NADA
network of alcohol & other drugs agencies

BENCHMARKING

A guide for the NSW non-government drug and alcohol sector

About NADA

The Network of Alcohol and Drug Agencies (NADA) is the peak organisation for the non-government drug and alcohol sector in NSW. NADA represents over 100 organisational members that provide a broad range of services including drug and alcohol health promotion, early intervention, treatment, and after-care programs. These community based organisations operate throughout NSW. They comprise both large and small services that are diverse in their structure, philosophy and approach to drug and alcohol service delivery.

NADA's goal is to advance and support non government drug and alcohol organisations in NSW to reduce drug and alcohol related harm to individuals, families and the community.

NADA provides a range of programs and services that focus on sector representation and advocacy, workforce development, information management and data collection, governance and management support plus a range of capacity development initiatives.

NADA is governed by a Board of Directors primarily elected from the NADA membership. It holds accreditation with the Australian Council on Health Care Standards (ACHS) until 2014. NADA is primarily funded by the NSW Ministry of Health.

Further information about NADA, its programs and services is available on the NADA website at **www.nada.org.au**.

Resource Development

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- We Help Ourselves

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Glossary

Accreditation – certification by a licenced agency ('conformity assessment body') that a service provider complies with standards

Actions (strategies or tasks) – the activities needed to achieve objectives and vision

Benchmark – a standard or point of reference against which things may be compared or assessed

Compliance – meeting specific requirements (of, for example, standards, legislation or regulation)

Continuous improvement/Continuous quality improvement (CQI) – the process of reviewing and making improvements in an ongoing manner

Data – information collected for use in planning, decision making or evaluation

Evaluation – the formal process of assessing whether the implementation of a strategic business plan, or an activity, has been successful

Evidence – documents, reports or other information that demonstrate compliance or performance

Implementation – putting a plan into action

Key Performance Indicators (KPIs) – the benchmarks or targets that have been chosen to measure how successfully a service provider has achieved its objectives

Milestones – the measurable stages of progress towards achieving a planned objective, such as the date something is achieved or the quantity of an output

Monitor – to check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis to identify change

Objectives – what a service provider wants to achieve as a result of its planned activities. Sometimes the term 'objective' is used interchangeably with the terms 'goal' or 'aim'

Outcomes – the results of planned actions

Performance indicators – information that provides a measure or reflection of what is being done or achieved

Performance measures – (see 'Performance Indicators')

Qualitative – a measure of the quality or qualities of an outcome

Quality improvement plan – plan for action to make improvements that will impact on the quality of service delivery or operations

Quality management process – any set of procedures or activities that control or monitor the quality of the service provider's work

Quality management system – a structured set of processes for monitoring and managing quality within a service provider

Quantitative – a numeric measure of an outcome

Stakeholders – any person or organisation with an interest in the operations of a service provider

Standards (industry or service standards) – specific procedures or outcomes that service providers are required to meet within an industry area

Strategic directions – the parameters for defining what a service provider will do, based on an analysis of its operating environment and its internal capacity

Targets – specific levels of performance set by the service provider in relation to plans and performance measures

Introduction

Benchmarking is one of a number of tools that an organisation can use to monitor and evaluate how well it is performing, and to drive continuous improvement in quality and outcomes.

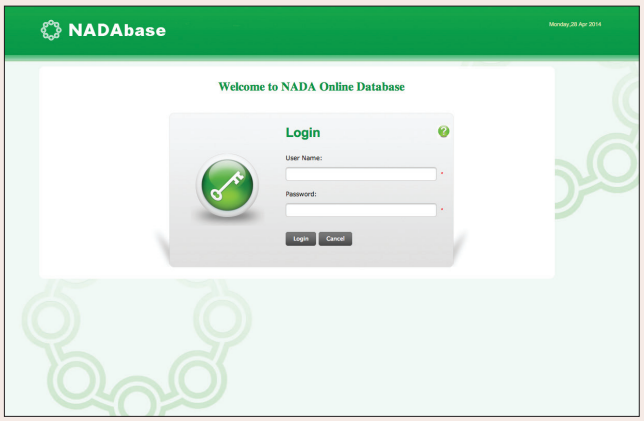
Benchmarking is primarily about comparison – comparing what a service is doing or how it is doing it with how it has performed in the past, with how other services are performing or with industry performance measures.

Benchmarking is also a vital tool in the implementation of evidence based practice.

This benchmarking guide is part of a suite of projects NADA is involved in which address quality improvement and performance management.

In particular:

- NADAbase, which provides a way for organisations to store and then access data on client information, service delivery and treatment outcomes. Reports from NADAbase provide organisations with valuable data for benchmarking and managing outcomes for clients.
- Resources such as the Governance Toolkit and the Complex Needs Capable resource, which provide guides to processes and procedures that form the basis for benchmarking against best practice.



This benchmarking guide gives drug and alcohol organisations an introduction to what benchmarking is and how to use benchmarking as a simple quality improvement tool.

The guide contains:

- an overview of benchmarking, its benefits and some of the issues involved in making best use of benchmarks
- a discussion of different approaches to benchmarking and what is involved in benchmarking
- a practical step by step guide to introducing benchmarks into your organisation
- a guide to selecting benchmarks and indicators that make best use of information already collected by the organisation.

1. Benchmarking

1.1 WHAT IS BENCHMARKING?

Benchmarking is the process of identifying and implementing best or improved practices by selecting and comparing aspects of service practice and performance against the best. The best may be the best result achieved within an organisation, the practices and processes of lead agencies within a sector or identified best practice within an industry.

