

# Understanding benchmarking

RCN guidance for nursing staff working with children and young people

CLINICAL PROFESSIONAL RESOURCE



# Acknowledgements

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## Publication

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## Description

This Royal College of Nursing (RCN) document explains how benchmarking can support the development of best practice, and how you can develop benchmarks for your area of clinical practice. This guidance is aimed at nursing staff working with children and young people.

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# 1. Foreword

Nursing staff go to work every day determined that each patient or client will receive the best possible care. The health service runs on limited resources – public money which has to be intelligently used. There is little time and no justification for unnecessary repetition of effort in identifying and implementing what is best practice. It is vital to all – staff and patients – that professionals truly collaborate.

Clinical practice benchmarking is a quality improvement tool. It facilitates, structures and formalises how best practice is compared, shared and developed. It supports nurses in effectively meeting patients' needs. Involvement in clinical practice benchmarking and the opportunity to share good practice rewards those who are willing to share. It inspires nurses to make changes in practice, and reassures everyone that they are doing the best they can to develop and improve the quality of care.

**Professor Judith Ellis MBE**  
**Chief Executive, Royal College of Paediatrics and Child Health**

## 2. Introduction

This Royal College of Nursing (RCN) document explains how benchmarking can support the development of best practice, and how you can develop benchmarks for your area of clinical practice.

This publication is an updated version of the original guidance published in 2007 and updated in 2014. The model identified in the original version is as relevant today as it was then. The aim of this guidance is to increase understanding of benchmarking and to encourage each of us to get involved. The process of benchmarking relies on you to share evidence of best practice with your peers.

### 3. How benchmarking developed

The concept of benchmarking was adopted from industry, where it had been used as a structured approach to quality measurement and improving services since the late 1970s. This process was competitive, with businesses striving to meet or surpass the best performer.

Benchmarking was first introduced to the NHS at the launch of the Benchmarking Club, sponsored by the NHS Management Executive, in January 1991. The club focused on benchmarking organisational issues rather than clinical ones, covering issues such as reducing cancelled operations or the number of non-attenders in outpatient clinics.

The benchmarking theory is built upon performance comparison, gap identification, and changes in the management process. From a review of benchmarking literature it is easy to conclude that benchmarking:

- identifies strengths and weaknesses within organisations
- identifies the level of performance possible by looking at the performance of others, and how much improvement can be achieved
- promotes changes and delivers improvements in quality, productivity and efficiency
- helps to better satisfy the customers' need for quality, cost, product and service by establishing new standards and goals.

In a health care setting, patients and their families are our customers. It is vital that we engage, empower, and hear patients and carers at all times in order to place the quality of patient care, and patient safety, above all other aims.

## 4. Why benchmark clinical practice?

Within the last few years, examples of poor care within the statutory and non-statutory sector have hit the public domain. The events at Stafford Hospital exposed in the two Francis Inquiry reports (2010), plus those in other settings which have been the subject of similar reports, demonstrate what happens when things go wrong, when the interests of patients are not put first, and when their concerns are not listened to.

As nursing staff we need to ensure that we are taking every possible step to ensure that patients and their families receive consistently high standards of care. Clinical benchmarking remains a vital tool to ensure that recommendations in reports, such as the Berwick report (2013), are put into clinical practice.

Most take this responsibility extremely seriously, but getting it right relies on knowing about best practice. With the vast number of developments in health care, it can be difficult to find out about current optimum practice. Benchmarking remains an effective tool that can help.

This is especially important for health care professionals who work in small or highly specialised paediatric units, where they can become isolated from others or swallowed up in large district general hospitals.

Benchmarking can particularly help when it becomes difficult to further improve a ward or unit's services without looking beyond an individual organisation or trust.

