Shaping the Future for Primary Care Education & Training Project

Best Practice in Education and Training Strategies for Integrated Health and Social Care:

Development of a Benchmarking Tool

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The Project Context:

Introduction

Collaboration and partnership working between Higher Education and the NHS is an essential requirement for effective delivery of care (Universities UK 2003). The North West Universities Association (NWUA) and the North West Development Agency (NWDA) are two organisations at the forefront of creating such alliances. The research project, Shaping the Future for Primary Care Education and Training Project is a collaborative partnership between both these organisations and seven North West Higher Education Institutions. In addition, the project brings together for the first time all the key partners in the health, social care and education sectors who are involved in supporting the delivery of integrated health and social care in the North West Region.

These include:

- The North West Development Agency who are funding the project as part of their key target areas, i.e. Health;
- The North West Universities Association;
- Three North West Strategic Health Authorities;
- Primary Care Trusts;
- Social Services;
- Higher Education Institutions and Further Education Colleges.

The project has a project management and development team and a participative Steering Group, which it is anticipated will be the precursor to a close regional partnership intended to create real synergies at a regional level. For ease of implementation the project has been divided into a series of Work Packages, based on the key objectives, each led by one of the partner Higher Education Institutions.

Aim and objectives

The main aim of the project is to identify the evidence base for delivery of integrated health and social care; the skills and knowledge required to deliver this care, together with the current and future education and training needs of the North West of England Primary Care Workforce.

The key objectives of the project are:

- To provide a comprehensive systematic review of the evidence base for integrated health and social care services within the regional, international and national contexts;

- To develop a Benchmarking Tool for achieving best practice in collaborative working and delivery of integrated health and social care;
- To develop a course finder tool and map the Higher Education/Further Education provision of education and training which can support the delivery of integrated health and social care services;
- To identify visions for the future, for both the health and social care workforce and service users, on education and training requirements needed to deliver integrated services;
- To develop and pilot an Education and Training Needs Analysis Model (ETNA) for identifying the education and training needs of the primary care workforce to meet the NHS and social care agendas.

Conclusion

Ensuring that the health and social care workforce is educated and trained to meet changing community needs is essential for current and future delivery of services. This project is an opportunity for a number of key stakeholders in health, social care and education to collaborate in a new and unique way to address this, both directly through the project outcomes and indirectly through creating communities of learning across the North West Region.

Chapter 1:
Developing the Benchmarking Tool

1.0 Introduction

Benchmarking best practice is not a new concept. Ellis (1995) purports that benchmarking originated from industry and was introduced into the NHS as a quality initiative through Clinical Governance structures. Since this time, Benchmarking has been viewed as a means of evaluating services against best practice. Ellis (1995) also describes benchmarking as a technique which involves achieving consensus of what constitutes 'best' practice. This then enables individual practices to be compared and highlights areas for further development. Similar to audit, benchmarking is an ongoing process which can positively influence practice development. As suggested, benchmarking is especially valuable as promoting external focus and the ability to share practice.

Benchmarking is not unique to the UK, for example, in a study of best practices in the US, benchmarking was used to develop a quality improvement programme (Mitchell, 1996). The findings from this study suggest that benchmarking can help improve process performance and save time, money and energy through good communication associated with benchmarking. In addition, benchmarking can provide a structured approach to practice improvement (Ellis, 2000) and support the development of clinical practice. Since its introduction into the NHS, benchmarking has been used favourably in a range of clinical settings and organisations, for example, wound care in A&E (Burton, 2004), Emergency departments in the USA (Burstin *et al,* 1999) and perhaps most noticeable, The Essence of Care (Department of Health, 2001).

As an organisation, the NHS is now required to benchmark quality care through use of a range of benchmarks techniques. Although most noticeable in nursing, other professional groups are beginning to value benchmarking (John *et al,* 2005). In addition, at a strategic level, benchmarking has been used widely and continues to help to develop quality service delivery and care. Benchmarking now sits at the heart of the NHS clinical governance agenda and is set to continue to help the NHS improve care and service delivery for both patients and staff.

Against this background, the Shaping the Future Project developed a benchmark tool based on six key themes identified through a systematic review (Howarth *et al,* 2004). The benchmark is designed to be used in Primary Care settings by key stakeholders within education and training and as such could offer valuable insight into the organisational services and care delivery.

1.1 Benchmarking Tool Development Group

A Benchmarking Tool Development Group was set up in January 2003 with representation from a number of the overall project key stakeholders, in this case Primary Care Trusts (PCTs), Social Services and Higher Education. The primary objective for this group was to:

- To develop a benchmarking tool for achieving best practice in education and training to deliver integrated health and social care.

A series of meetings were held in 2004-2005, with an initial workshop to establish the overarching framework for the tool development and agree the benchmarking statements. The model used for the Essence of Care Benchmarking Tool (Department of Health, 2001) was found to be particularly valuable, in particular the use of a continuum from *worst practice* to *best practice*. The developing findings from the other Work Packages in the overall Shaping the Future Project also contributed to the development of the final tool.

