/paper: Paper

Pages: 136

Focus: Disabled children under 3 and their families

Topics/org: 26 standards with suggested indicators contributing to standard organised under 4 functional areas of service delivery identified as critical during development phase: a) Leadership, management and organisation of services; b) Referral, identification and initial assessment; c) Ongoing support; d) Providing and sharing information.

Rating system: 7 point rating scale N=not in place; I=emerging; P=partly in place; E and EO=established; F=fully in place and A=exceptional. Rating must be supported by evidence. Encourages move towards 'gold standard' while acknowledging and valuing emerging and improving practice.

Purpose: Multiple uses and flexibility. Adopts QA model – audit strengths and weaknesses against a set of standards, identify areas for improvement and develop action plan.

Audience: Broad – strategic and operational managers; practitioners. Multi-agency – health, social care and education. For individual agency or cross-agency use.

Development

Developers: DfES/DH

Year: 2003-2004

How: Evolved from the work of the DH/DfES guidance *Together from the Start* which concentrated on the needs of the 0-3 age group (because it in turn arose out of the working party set up to address the needs of this population). Informed by review of audit tools/approaches, literature and views of stakeholders (services and families). Extensive consultation and piloting in 45 pathfinder sites. Large study underway at Manchester University designed to evaluate impact, effectiveness and outcomes of ESP. www.earlysupport.org.uk/Default.aspx?tabid=89

Resources: Early Support Programme involves more than audit tool. £13m budget – comprehensive training and support network/services – dedicated team based at RNID with own website www.earlysupport.org.uk. Tool development estimated £150K.

Coverage Standards and exemplars of good practice extend beyond needs of children under 3, but although it will cover much of Standard 8 there are inevitably gaps because of the age range it was designed for (e.g. transition from children to adult services). Requires mapping exercise to identify these gaps.

Contact John Ford, ESP Director (on secondment from DfES) at RNID
John2.Ford@rnid.org.uk

AUDIT TOOL SUMMARY No. 4

Publication details

Name: **CAMHS Partnership Self-Assessment Matrix 2005-6**

Author: National CAMHS Support Service and Health and Social Care Advisory Service

Date: 2005

Copy from: www.camhs.org.uk

Type of Tool

Online/paper: Paper and online

Pages: 23 pages

Focus: Child and Adolescent Mental Health Services

Topics/org   10 standards each with a policy rationale, the indicators for the standard, and guidance as to what to look for as evidence of progress, though little guidance on scoring.

Rating system: Indicators rated on 4 point scale 0=not achieved; 1=Started working towards; 2=Good progress; 3= Achieved fully. No evidence required to justify rating. Maximum score for each standard entered onto a summary sheet and translated into an overall rating for that standard using the same 4 point rating scale eg. standard 1 'functioning and inclusive partnership' has 8 indicators and could achieve a maximum score of 24, which would be rated overall as '3 - achieved fully'

Purpose: Reviewing and evaluating progress in offering comprehensive CAMH Service

Audience: Local CAMHS Partnerships, but can also be used by Strategic Health Authorities (SHA), Social Services Inspectorate (SSI) and CAMHS Regional Development Workers to assess and plan services

Development

Developers: National CAMHS Implementation Lead (Bob Foster) and Regional Development Worker for East Midlands (Fiona Gale)

Year: 2003-2004

How: First matrix 2003-4 locally developed and then rolled out nationally. Second matrix 2005-6 developed against the NSF standards taking account of issues raised in national analysis of first matrix. Problems with: internal validity (Do users use same criteria to base their score? Does a score of 1 on any particular item mean the same across users?); 3 point traffic light system often insufficiently sensitive and leads to respondents making repeated use of the middle option. Greater consultation following refinement to first matrix which included 4 point rating system with more rigorous definitions for each point and more descriptors of the standards to reduce individual interpretation.

Resources: Regional staff time plus £20K for design and analysis of second matrix

Coverage   Elements of most of the 11 NSF standards covered though focus on Standard 9. Very little from Standard 8 though some of other standards and indicators would apply - would need mapping against Standard 8 and some obvious rephrasing as refers to children/young people with mental health problems.