The advantages of benchmarking include:

- providing a systematic approach to the assessment of practice
- promoting reflective practice
- providing an avenue for change in clinical practice
- ensuring pockets of innovative practice are not wasted
- reducing repetition of effort and resources
- reducing fragmentation/geographical variations in care
- providing evidence for additional resources
- facilitating multidisciplinary team building and networking
- providing a forum for open and shared learning
- being practitioner led, and giving a sense of ownership
- accelerating quality improvement
- improving the transition of patients across complex organisational care pathways
- contributing to the NMC revalidation process (NMC, 2015) in both reflection and CPD elements.

In 2010 the Care Quality Commission refreshed their *Essence of care* guidelines and it now contains 12 benchmarks. It aims to support quality improvement, by providing a set of established and refreshed benchmarks supporting front line care across multiple care settings at a local level.

Benchmarking influences both local clinical commissioning groups and specialist commissioners to ensure that they purchase quality services. It reassures them that there is a national quality benchmark in place to ensure equity of quality. NICE and SIGN have developed audit tools for a number of patient pathways; it is these tools that will be used to measure quality.

## 5. Clinical practice benchmarking explained

Benchmarking has been described as:

*“The practice of being humble enough to admit that someone else is better at something and being wise enough to try to learn how to match and even surpass them at it.”*

(International Benchmarking Clearinghouse, 1992)

Clinical benchmarking is a “systematic process in which current practice and care are compared to, and amended to attain, best practice and care” (DH, 2010b).

Benchmarking is a system that provides a structured approach for realistic and supportive practice development. It allows practitioners to identify and compare best practice.

Best practice is drawn from:

- available research – through literature searches and sharing articles and references
- practice examples – which practitioners bring to meetings for sharing and comparing, or that has been generated by children, young people and their families
- professional consensus – debated by practitioners at meetings.

Each benchmark acts as a standard against which:

- services and practices can be compared
- difficulties can be shared
- practical support and encouragement can be offered by peers in a clinical setting.

Benchmarking therefore provides a structured form of networking. Sharing and comparing best practice means nurses can avoid unnecessary repetition and use resources effectively for innovative ideas.