1.2 Benchmark Tool Development

The tool has been designed to encourage the systematic evaluation of current services offered in the organisation to support those practitioners working with integrated services in primary care. The aim of the benchmarking process is to empower organisations to score and measure current education and training provision against evidence based domain benchmarks. There are six domain benchmarks which prompt questions about education and training services in relation to integrated care. Each domain is described and a range of key indicators are included to help the organisation describe the provision. In addition, a range of suggested evidence is provided which can be used to help the organisation identify indicators of achievement. The scores from each domain benchmark are accumulated to achieve an overall organisational score.

1.3 Benchmark Structure

The benchmark has been structured to promote ease of use. In an attempt to make the benchmark 'user friendly', clear instructions including a description of the benchmark process and flow chart have been used. There are five distinct sections which guide the user through the rationale and use of the benchmark tool. Each section describes the content and/or provides examples. (See Howarth, Holland, Hardiker & Lunt, 2006: A Benchmarking Tool)

Chapter 2:
Evaluation of the Benchmarking Tool

2.0 Introduction

The importance of evaluation and evaluating new innovations, in this case a benchmarking tool, cannot be overemphasised (Robson, 1993). This evaluation has enabled the project team to identify the strengths, weaknesses and applicability of the benchmark. Specifically, the evaluation took account of the face and content validity, applicability, relevance and utility of the benchmark tool, following which, amendments were made as necessary. The benchmark tool has been evaluated with those who have been involved in its development and with PCT staff. In addition, the tool has also been reviewed within the Shaping the Future Project management and Steering groups, as these represent a wide range of professionals involved in the delivery and organisation of education for Primary Care, Further Education and Higher Education.
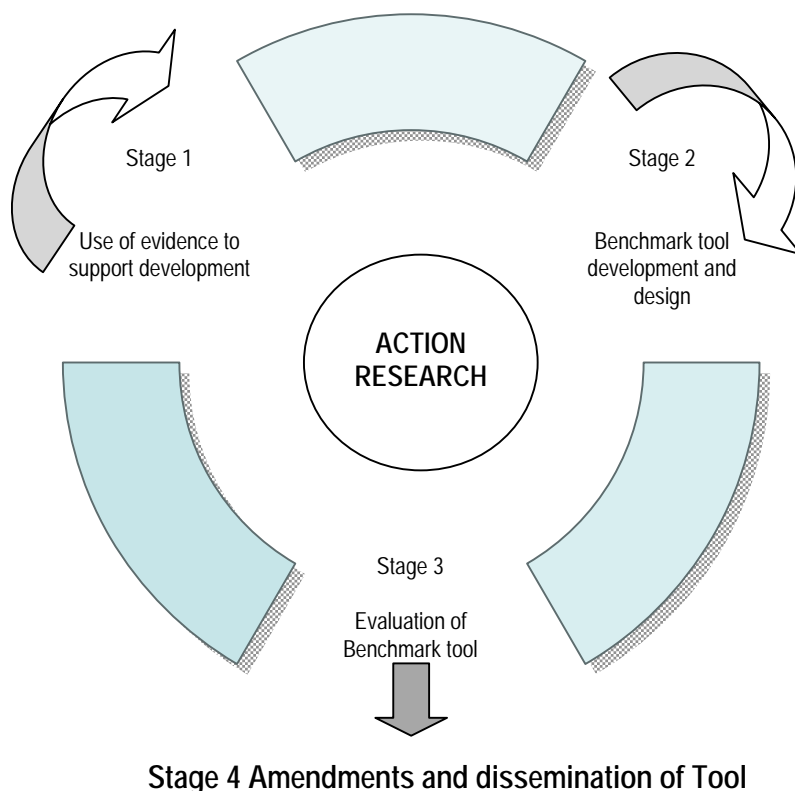
2.1 Methodology

To ensure that the research was done *with* rather than *on* the organisation, an action research approach was used. This is an empowering approach with two main foci. The first is to instigate change within an organisation or community and the second is to enhance understanding of the chosen topic area (Hart 1998). The vehicle for change is learning and participation. This was complemented by a case study design which allows the cases, in this instance, the Primary Care Trusts, to be described in full. This provides insight into the potential transferability of the findings and highlights how the benchmark tool was piloted within the context of the participating organisations.

Each stage was carried out with the involvement and participation of those involved in the project. Using an action research approach provided key stakeholders, users and carers with ongoing findings and recommendations from the focus groups and key stakeholder events. The central tenet of an action research approach dictates a cyclical process of exploration, dissemination and review which then runs throughout the project (see flow diagram). This ensures that all the research participants are involved and interim findings disseminated. In particular, action research is most suitable this type of evaluation as it allows an opportunity to use a variety of data collection tools which can provide a complete picture of the phenomena under study, in this case, the benchmarking tool. Feedback of findings will provide opportunity for reflection on the benchmarking tool and its potential applicability.