Contact   Fiona Gale (Regional Development Worker for East Midlands CAMHS)

AUDIT TOOL SUMMARY No. 5

Publication details

Ref No:
Name: **Are We Getting it Right?**
Author: Association of Children's Hospices (ACH)
Date: 2004
Copy from: ACH Bristol www.childhospice.org.uk

Type of Tool

Online/paper: Paper
Pages: 70
Focus: QA tool for Children's hospices to assess quality of their service
Topics/org   6 themes: access; the child; the family; the staff; environment and communication under which are a set of questions to be answered with indicators/criteria as to what staff should be looking for. Eg. 1st question under 'the child' asks how successful staff are at recognising and respecting each child as an individual and one of the four criteria is 'each child receives personalised care'. Answers/ratings must be justified with evidence.
Rating system: 4 point scale from major strength (+ +) to significant weakness (- -)
Purpose: QA – audit strengths/weaknesses; identify areas for improvement; develop action plan.
Audience: Hospice staff, though multi-disciplinary

Development

Developers: ACH
Year: Project started in 2001
How: Consultation phase involving 26 hospices and 80 children plus parents and six healthcare professionals to establish what was considered good practice. Results informed structure and themes. Piloted in 6 hospices and revised. QA regional network established for support.
Resources: Cost over 4 years was £80K – one p/t development worker and a steering group of 6

Coverage   Covers palliative care only. This QA package is referenced in the DH publication 'Commissioning Children's and Young People's Palliative Care Services' as a useful resource. ACH also produced guidelines for good practice which are again referenced in the DH publication.

Contact   ACH Quality Assurance Project – Eve Herd eve@childhospice.org.uk
                     0117 989 7820

AUDIT TOOL SUMMARY No. 6

Publication details

Ref No:	ISBN 1 904787 41 X
Name:	**Healthy Care Audit Tool** (a part of the Healthy Care Programme)
Author:	National Children's Bureau
Date:	2005
Copy from:	http://www.ncb.org.uk/healthycare/pdfs/hcp_handbook.pdf

Type of Tool

Online/paper:	Paper
Pages:	25 (appendix to Healthy Care Programme Handbook – 70 pages)
Focus:	Health and well-being of looked after children and young people
Topics/org	The National Healthy Care Standard has 6 overarching 'standards' underneath which are a number of outcomes. Evidence is provided for the criteria/indicators for each outcome under the headings policy, partnership, participation and access.
Rating system:	None. Left to Partnerships to decide what are the areas needed for improvement/development, to prioritise and develop action plan (example of an action plan and guidance are provided in the handbook).
Purpose:	A QA cycle of continuous improvement. Provides a framework for Healthy Care Partnerships to assess their current position for delivery of healthy care outcomes in the context of the national outcomes for all children. It provides a framework to audit service provision within each entitlement and outcome considering policy, partnership, participation and practice.
Audience:	Healthy Care Partnerships – partners can be drawn from across health, education and social care

Development

Developers:	Helen Chambers led the project at NCB
Year:	2001-2004 (for the programme)
How:	A 3 stage project – details on the website. http://www.ncb.org.uk/projects/project_detail.asp?ProjectNo=241 Included literature review, mapping of practice and consultation with young people. Developing standard and piloting. Developing practice tool kits including the criteria for the standard, auditing and action planning. Same model as National Healthy School Programme (i.e. national and local support structure and accreditation process).
Resources:	Approximately £300K over 4-5 years

Coverage   It can be used to assess parts of NSF, but no easily identifiable correspondence to Standard 8

Contact: Helen Chambers who was the project director at NCB.

AUDIT TOOL SUMMARY No. 7

Publication details

Name:	**Learning Difficulties and Ethnicity: A framework for Action**
Author:	Department of Health (Valuing People Support Team)
Date:	2004
Copy from:	www.doh.gov.uk

Type of Tool

Online/paper:	Paper
Pages:	44 (Audit Tool)
Focus:	People with learning difficulties from minority ethnic groups
Topics/org	The Framework consists of a guidance booklet, audit tool and file of examples and resources. Audit Tool is in 3 parts: 1. How many within target group would expect in area and how many known about. 2. How many are using services. 3. How well are we doing. Parts 1 and 2 require users to count the number of people in different categories and along different dimensions (e.g. how many in each ethnic minority group are in mainstream schools, how many in special schools etc.) to complete 9 tables. The information is used to address a number of questions under 'what can we learn from these tables' (e.g. are some group over/under represented in particular services and why might this be?). Unlikely that the data needed is collated and easily accessible in a database – though not being able to fully complete the table and why is addressed. Part 3 contains 2 simple checklists – one for Partnership Boards and the other for any service. 4 descriptions of practice are provided under each statement/question (not standards) and users decide which applies to their service/board. No guidance as to what practice might look like so users may be interpreting options differently.
Rating system:	None. Checklist involves deciding which of the 4 options best applies, but 1 means not so good and 4 means good practice though this is not explicit.
Purpose:	To assess where they are and what they need to do to improve, though the tool fails to provide a clear 'picture' for users.
Audience:	Learning Disability Partnership Boards and for Part 3, any service

