Title: **Benchmarking School Nursing Practice: The North West Regional Benchmarking Group Experience.**

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Benchmarking School Nursing Practice

The North West Regional Benchmarking Group Experience:

Abstract

The North West School Nursing Benchmarking group provides a "*systematic approach to sharing best practice, networking, reflective practice and a forum of open and shared learning*" (Royal College of Nursing 2007:1) with other school nursing professionals across the region. In the current healthcare landscape it is paramount that the quality of care is reviewed regularly through robust processes such as benchmarking to ensure all outcomes and resources are evidence based so that children and young people's needs are met effectively.

Key words

- Benchmarking
- School Nursing
- Best Practice

What is benchmarking:

Benchmarking has been defined as a process for finding, adapting and applying best practices (Camp 1994). This concept was first adopted in the 1970's "*from industry where it was used as a structured approach to quality measurement and improving services*" (RCN 2014: 5). The first "*paediatric clinical benchmarking group was set up in the North West in 1994 in response to the Chief Nursing Officer requiring a quality tool for paediatric practice"* (RCN 2007: 2). Since this initial benchmarking group being developed the North West has continued to lead the way in benchmarking in other areas of clinical practice such as cardiac surgery, neonatal and neurosurgery. The benefits of benchmarking include; reflective practice, sharing of innovative practice, reducing duplication and repetition, promoting a bottom up approach to quality improvement, evidence base for outcomes and resources and provides an avenue for implementing change in practice (RCN 2007).

Introduction:

The North West School Nurse Benchmarking Group was established in the late 1990's and has since continued to expand and develop by incorporating ten health care trusts across the region (North West School Nurse Benchmarking Group, NWSNB 2003). The aim of this group is to meet six times a year to facilitate networking, provide opportunities to compare and share best practice, review current standards of care and to benchmark key aspects of school nursing practice. For example, over the past 10 years areas such as school nurse drop-in services, school-nurse led enuresis clinics, provision of personal, social health education (PSHE), clinical supervision, safety and school-entry health assessment have all been subject to the benchmarking process (Figure One). The group utilises a rotating chair and minute-taker, and there is an expectation, written within terms of reference, that members will attend or send a deputy, and fully engage with the process, in order to get cross-region involvement. Two external validators are affiliated to the group; a Senior Lecturer

from another University within the North West region and a School Nursing Professional Officer from CPHVA whose roles are to proof-read and validate the benchmark prior to use (NWSNB 2003).

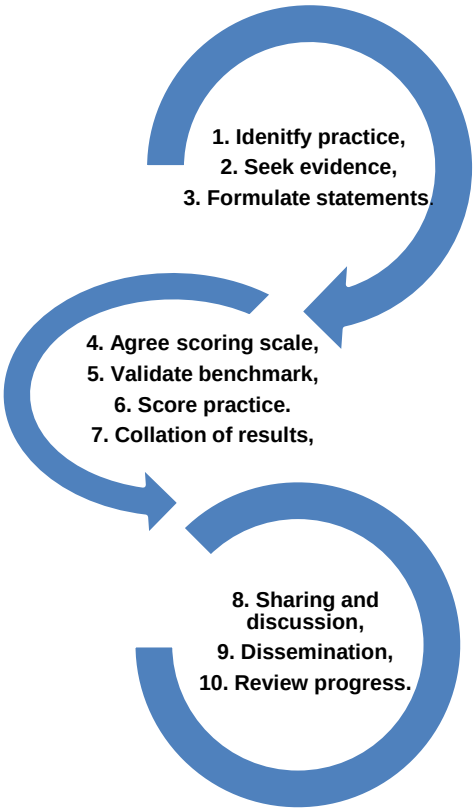
Figure 1: School Nurse Benchmark Activity
1. Reception school health entry assessment (Sept 2008)
2. Follow up of A&E attendance for children and young people (Mar 2010)
3. Drop in for secondary pupils within an educational setting (Jan 2011)
4. Alcohol identification and brief intervention with children, young people and adults (Dec 2011)
5. Clinical supervision (Jan 2012)
6. Leading and supporting children with medical needs (April 2013)
7. School nurse role in response to self-harm in children and young people (Feb 2014)
8. Transition to school nursing service at reception level (In progress)

The Benchmarking Process:

The benchmarking process used by the group consists of 10 stages:

1. Identifying an area of practice
2. Seeking the evidence for establishing best practice / writing the preamble to the benchmark
3. Formulating statements to benchmark practice and any other information / comments to be requested during benchmarking process
4. Agree benchmark scoring scale
5. Validation of the benchmark by two external experts
6. Scoring of practice against the benchmark by school nurses across the region
7. Collation of the benchmark results
8. Sharing and discussion of the results within the benchmarking group
9. Dissemination of the results to school nursing teams and managers
10. 6 month review of progress / actions taken following dissemination of results.

Figure Two: The Benchmarking Process



1. Identifying an area of practice:

In order to identify an area of practice to benchmark, the group considers national and regional priorities in school nursing practice, as well as contemporary practice developments and guidelines. For the future the group are keen for young people to be involved in the benchmarking process, in order to ensure children and young people's knowledge becomes part of the evidence base underpinning school nursing practice (Branfield & Beresford 2006).