To facilitate the cyclical approach of action research, the project was divided into four stages. Each stage was designed to ensure that the benchmark incorporated evidence from the systematic review and participants/ organisations involved in the development process (see Figure 1 below).

The first stage explored the evidence base, user perspectives and context of benchmarking. The second stage focused on the actual design of the benchmark tool, based on the thematic evidence identified in the systematic review and user perspectives. The third stage of the project evaluated the benchmark tool through semi-structured focus group interviews with key stakeholders. All three stages informed the fourth stage which provides recommendations and has made amendments to the tool based on the evidence from the focus groups. The final amended tool is now available for use within primary care.

Figure 1: Flow Diagram of the Four Stages

Stage 1

Use of evidence to support development

Stage 2

Benchmark tool development and design

ACTION RESEARCH

Stage 3

Evaluation of Benchmark tool

Stage 4 Amendments and dissemination of Tool

2.2 Sample

A purposeful sample was used to generate the data. As Morse (1991) advocates, participants should be selected who have a broad general knowledge of the topic area whose experiences are considered to be 'typical'. Our sample reflected these principles and participants were drawn from education and training departments in two Primary Care Organisations in the North West. Both organisations have a vested interest in developing practitioners to deliver integrated services. In total 14 people attended two focus groups. The participants worked at a strategic level within training and education in the PCTs. All were experienced staff who were keen to develop education and training in order to to prepare practitioners for work within integrated services. In addition, another sample was drawn from the PCET Steering group and Work Package Leads to establish the face and content validity of the tool.

2.3 Data Collection

The applicability of the benchmark tool was ascertained through focus group meetings with two PCT organisations. The data collection methods used was based on Kreuger (1998) framework for undertaking focus groups. The focus groups were tape-recorded and transcribed. Two interviewers attended the focus group. Detailed notes were taken about emerging key concepts which were then used to stimulate further discussion. Both interviewers read the transcripts independently and the key analyses were given back to the participants for comment. This allowed for full and in-depth exploration of the usefulness, validity and applicability of the tool.

2.4 Data Analysis

Kreuger's (1998) framework for focus groups was also used to analyse the data. The 'systematic analysis process' as described by Kreuger advocates that the analysis starts during the focus groups followed by continued analysis after the interviews and then later with the next focus group. This allowed for the key concepts raised from focus group one to be explored and discussed in focus group two. A thematic analysis of the taped focus groups was used to identify emerging commonalties between the groups about the strengths, concerns and the utility, applicability and relevance of the benchmark tool for practice. Common suggestions made through the focus group meetings were discussed and added to the Benchmark tool where applicable. To enhance the credibility of the findings, the analysis was returned to the participants for verification through 'member checking'. Credibility and confirmability of the interpretations were enhanced by returning the analysed focus group transcripts to the participants for verification (Lincoln and Guba, 1998).

2.5 Limitations

The main limitation of this evaluation was that the amended tool was not evaluated. The aims of this study were to pilot the draft benchmark tool and make suggested amendments where appropriate. Whilst the remit allowed opportunity to explore the applicability, relevance and usefulness of the tool, further research is needed following the implementation of the tool to ascertain its effectiveness in promoting education and training to support integrated working.

The transferability of the benchmark tool to other settings may be limited due to the small sample size. That said, however, the sample used in this evaluation was varied and represented the key stakeholders involved in primary care, higher education, social care and further education. Readers should be cognisant of the need to examine their own organisation prior to introducing this benchmark tool into their practice.

Chapter 3:
Findings

Five themes emerged out of the analysis. These were; purpose of the tool; the language used; responsibility for completion, adaptability of the tool and implementation. Commonalities identified in the two focus groups have helped to generate the themes. Participant details have been numbered to maintain confidentiality. Details about the participating organisation have been not been included. The different focus groups have been labelled as FG 1 or FG 2 followed by the participant number e.g. FG1: 2:

3.0 Format/Purpose of the tool

Generally, participants in both focus groups felt that the tool lacked clarity but that this could be enhanced by redesigning the format. For example, the way in which the tool is presented visually was thought to be an important factor. Some suggested that clearer instructions for use should be presented at the start of the tool:

> **FG1 1**: *"I mean just flicking through it then, it does seem quite complex erm and I don't think that there is clarity and I'm not sure that it's as user friendly as it could be erm – I'm not sure whether I had several pieces of paper that were the same erm or is it simply some repetition."*

Others also suggested that although the tool seemed quite complex, the flow chart was a useful 'visual aid'. Similar comments were made by participants in FG2 who suggested that an executive summary may also be a "useful guide for users."