Development

Developers:	Framework prepared by Bridget Fisher and Sid Jeewa, Association for Real Change. Audit Tool developed by Professor Chris Hatton, Institute for Health, University of Lancaster
Year:	2003-4?
How:	Preparation of Framework involved steering group and reading groups – no other information
Resources:	No information

Coverage   Access, transitions, consultation, ethnicity

Contact: Valuing People Support Team, DH?

AUDIT TOOL SUMMARY No. 8

Publication details
Ref No:
Name: **Health Equity Audit: A Self-Assessment Tool**
Author: DH
Date: 2004
Copy from: www.doh.gov.uk

Type of Tool
Online/paper: Paper
Pages: 25
Focus: To facilitate and demonstrate service planning within a PCT
Topics/org   8 overarching statements with guidance points as to what to consider (framed as questions) under each. The statements are organised around the 6 steps of the audit cycles: 1. Agree partners and issues; 2. Equity profile: identify the gap: 3. Agree high impact local action to narrow the gap; 4. Agree priorities for action; 5. Secure changes in investment and local delivery; 6. Review progress and assess impact. Summary sheet for overview and action plans provided.
Rating system: The statements rated on a 3-point scale using a traffic light system (green, amber or red), with criteria under each rating.
Purpose: To provide evidence on health inequalities to inform decisions on investment, service planning, commissioning and delivery and to review impact on inequalities
Audience: PCT Board and PEC – should be completed collectively e.g. at a board meeting. Mandatory completion

Development
Developers: DH
Year: No information
How: "   "
Resources: "   "

NSF Coverage   Access

Further info: DH

AUDIT TOOL SUMMARY No. 9

Publication details
Name: **Quality Protects: Quality Self-Assessment Tool**
Author: DH
Date: Undated
Copy from: http://www.dfes.gov.uk/qualityprotects/

Type of Tool
Online/paper: Paper
Pages: 18
Focus: Children and Families Service in local authorities
Topics/org   A questionnaire organised around 8 headings. Under each heading a set of objectives and a series of questions against which to assess service and consider strengths and identify areas for development/improvement. For example, heading 1 - 'Services make a positive difference to children and families' has 5 objectives including 'improve health, education and well-being of children and young people' and 8 questions including 'do we set local objectives and performance measures for our service?'
Rating system: 4 point scale + DK response. A=yes, comprehensively and across the whole of our service; B= Yes, comprehensively but only across parts of our service; C=Patially, we are at an early stage of development; D=No, not at all. Users invited to record comments/actions on a page provided after the questions. No guidance provided as to how to interpret scale nor examples/indicators of practice to illustrate questions. Thus, what may be considered gold standard in one authority may be seen as minimal in another.
Purpose: Assessing effectiveness of the service - can be used at different levels (individual team level or children's services). Can use complete tool or focus on particular sections. Can be used for pre-inspection purposes, assist action planning, and/or compare systems used by different teams.
Audience: LA mangers of children and families services

Development
Developers: DH (no further information)
Year: No information
How: "   "
Resources: "   "

Coverage   Not very much, though culture of learning and continuous improvement and empowerment of children, young people, their parents and carers could map onto NSF staff development and consultation.

Contact: Kathleen Glazik, Quality Protects Co-ordinator 0207 972 4148

AUDIT TOOL SUMMARY No. 10

Publication details

Ref No:	ISBN 1-84562-004-6
Name:	**Self-Assessment Tool for Child Protection for Clinical Teams**
Author:	Commission for Healthcare Improvement (CHI)/Healthcare Commission (HCC)
Date:	2004
Copy from:	www.healthcarecommission.org.uk