2. Seeking the evidence for best practice:

The foundations of the benchmarking process involve adopting the following key aspects of an evidence based model which include "*searching the evidence base, analysing, critiquing, using research and other forms of evidence in practice*" (Nursing and Midwifery Council, NMC 2004: 5) such as policies, procedures or guidelines to inform the area of practice to be benchmarked. The findings of this are discussed and debated within the group, until a decision is made about what

constitutes best practice from the available evidence, thus providing an analysis of practice across the region through sharing knowledge and experiences within the group. Whilst this aspect of the benchmarking meetings can be time-consuming, it is paramount to the overall benchmarking process which cannot proceed until best practice has been established and agreed. Furthermore it is important to recognise at this point, that the benchmarking process is not seen by the group as a management process to standardise practice, but it is a supportive mechanism to enable autonomous public health practitioners to utilise their professional judgement and deliver best practice in meeting the needs of individuals, families and populations.

3. Formulating statements to benchmark practice:

Once best practice has been established from the available evidence, the benchmark is broken down into factors or elements which can then be benchmarked. See Figure three for an example of benchmark factors. For each factor, statements are compiled that capture best, good, satisfactory or more inadequate levels of practice, which school nurses undertaking the benchmark can compare their practice against.

Figure Three : Benchmark: School Nurse Follow-Up of Children's and Young People's Accident and Emergency Attendances.

Benchmark Factors:

- Guidelines for school nurses follow up for children and young people's attendance at Accident and Emergency
- School nurse role in the identification of trends and patterns of attendance.
- Accident and Emergency written information receipt and record keeping by school nurse
- Receipt of verbal Accident and Emergency information by school nurse
- School nurse follow up of safeguarding concerns following receipt of A&E information
- Public Health interventions following trend identification from receipt of A&E information
- Evaluation and audit of school nurse's follow up of children and young people's attendance at A&E.

4. Agree benchmark scoring scale:

The benchmarks are scored from 10 indicating best practice, down to 0 indicating a lower level of practice. The levels of scoring tend to move up by multiples of two (0, 2, 4, 6, 8, 10) although there is not always a need to use all levels. Alternatively if only 3 levels are needed and the difference in practice improvement between each level is evenly spaced, a scoring system of 0, 5 and 10 may be used. The scoring of the levels of a benchmark needs to be as objective as possible and this is reviewed by an external panel member. The scoring system for the benchmarks uses two measures – the range and the median. The range provides the lowest and highest score, an example of this is if the lowest score given for a factor is 2 and the highest score is 10, then the range would be 2-10. The median is the middle number, some scores will fall below and above this number, this is sometimes confused with the mean number, an example of this is: scores of 2, 4, 4, 4, 6, 6, 8, 10, 10, therefore the median number would be 6.

5. Validation of the benchmark by two external experts:

Once stages 1-4 have been completed the benchmark needs to be validated by the two external experts before school nursing team members can benchmark their practice this is to ensure that support can be provided in relation to national guidance, current research and evidence based practice in relation to the proposed benchmark.

6. Scoring of practice against the benchmark by school nurses across the region:

Each school nurse representative returns to their practice area and distributes the benchmark out to the school nurses within their teams in order to gather information and score their practice against the benchmark, using the agreed benchmarking scale. Once this benchmark information has been collected this information is then forwarded to the benchmark collator.

7. Collation of the benchmark results:

Once the collator has received all the results this data is gathered and a report is produced outlining the identified area of practice, evidence base/rationale for benchmark, and a summary of results from each Trust which clearly identifies good practice and areas for development.

8. Scoring of practice against the benchmark by school nurses across the region:

At the next benchmarking meeting the results are disseminated to all school nurse members. This is an opportunity for staff to review the results from all Trusts and identify their own Trust's areas of good practice and areas for development.

9. Dissemination of the results to school nursing teams and managers:

The school nurse representative disseminates the benchmarking report to their team and managers in order to discuss a plan of action for implementing changes within the practice area.

10. 6 month review of progress / actions taken following dissemination of results:

Following completion of this benchmark, a six month review is undertaken to see if any of the proposed changes identified on each Trust's action plan have been implemented (Figure four).

Conclusion:

Benchmarking is a structured process which enables school nurses passionate about providing quality evidence based care the opportunity to "*make a positive impact and difference to children, young people*" (RCN 2014:11) and their families through this positive, supportive, networking approach.

Figure Four: Benchmarking Action Plan: School Nurse Follow-Up of Children's and Young People's Accident and Emergency Attendances – one Trust's action plan example.		
Action	**Target Date**	**Progress to Date**
Factor 1 – Guidelines for school nurses follow up for children and young people's attendance at Accident and Emergency Raise awareness of Chronology of Significant Events	September 2012	Standard operating procedure in place. To circulate to all staff
Factor 2 – School nurse role in the identification of trends and patterns of attendance Paediatric Liaison to collate data, audit and produce report bi-annually	April 2013	School Nurse to liaise with Paediatric Liaison
Factor 3 – Accident and Emergency written information receipt and record keeping by school nurses (information pertaining to school aged children)	Ongoing	School Nurse to continue to use professional judgement

If you are interested in finding out more about the North West School Nursing Benchmarking group or if you work as a School Nurse in the region and would like to join please email: schoolnursingbenchmarkingnw@gmail.com.

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