> **FG2 2**: *"I liked the flowchart sort of a visual aid always helps me, so I think from breaking down into steps in a process – that was really good .... I think once you start to work through it and when you look again that actually becomes clear – so I actually thought erm that the tool was quite clear in terms of following a process."*

> **FG2 3**:, *"You could really do with an executive summary in the first page selling its flexibility, value and how it can improve performance".*

The need to breakdown the tool into sections was a suggestion highlighted in both groups. The participants felt that this would promote a degree of flexibility so that the tool could be completed over time. Given the busy schedules of those who may complete this tool, breaking the tool into sections meant that they would be able to focus on certain sections and then return at a later date to other sections.

FG1 2: *"I think that it is extremely clear and that if I had to use something like this that is broken down into domains then you could do one and perhaps if you haven't got time to finish the other you could come back to it at a later date."*

FG2 3: *"Most Benchmarking tools you have to use it as it says but the fact that this is flexible needs to be sold so that it will add value – you could just concentrate on one section – a quick and dirty way to show where the organisation stands in a particular section."*

FG1 4: *"Maybe it looks like a lot of paper and it looks quite wordy and complex at first look, but I agree, I think that it is broken down and I like that, you know, break it down into sections or domains."*

In relation to enhancing the purpose and, therefore, the clarity of the tool, two participants suggested that the organisational score be relocated to the front of the tool so that practitioners completing it would be able to ascertain the end product. Similarly, the participants also thought that it would be advantageous to place the level indicator scores on the same page as the evidence types. This, they suggested could help increase the user friendliness and provide a visual score for each section.

FG1 1: *"I'd actually like to see the score down the side of the page – because I would want to know as I was going along what level I thought I was at and its no good doing it at the end [scoring] you need to be doing it as you are going along."*

FG2 2: *"It may be more useful [to have the overall organisational score] at the beginning to help people with their perspective having the answer to the query at the beginning and then they work through how they get their answer for their organisation maybe."*

In both focus groups there was some discussion about the layout and design of the tool and whether an electronic version would help to simplify the process and aid access. There was some divergence noted, however, between the groups. Whilst FG 1 was quite clear about the need for electronic version, FG2 suggested that a paper and electronic version should be offered. This would provide the user with a choice depending on his or her personal preference and may help with the uptake and use of the tool.

FG1 1: *"You know how I would like to see this as an electronic decision tree……if I could see this as a decision tree like I can with the national patients safety agency decision tree around critical incident, this [tool] would be so much easier".*

FG2 3: *"An electronic and paper version of this would also be useful – some people would prefer a paper version."*

3.1 Use of a Common Language

A consensus was palpable in both groups about the language used in the tool. Given the purpose of the tool and the need for a range of people to be able to use it, the participants felt that the language was too health focussed. In particular, the social care perspective was notably absent from the tool. This, they felt would impede the uptake and utility of the tool as some users may struggle to understand the language and relevance of the

statements. It was agreed that a 'common language' should be used where possible in the tool to enable a range of different audiences to use it effectively. This concern was an overwhelming consensus between both groups, with many participants providing examples and making suggestions about the use of language.

> *FG1 4:* "*I think that the other point about language is…….. I do think you need to make the language very clear bearing in mind the different audiences…….. if they don't understand the language they are likely to put it in the top shelf so you do need to make the language clear to your average person I think that would be better.*"

> *FG2 3:* "*There is a lot of social care evidence that is missing, you need to put the social perspective in rather than health - maybe do a readability test on it so that there is a common language that everyone can understand*".

> *FG1 5:* "*Under the suggested examples of evidence you need to be careful of the use of language in terms of turning off non-NHS, non-PCT staff. The examples that are given about exact points of reference are all to do with health, whereas actually there are equally things in social care that are relevant to this.*"

3.2 Responsibility

Concerns were raised in both focus groups about responsibility for completing the benchmark tool. Participants generally agreed that guidance as to who should complete the tool was essential. Whilst some participants appreciated the flow chart used to outline the benchmark process, others wanted further written user guidance as to who should complete the benchmark, when and how often. All the participants believed that enhancing the format would help clarify the purpose and importance of the tool, however, there was some ambiguity between the participants about who should take responsibility for completing the tool and whether a number of people should help coordinated by a central person. It was suggested that whoever completed the tool may come armed with pre-existing assumptions about the organisation which may deter from an accurate assessment. Others argued that given the size and complexity of the document, a number of different departments could become involved and take responsibility for the appropriate section.

> *FG1 2:* "*Who would actually be using it or would they just know who you would give sections to or would somebody take responsibility for it and then inform service areas that they take overall responsibility and so some of the comments…… I would like to see really clear guidelines to say who you would involve, for example ….. you may like to involve others such as service users and practitioners who may help provide some of the evidence needed to complete the benchmark – well to me it would I would ask who do we need to involve, because if we are going to be benchmarking we need to make sure that the we are working within a clear protocol.*"

Some participants raised questions about who would follow the tool through – and whether in areas of joint strategic planning, someone would take responsibility for its completion on behalf of other departments.