Type of Tool

Online/paper:	Paper
Pages:	28
Focus:	All children and young people coming into contact with service including disabled children
Topics/org	11 statements to rate -1 statement each on child centred approach; a safe environment; policies and procedures; professional responsibilities and roles; education and training; clinical supervision and support; interagency working; record keeping; assessment; referrals; transfer of care/discharge. Examples of questions to ask when considering the rating for each statement are provided though not all may be applicable to every team/organisation using the tool. A comments box next to these questions invites users to record discussions, examples of good practice and areas where development is required. Instructions as to how to complete the tool and what to do next in terms of action planning.
Rating system:	6 point scale. Each statement given 2 ratings: 1) extent to which it is met (scarcely if at all; slightly; somewhat; substantially; strongly; fully) and 2) degree of influence to improve this situation (none to full). Generic descriptions for each part of the 2 scales are provided.
Purpose:	Identifying strengths and weaknesses of service in terms of child protection arrangements; reflect upon practice; plan for improvement
Audience:	Clinicians within health working or who may work/care for children e..g paediatric team, child development team; school nurses, health visitors, etc. Encouraged to complete as a team.

Development

Developers:	CHI/HCC
Year:	2003-2004
How:	Part of a programme of work on child protection. Commission for Health Improvement and based on pre-existing self-assessment tool. Advisory group (of 10), expert advisory group (of 13) and 13 healthcare organisations who nominated reps to attend workshops to provide feedback on drafts of the tool. National Public Health Service for Wales, the London Ambulance Service and trusts shared examples of child protection audits.
Resources:	6 months salary plus workshops, website development (approx £20K) and publication of documents.

Coverage   Child protection

Contact: Alison Loftus-Hills, Project Lead and Review Manager, 202 7448 9200

AUDIT TOOL SUMMARY No. 11

Publication details

Ref No:

Name: **Children's National Service Frameworks Audit Tool**

Author: Great Ormond Street Hospital, UCL, North Middx and Whittington

Date: 2004

Copy from: http://www.ich.ucl.ac.uk/cypph/cnsf_audit_tool.pdf

Type of Tool

Online/paper: Paper

Pages: 64

Focus: Standards for hospital services for all children and young people

Topics/org: 10 topic sections with between 5 to 15 benchmark headings (e.g. within section 2: 'child protection and safeguarding' there are 8 benchmarks one of which is 'disabled children (child protection & general issues)'. Evidence is provided as to what to consider when rating and criteria provided for each point of the scale. So with the same example again - evidence includes 'children with disabilities can access all areas – see access audit and under scoring 1 = the needs of disabled children and their families are not met and 5=staff and environment meet all the needs of disabled children and their families (including communication and protection needs). Users have to provide evidence to justify their score. Forms for action planning and review are provided as part of the tool.

Rating system: 5 point scale (1= not delivering or only at minimum standard and 5= delivering comprehensively to a high standard)

Purpose: Monitor and improve services for children. Referred to as a benchmarking process whereby best practice is identified and action plans developed to remedy poor practice

Audience: Teams working in hospitals within the NHS Trust

Development

Developers: NHS Trust

Year: 2004?

How: Little information although the benchmark standards were established using different sources of evidence including research evidence, national guidance and policies. The benchmark standards (though questionable as to whether these can be defined as standards) will be piloted and refined through 'a process of consensus agreement (how will they manage disagreement?) involving teams, patients and carers. This may have been done already.

Resources: No information

Coverage Standards 2, 3, 4 and 5 including safeguarding and access for disabled children; children and parents partners in care;

AUDIT TOOL SUMMARY No. 12

Publication details

Ref No:	ISBN: 1 898447 07 1
Name:	**Integrated Multi-Agency Care Pathways for Children with Life-Threatening and Life-Limiting Conditions**
Author:	Association for children with life-threatening or terminal conditions (ACT)
Date:	2004
Copy from:	www.act.org.uk

Type of Tool

Online/paper:	Paper
Pages:	32
Focus:	This document sets out to describe what an integrated care pathway is and provide guidance for the 5 standards identified as important for palliative care involving children. Guidance includes evidence supporting the importance of the standard and good practice guidelines. It is not an audit tool, since there is no system for assessing performance. It is described as a pathway because care is seen as a journey in this case with 3 stages or pathways – diagnosis; ongoing care; final stages – and integrated because its aim is to involve all services.
Topics/org	5 main standards and key goals relating to the standard. For example, a key goal for the second standard concerning planning for going home includes 'community services should be notified as soon as practical'.
Rating system:	None
Purpose:	ICPs are a framework for improving standards
Audience:	Focus on health-led care, but intended to involve all disciplines and agencies that come into contact with the child and therefore multi-agency

Development

Developers:	ACT (funded by DH)
Year:	2003-2004 (2 years)
How:	Set up a working party of 18 who established structure and content and developed working draft, which was given to an independent consultant to devise standards, revise and edit text and design the three pathway diagrams.
Resources:	£18K for development, but included a lot of unpaid work plus £14K for consultation etc.