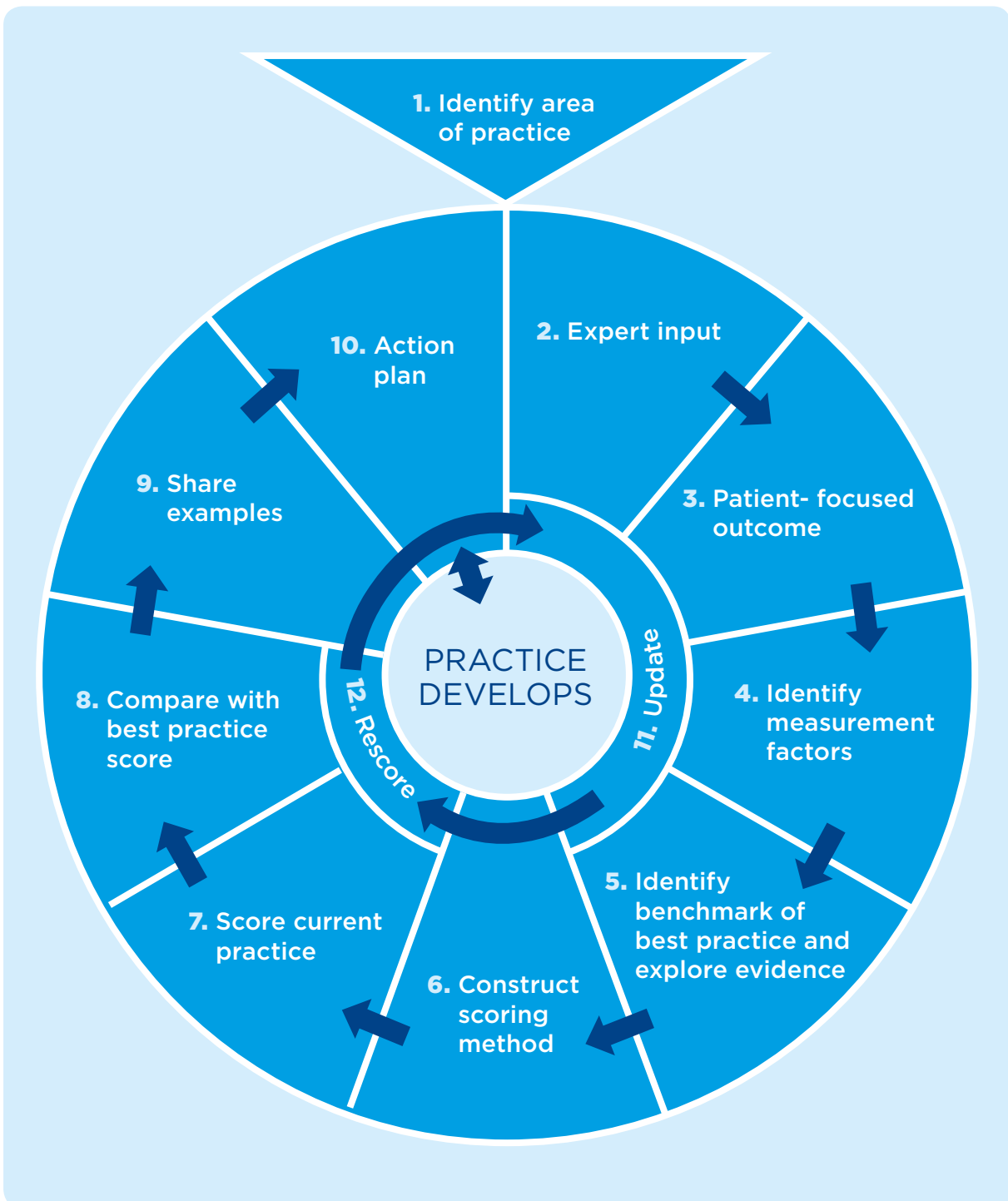
The emphasis of benchmarking must be to improve practice with essential information. Nurses can then develop practice through action planning and implementation.

Benchmarking is not just copying what others are doing. It involves understanding what the best organisations’ goals are and how they have achieved those goals through process and operational improvement, and taking that information back to your own organisation to determine how to achieve comparable results given your unique internal and external conditions.



## 6. A model of clinical practice benchmarking

### The benchmarking wheel



## 1. Identify area of practice

Which area of practice would you like to improve? Has there been any feedback – for example, national or local user groups, patient safety, risk management, NHS Litigation Authority (NHSLA), patient experience/patient journeys or effectiveness of care delivery – that needs addressing? Is there an area of good practice you would like to share with others? Have you and your colleagues developed an area of clinical practice and now want to push the boundaries further?

## 2. Expert input

The Francis, Keogh and Berwick reports all cover common themes: learning from patient experience; transparency in all we do; and involving children, young people and their families in quality improvement.

Other professionals to consider involving include:

- nursing team members
- staff with special interest or skills in the specific area
- specialist nurses
- consultant doctors and nurses
- pharmacists
- the directorate and local clinical governance team
- educational facilitators.

Are there any national guidelines such as NICE or SIGN? What current research or evidence-based practice is available?

## 3. Patient-focused outcome

Remember that clinical practice benchmarking aims to improve care. The outcome must reflect this. Look at local patient survey findings and national standards of best practice. Contact the Patient Advice and Liaison Service (PALS) or the local risk manager to provide information on relevant adverse risk incidents that can justify your choice.

## 4. Identify measurement factors

These are elements of practice that would support achieving a patient-focused outcome. Consider conducting an audit of current practice. Audits help to make a baseline assessment and measure any impact/improvement achieved by the changes in practice. Audits need to be organised carefully and must be meaningful, both to those that undertake them and those who receive the results. When planning the audit tool, identify how the data will be collected and by whom. You may consider a combination of nurses and a practice development nurse or nurse from another department to undertake the benchmarking. Contact the local clinical governance team for support.