> *FG1 2*: *"Who would be completing this and following it through – would it be a more direct level or would it be more middle managers they might come up with very different answers depending on what level it was filled in at – I think that you need to come up with some clearer guidance about who will complete the tool."*

> *FG2 2:* *"Or would it be different representatives from different parts of the organisation cause then you'd be getting a very holistic approach to how education was seen within that one organisation?"*

Some participants suggested that the tool needed to be completed through a partnership arrangement. This would ensure that the score reflected an accurate picture of organisational capability. Questions were then raised about whether the benchmarking would be undertaken by internal or external bodies. Two participants felt that an external assessor similar to that of the Improving Working Lives (IWL) validation, would be best suited to undertake the benchmarking:

> *FG2 1*: *"It's almost like the IWL validation – that you actually do the self assessment and then you have somebody come in and just validate it and say yes we agree with this point or not – maybe that should be the local health community."*

> *FG2 4*: *"I don't think that it would be something we could do within the local health community. I also think that it may be useful if there were outside assessors who used the standards."*

Others thought that the process should be managed internally, providing time for the organisation to reflect on areas for development and make strategic plans to remedy any identified limitations. In addition, it was felt that outside agency assessment may prove problematic given the lack of an insider (emic) perspective about the particular organisation.

> *FG2 3:* *"I saw it more of across different organisations because – it [the tool] talks a lot about partnership organisations – so I would see it being a collaborative thing between the local health community and health and social care community that might be quite tricky – I think we could relatively easily do it for our individual organisations but to suss out where different organisations are may be a bit tricky".*

3.3 Adaptability and Interpretation of the Tool

The adaptability and subsequent interpretation of the tool to be used across a range of organisations and departments was ardently discussed within both focus groups. In one sense, problems related to objectifying a subjective and changeable phenomenon, such as NHS services seemed to be at the crux of the participants concerns. The disparity and subsequent divergence in interpretation raised concerns. The practicalities of integration itself remain problematic. In both focus groups, remarks were made about the disparity between different departments and agencies and the pessimistic impact this would have on the completion of the benchmark tool. The participants believed that the disparity would be problematic when attempting to complete the tool.

> *FG2 5: "This is one of the woolly areas though for us – we would send it around the HR and certainly within the PCTs at the moment, but now HR are quite removed and since they have moved over to the ******** and there is a lot of work going on behind the scenes".*

Given the tools purpose, however, the participants also realised that this could help to resolve some of these issues and provide some guidance to support future development. However, some participants suggested that the tool should itself be standardised so that it could be used across other organisations.

> *FG2 4: "It would need to be standardised so that one organisation didn't use it in a different way to another organisation because then it would actually skew what you are trying to achieve from it so I guess I was coming from it at a slightly different angle, but we need to be really clear about – for me, I need really clear guidelines".*

> *FG1 1: "I think that one of the dangers with this is that it reminds me of Department of Health policy – 'It's a local implementation and interpretation' and I would actually suggest that you do need to do what the modernisation agency have done and make a toolkit which is nationally applicable and not open to local interpretation".*

> *FG1 2: "I sort of put myself in a quiet place because I wanted to sort of get my head around it and, for me, I had a number of questions that I think became answered – but I went through it and I had to concentrate initially and I was thinking do we use this organisation wide or could we use it for maybe a service that is looking towards moving towards integration so, therefore, how adaptable is the tool?"*

Others argued that this would reduce the flexibility of the tool suggesting that the adaptability of the tool was important. The subjectivity of the scoring and suggested types of evidence led to some discussion about the interpretation of the benchmark tool. Similar concerns were echoed in both focus groups which indicated that the actual scoring may prove problematic depending on how they were interpreted within the organisation. In this instance, organisational culture may influence the way in which the tool was used:

> *FG2 4: "It depends on the organisation – we are a shared service and a shared training team across 2 PCTs so would a joint education training strategy do it would our department do it on our behalf?"*

> *FG1 5: "I suppose it's different cause when you've got the different key indicators and the suggested examples of evidence ………. That's when the subjective comes in because some people will think that actually they will have to give 3 or 4 examples of evidence to meet a key indicator – others will use the bare minimum in order to meet a key indicator".*

> *FG2 2: "Its making the scoring clear, robust and equal because it would be quite easy to find the evidence – but we could all find the evidence to suit the results that we would desire to have – but its about making sure that the evidence has had a wider audience and its true and genuine."*

Participants in both focus groups suggested that some types of evidence may need to be weighted. Similar to that of National Vocational Qualification (NVQ) documentation and assessment, the participants felt that some aspects should be mandatory and some optional. This would enhance the applicability of the tool and provide more accurate data for the organisation. It could also help to objectify the benchmark and make it more meaningful to the user.

> **FG1 4:** *"The evidence for example 2.1 are all of equal value, but I think that some more important than others – so if you look at it from an NVQ point of view, some of these may be mandatory – and some optional".*

3.4 Implementation

Amongst the groups, the most frequently debated issues were that of the implementation process. All the participants believed that a well thought out implementation strategy needed to be considered before any attempt was made to introduce the benchmark tool into practice. This also included the need for training on the correct use of the tool.