Coverage   Palliative care in relation to Standard 8

Contact: ACT 0117 922 1556 (Lizzie Chambers – Acting Chief Executive at time and project coordinator)

Publication details

Name:	**Valuing People: An Audit Tool for Social and Health Care Agencies**
Author:	North West Training and Development Team[6]
Date:	2001?
Copy from:	www.nwtdt.u-net.com

Type of Tool

Online/paper: Paper

Pages: 17. This audit tool is part of a paper summarising the key tasks and activities for social and health care teams within the White Paper, Valuing People: A New Strategy for Learning Disability for The 21st Century published in 2001

Focus: Children and young people with learning disabilities

Topics/org: Structured around the objectives, targets and performance indicators of the White Paper (annex A pages 122-131). 11 objectives (or standards) sub-divided into components of the standard. Thus: Objective 1 = 'to ensue that disabled children gain maximum life chance benefits from educational opportunities, health care and social care….where their assessed needs are adequately met and reviewed' has 6 accompanying statements one of which is 1.3: 'increasing the number of disabled children in receipt of a range of family support services and the number of hours provided'.

Rating system: None. No instructions. Users note present position in relation to the objective, action required to maintain or to develop objective and dept/service responsible

Purpose: Audit of current practice, though there is no benchmarking so no means of assessing how well they are doing

Audience: Social and health care teams, but not specific

Development

Developers: Ali Gardner, Nick Morey and Martin Routledge, NWTDT

Year: 2001?

How: No information

Resources: "   "

Coverage   Some of the 11 key objective of the white paper cut across Standard 8 themes, e.g. Transition into adult life and need to ensure continuity of care and support; Consultation through advocacy and person-centred approach to planning services; Access to health, education, and leisure services; Workforce training and planning and Partnership Working

Contact: As above

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[6] The North West Training and Development Team is a small not for profit making training and development team jointly funded by local authorities, health commissioning agencies in the Northwest and national grants. Originally set up by the previous North Western Regional Health Authority, all Health Authorities and Social Service Departments currently provide funding for the NWTDT in the area covered by the NHS Executive.

Publication details

Ref No:	
Name:	**Taking Part Toolkit: Promoting the Real Participation of Children and Young People** (includes Participation Audit Tool)
Author:	Barnardo's
Date:	2002
Copy from:	Kall Kwik, Telephone: 0161 876 5111 Email: sales@kallkwiksq.com
Cost:	£27.00 plus £7.25 p+p

Type of Tool

Online/paper:	No copy. Information taken from summary
Pages:	The audit tool is part of the toolkit which consists of 4 separate docs 1. main report of literature review and results of consultation including signposting for practitioners of useful resources (important element of QA); 2. resource pack; 3. Participation standards covering 4 areas considered key in participation and 4. Participation audit tool.
Focus:	The participation of children/young people in services/agencies working with children/young people (disabled children too?)
Topics/org	Participation standards under 4 areas: establishing commitment; planning and development; ways of working; skills, knowledge and experience.
Rating system:	Developmental – recognises that organisations at different levels of participation and guide agencies through emerging, established or advanced levels. Each of the statements making up the standard must be evidenced so avoiding the 'tick box' approach.
Purpose:	Assessing how organization meets standards, but emphasis not on level reached, but what can be done for further development and promotion of participation within their organisation.
Audience:	For practitioners and young people

Development

Developers:	Polly Wright and Deena Haydon, Barnardo's
Year:	2002
How:	NW Children's Taskforce[7] commissioned Barnardo's to produce toolkit. Reviewed policy and literature about participations; mapping exercise of participation initiatives in 22 NW local authorities; focus groups with 29 young people to ascertain views on participation; produced report, resource pack, participation standards and audit tool. Employed 2 young people on the project.
Resources:	£15,000 for 5 months for development and £4,000 for 4 months for piloting and production

Coverage	Participation
Contact:	Polly Wright, Barnardos

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[7] A Department of Health initiative, which brings together representatives from both voluntary and statutory sectors (including health, education, social welfare and youth services). The Taskforce aimed to develop a participation resource combining the wealth of material produced in the past and providing a set of 'Participation Standards' relevant to all agencies working with children and young people.