## 5. Identify benchmark of best practice and explore evidence

What is best practice in the area of practice you have selected? Consider the available evidence. Investigate the standards and criteria that apply to your chosen area. The benchmark needs to reflect the best possible achievable practice by professional consensus (Ellis, 2000a&b).

## 6. Construct scoring method

Scoring of benchmarks is mandatory in all clinical areas. Construct a scoring method for each factor, from poor to best. Early benchmarking systems were scored on a numeric 1-10 scale, then an A to E scale. Some benchmarks are scored from red, through to green, and to gold. Red indicates that anywhere up to half of the standards have been achieved and gold indicates all have been achieved. Other benchmarks use a statement of best practice. It will be up to you to decide which works best for your organisation. Initially, you may find it reassuring to use benchmarks with a scoring method, so users can easily identify their progress. Time invested in your question selection and formulation is valuable. Ensure the questions are clear, fair, rigorous and are able to be scored. As confidence with benchmarking and the process increases, many organisations move to benchmarking against a best practice statement.

## 7. Score current practice

Assess where you are now against the factors in the scoring method, or against the best practice statement. Remember you will need evidence to support your 'score'. Asking patients to comment on care received when they are still dependent on the goodwill of staff who provide their care requires patient confidentiality to be maintained. The NMC Code (2015) states that nursing staff should respect people's right to confidentiality and ensure people are informed about how and why information is shared.

## 8. Compare with best practice score

Identify the area or organisation with the best practice. Obtain copies of their evidence, arrange a professional visit and discuss with practitioners.

## 9. Share examples

What is considered best practice by one area could be improved through the sharing of practices, document examples, policies and guidelines. Sometimes you don't know what you don't know. Any changes needed can be uncomfortable for some members of the nursing team. Some may question and resist your leadership and determination. It is important to identify people who can support you and help you to change the area of practice needed to achieve the benchmark.

## 10. Action plan

Plan what you are going to do now to improve your evidence and scores. Identify the training, education, communication and documentation which staff will need to implement on a daily basis to ensure they are meeting the benchmark. Arrange formal and informal information sharing sessions, develop display boards, hold team meetings and so on. The key is to network and ensure that the benchmark is met and everyone understands what is expected of them in order to obtain the best possible achievable practice. Set dates for reviews. A named, lead person must be responsible and act as the driver to maintain progress. The success of benchmarking in an organisation often rests with the determination and skills of this individual.

## 11. Update

Standards must be reviewed periodically if they are to remain valid and if the commitment of staff is to be secured. If you are using an existing benchmark, before scoring your area or organisation, make sure you are using a benchmark which is still valid and up to date. You can rewrite benchmark statements to reflect new evidence including new policies, procedures, directives and research.

At organisation/trust level, collation of benchmarking data ensures that areas of overall improvement and those with areas for improvement are identified and staff are supported to achieve optimum patient outcomes.

## 12. Rescore

Reassess your area/organisation to identify areas of improved practice and the progress that has been made. Highlight any new areas for development.

You can use the benchmarking wheel from page 8 to develop new benchmarks and/or review existing ones. If you are using an existing benchmark which has been recently reviewed, you can move straight from point 1 of the wheel to point 7. If you need to review evidence, refer to points 2, 3, 4 and 5 when you are updating at point 11.

Review benchmarks annually in the light of any new developments – remember the length of consultation involved in developing new policy. For example, you will find government green papers and NICE/SIGN guidance can alert you to new developments and research.

## 7. What makes clinical practice benchmarking work?

The process of benchmarking relies on you to share evidence of best practice with your peers.

Nurses who are passionate about improving nursing care, and who are committed to providing high quality evidence-based nursing, will find benchmarking a very effective way of engaging with colleagues. It will help you demonstrate changes in practice that make a positive impact and real difference for children and young people in your care.

One small change you make could create a great improvement for the next child, young person and family who comes into your organisation's care.

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