In addition, duplication of work was a key concern for the participants who felt that staff are 'battle weary' and anything that could help to the complete the tool, save time and ensure that it wasn't just another paper exercise. All the participants felt that an emphasis should be placed on how the tool could help with the completion of other documents, audits and assessments. The participants suggested that the way in which the tool was 'sold' and that the level of ownership was an important factor which would influence its successful implementation.

> **FG1 1:** *"The messages that I'm getting very clearly from different groups of staff ……is how battle weary they are with this kind of work."*

> **FG1 1**: *"We have a substantial amount of our own internal procedures and policies to take account of in terms of integration and that's pretty needed – but that [the tool] is a substantial piece of work across health and social care and this[the tool] will support some of that."*

A concern both groups had was the need to avoid duplication of work. To avoid this, the participants suggested that the benchmark tool should tool dovetail with other similar benchmarks so that the same evidence could be collected. In addition, two participants argued that the benchmarking tool could act as a form of evidence to support other benchmarking processes.

> **FG2 1**: *"I think that there is something about the context and it fitting into what we are already doing that seems to come from no-where because I have read all of this beforehand – I think I was coming at it from a different angle and maybe I saw it differently."*

> *FG1 1:* "*I'm tying to make some linkages about how those things hang together and they do but I'm not sure that some of this doesn't duplicate some things that we are doing in other areas and actually some of it [tool] fills gaps in other areas that we haven't thought about which is very positive*".

The need for training to help implement the tool was a repeated suggestion in both groups. Although some believed the tool to be well structured, nearly all the focus group participants argued that it was difficult to read and 'wordy' and that some type of training would help people to understand the purpose and importance of the tool.

> *FG1 1*: "*I would want a 2 day event to make sure that the message is clear, that the objectives of what we are setting out to do are clear and that people are clear about what they need to do. …….. especially if the end result is potentially a need for change as the inference and the impact of that benchmarking tool on practice and service delivery across both organisations is massive and wouldn't want that done in a piecemeal way – I would want that done in a co-ordinated, timely consistent way with people who are well trained and well educated and understand the tool well and know what they are going to do.*"

> *FG2 3:* "*I wondered whether it would be a tool that could be used with some training and explanation so that we would be able to ask questions, because on its own it takes a lot of getting to grips with what it is all about*".

> *FG2 3*: "*I think just perhaps a bit more behind it – because it does assume a certain amount of understanding so, therefore, that is what made me think about whether it was intended to have some sort of training or have some minimal training with someone who could explain what this was all about as I think once its in use and you're familiar with it – it's a bit scary*".

The focus groups revealed a number of areas which required amendments. This insight provided a range of recommendations which have been integrated into the benchmark tool. In addition, piloting the benchmark has allowed an opportunity to explore how new initiatives could be implemented into service from the users perspective. These findings and following recommendations may, therefore, be transferred to a wider population of similar characteristics.

Chapter 4:
Discussion & Recommendations

4.0 Introduction

A number of recommendations have been drawn from this study. These are based on the participants' comments and reflect contemporary literature. It is acknowledged that standards and guidance in health and social care are needed to warrant quality services (NHS Wales, 2004); however, the introduction or change of any new standard or benchmark invariably needs careful consideration. It is suggested that change disrupts the homeostasis of current ways of working (Casson *et al,* 2005) and as such may induce a perceived threat (Lorenzi, 2000). To create a shared vision, stakeholders need to be able to understand the benchmark tool and participate fully in its implementation. The vision must be communicated, described and above all stakeholders need to energise commitment (European Health Management Association (EHMA), 2005). Therefore, the implementation of any organisational change necessitates that those involved within the service are consulted. Even the implementation of this benchmarking tool will have, for some, connotations about the impact of the tool and apprehension about current education and training services.

Benchmarks enable comparisons to be made across a range of services, normally through the use of standards (Malcolm *et al,* 1999). In essence, benchmarking *guides* the user towards developing best practice, however, the evidence base on strategies used to implement benchmarks is limited. To address this deficit and provide insight to support implementation, parallels have been drawn between the implementation of guidelines and benchmarking. Both are recognised as potential tools to promote effectiveness and positively impact on service delivery.

The development of this tool through consultation has empowered key stakeholders with a sense of ownership. Similar strategies to promote the implementation of a new policy through ownership were reported by Rees *et al* (2004). In an attempt to implement an integrated care pathway in mental health, Rees *et al* note that local ownership and flexibility were essential to the success of pathways. In addition, the need for the pathway to be flexible and adoptable to the local population was highlighted as a contributing factor to the successful implementation process. Moreover, Silagy *et al* (2002) suggest that achieving local ownership and relevance or clinical practice guidelines is likely to improve their uptake. When parallels between Rees *et al* (2004) and Silagy *et al* (2002) work with our benchmarking study are drawn, it becomes evident that ensuring the successful use of the benchmarking tool, indicates the needs for local ownership and adaptability to be premeditated.

4.1 Transparency, Flexibility and Utility

Malcolm *et al* (1999) suggested that benchmarks need to be written specifically with flexibility in mind. Likewise, Bandolier (1995), reported that guidelines are more likely to be effective if they are adaptable to local circumstances. Benchmark utility and subsequent compliance could be enhanced by ensuring the transparency of the tool. Similar attributes associated with the implementation of guidelines were described by Boxwala *et al* (2001) when they attempted to implement a hypertension guideline in health information systems. In their paper, they advise that guidelines should be integrated into a generic system and that guidelines should be adaptable enough to accomplish this. Similarly, the flexibility of the tool was discussed in the focus groups which clearly highlighted the need for some degree of freedom so that the tool could be used across a diverse set of organisations.

As illustrated by the focus groups, the language used in the tool could be decisive in determining its use. In both groups, there was a high expectation that the tool would embrace a 'common language' which could be easily understood by a range of users. This is not unique to benchmarking – the use of a common language is well recognised in the literature and many have suggested methods for enhancing the language style. This ranges from readability testing to the use of peer reviews by colleagues and users involved in services and benchmarking. Others, such as the Department of Health (Department of Health Wales, 2004) attempted to establish a common language through defining terms most frequently used. In setting standards for NHS care and treatment in Wales, consensus agreement for key terms was sought through public consultation prior to the publication of the standards. In our study, the consultation of the benchmark took place as part of the initial evaluations. Participants in both focus groups agreed that the language used needed further clarification – in this instance – a reduced 'health' focus was required. To promote the utility of the tool, transparency and a 'common language' should be promoted to support the local adaptation needs. To facilitate this, any new benchmark tools should be piloted and reviewed by the intended audience and changes made accordingly. The language used in the tool will be reviewed by peers from social care and representatives from user groups.

Since the introduction of the NHS New Information strategy in 1999 – *Information for Health*, the prevalence of electronic communication has increased. De Lusignan *et al* (2001) suggests that central to this policy was the need to adopt electronic information into communication systems. The emergence of electronic records, email and innovative IT systems, has been at the forefront of changes. There is a growing pressure for communication systems in the NHS to comply with the digital era. Communication in the NHS has subsequently been transformed over the past decade. Not surprisingly, the need for an electronic version of the benchmark tool was repeated in the focus groups and illustrates the technological advances witnessed in recent years. Similarly, in their study exploring the effects of electronic communication in GP practices, Van Der Kam *et al* (2000) suggests

that the rapid development of information technology has created potential new methods for communication and identified that electronic communication has the potential to improve communication – however, the effects of electronic communication may never be measured. As manifest with industry (Electronic Document Systems Foundation (EDSF), 2005), the NHS is now employing a variety of digital documents and electronic communications. It would, therefore, seem sensible to make provision for an electronic version of the benchmark tool in line with contemporary technological advances in the NHS.

In our study, a divergence of opinion in relation to electronic documentation between the two focus groups was noted. Whilst participants in focus group 1 promoted the 'electronification' of the benchmark tool, those in focus group 2 were more reticent and suggested that an electronic and paper version of the benchmark should be available. The rationale supporting this statement stemmed from the individual needs and preferences. A similar preference was raised in industrial settings, where the survey by the Electronic Document Systems Foundation (2005) identified that 30% of those survey respondents requested that both electronic and paper formats be made available. It would appear therefore, that every effort to comply with stakeholders wishes should be considered and dual formats offered.

4.2 Training and Education

Implementing any guidance can prove problematic – the simple production of guidance does not necessarily mean the successful uptake into practice (Craft *et al,* 2000). Potential constraints such as staff concerns and lack of knowledge about the change may impede implementation and acceptance (Vance, 2002). To combat this, training and education about the nature, purpose and use of the tool should be considered contemporaneously. For example, guidelines have been known to be successfully implemented when disseminated through an active educational intervention (Bandolier, 1995). Concordance between both focus groups clearly reflected training as a pre-requisite prior to the introduction of the tool.

Structured training on the use and purpose of the tool could help to motivate staff and enhance compliance. As evidenced through Casson *et al's* (2005) study, changes made when implementing a single assessment process were supported through a training programme. In this instance, a common language was used to support staff through the changes which provided staff with a common understanding of new expectation. Additionally, potential conflicts which may hinder the successful implementation may be resolved and staff will feel more confident about its use and application.

To ensure that the tool is accepted into practice, stakeholders must be aware of its potential to improve integrated services through appropriate education and training strategies. Acceptance of the benchmark tool will only occur when stakeholders demonstrate a commitment to the change and are encouraged to support it

(Casson *et al* 2005). The need to 'sell' the tool and clarify its purpose resonated in the focus group discussions and is also echoed in the literature (Lorenzi 2000, Casson *et al* 2005). In Casson *et al's* study, the decision to use 'cohort; training to support the implementation of the single assessment process was used. They suggest that this "provides all staff and managers with a common understanding of the new expectations", harnesses ideas for successful implementation and ensures that staff are provided with the same information, reinforcing a common understanding across disciplines. A similar strategy could be applied to the implementation of the benchmark tool. To promote uptake of use, a suitable training programme should be offered which guides users through the process, purpose and outcomes expected. Given that a range of evidence from different departments needs to be collected to complete the tool, a strategy such as the one used by Casson *et al* (2005) may prove beneficial.

4.3 Organisational Culture

Schein (1985) suggests that the way organisational members behave and the values that are important to them play a large part in the successful implementation of change! Organisational culture, therefore, needs to be considered before any change management strategies are planned. In our study, both organisations involved in the evaluation of the tool are innovative and forward thinking – this type of 'organic' organisation (Hamer & Collinson, 1999) means that change and adaptation to change is more likely to be supported. However, as the participants in the focus groups remarked – the benchmark tool should be flexible enough to integrate into any type of organisation. Differences in strategic management between the PCTs illustrated this and was highlighted by participants in focus group 2 who purported that collaboration between departments to complete the benchmark may prove problematic. To ensure successful and appropriate use of the tool, agreements in and between departments need to be reached to provide the evidence needed to complete the benchmark. This was an area for concern with some of the participants especially in relation to HR, co-location and existing un-reciprocal relationships between departments. Whilst PCT 1 was integrated in terms of its services and new systems, PCT 2 had some concerns about the level of involvement from other departments needed to collate the evidence.

Responsibility for the completion of the benchmark was also discussed and highlighted as a potential problem. The participants advised that a full description and guidance as to who should complete the tool needs to be included. Both focus groups discussed the need for clarity and suggested that there was a potential for the person completing the tool to co-ordinate the collection of evidence. This would invariably mean that the person responsible should be in a position to facilitate this process and should be cognisant of the organisation, management structures and have a relationship with a range of departments. In addition, the 'co-ordinator' should ensure that the benchmark process is audited and findings disseminated. This implied that responsibility for the completion of the benchmark should rest within a middle management level.

4.4 Summary

As illustrated in the literature, change is more likely to be accepted if there is a shared vision. Benchmark tools, standards or guidelines should be flexible enough for the local organisation to adopt the key principles within practice. The tools ability to adapt to these needs is essential in contemporary 'fluid' services. Finally, to maintain an evidence-based culture, organisations need to take responsibility for the maintenance of new benchmarks and make changes when indicated. Benchmarks should, therefore, be reviewed and updated on a regular basis.

The evidence suggests that change is not easy. To accept a new method or intervention into practice is fraught with difficulties and resistance. As Lorenzi (2000) suggests, there is no quick fix solution – change occurs over time and with it comes acceptance. To avoid the pitfalls, innovative creations of the future need careful thought about the impact of benchmarks on individuals and the organisation.

4.5 Amendments to the Benchmark Tool

The following amendments have been made to the benchmark tool:

1. Clearer instructions for use including guidance about who should complete the tool, when and how often. A frequently asked questions section has been included to promote the uptake of the tool into practice;
2. The need for training on use of the tool is emphasised. It is recognised however, that organisational requirements in relation to education and training will differ;
3. The organisational score is now located at the start of the tool to provide the user with direction and to clarify the purpose of the tool;
4. A column has been included to help the user visualise areas for development within each domain;
5. There is now an electronic version available;
6. It is asserted that organisations operate and respond to different Department of Health and Social Care initiatives. To prevent duplication of effort and evidence collection, guidance is provided which suggests that each organisation dovetail the benchmark tool with other benchmarking or standard activity;
7. Suggested evidence types have been weighted as either 'mandatory' or 'optional'. This reflects the participants concerns about the amount and type of evidence required and the need to promote flexibility in the scoring.

Appendices

Focus Group Interview Guide

Clarity and Organisation of the Tool

1.   What do you think about the clarity of the benchmark tool?

2.   What do you think about the organisation/structure?

3.   What did you think about the clarity of the instructions?

Relevance and Usefulness of the Benchmark Tool

1.   What are your perceptions about the relevance of the <u>Domain Key Indicators</u> to the domains (ie communication etc)

2.   What do you think about the relevance of the <u>Domain indicators</u> to your organisation?.

3.   What are your thoughts about the relevance of the <u>suggested examples of evidence</u> in relation to the domains?

4.   What are you thoughts about the relevance of the <u>suggested examples of evidence</u> to your organisation?

5.   What are your thoughts about the score descriptions for:

a.   Each domain

b.   The final organisational score

6.   Is the suggested number of indicators needed to achieve a score realistic?

7.   What do you think about the clarity and realistic nature of the suggested <u>evidence types?</u>

8.   Please describe whether you think each <u>level indicator</u> used in the tool is realistic and clear?

Overall comments

1.   Do you have any general comments or suggestions about the tool?

2.   Would you use this tool in your organisation to help identify the education and training provision?

3.   What amendments would you make to the tool?

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