The purpose of benchmarking is to enable an organisation to identify how much better they might do things and what might be changed to improve performance. Essentially, it involves selecting particular measures of performance 'benchmarks' and using these to make comparisons, identify more effective practices and processes, implement these and measure change.

Benchmarking is a tool that organisations can use to research the best ways to achieve good outcomes, using their findings to take action and to set their own goals. It is essentially an internal quality management tool for organisations, helping them make informed decisions about how they conduct their business and provide their services.

Benchmarking can be a simple process, using a few key indicators, or, for more adventurous organisations, an integrated way of how they monitor results.

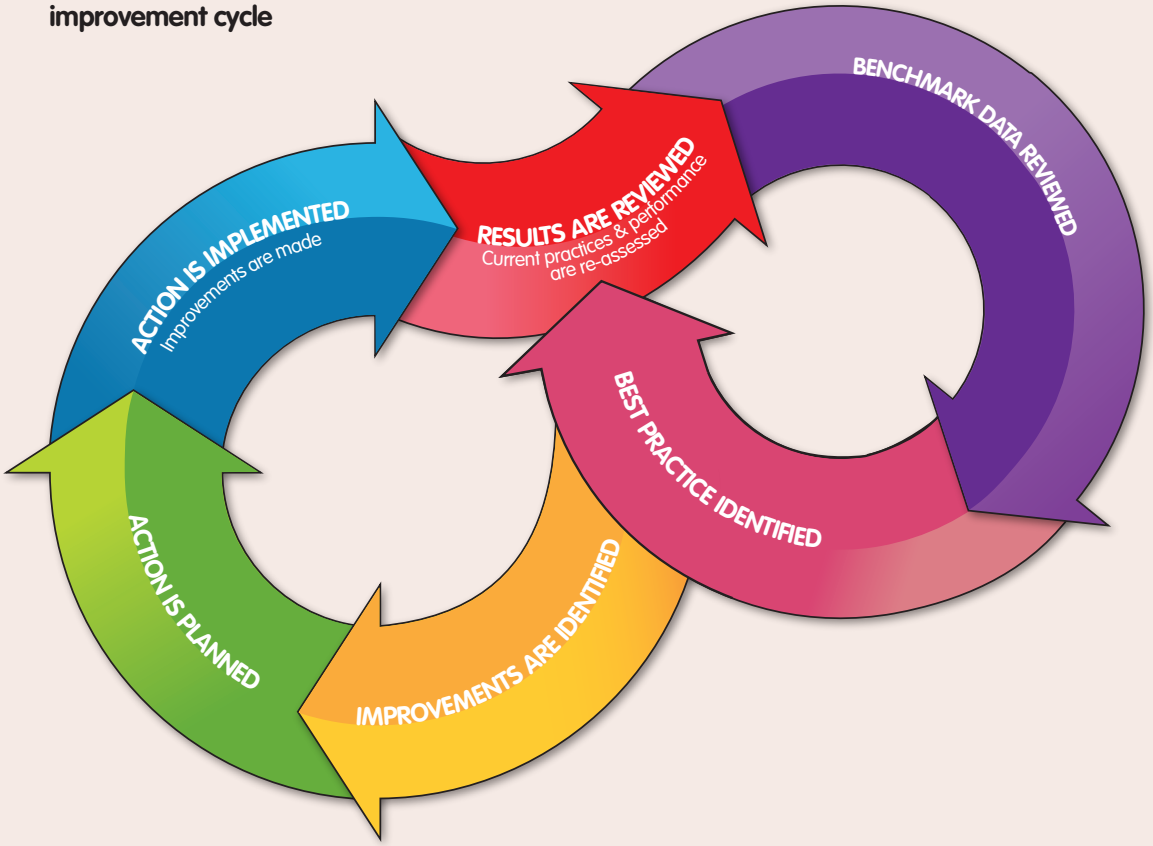
It is important that organisations make their own decisions about how, and at what level, they engage with benchmarking as a practice, based on their resources and needs.

Benchmarking can be used to identify:

- how well the organisation is achieving its service aims
- changes in performance
- how well the organisation meets best practice
- processes and practices that will produce the best outcomes.

Benchmarking is one part of a cycle of continuous improvement. To ensure that they are performing at their best, organisations increasingly need to set standards for themselves and measure their processes and performance. Using benchmarking to compare results over time or compare results with the results of leading services, provides the organisation with a sense of its own progress or achievement and evidence of the effectiveness of its treatment programs and activities.

Diagram 1: Benchmarking and the continuous improvement cycle



Benchmarking can be an individual organisational activity or can be an industry led initiative where industry wide benchmarks are developed. Comparisons against recognised industry leaders or against best practices from other industries, which operate in a similar environment, can provide an external validation of how well the organisation is performing.

A benchmark refers to a measure of performance. Benchmarks are not arbitrary – they are derived empirically from data and clinical practice. Benchmarks can represent the highest points in performance (for example, the highest average treatment outcome score for an organisation or group of organisations) or best practice (for example, the expected average treatment outcome score for an organisation using identified best practice approaches).

Benchmarking refers to the process of searching for the best practices that yield the benchmark performance, with emphasis on how an organisation can apply the process to achieve superior results.

1.2 BENEFITS OF BENCHMARKING

Benchmarking can help an organisation understand:

- where their strengths and weaknesses are; and
- what level of performance is possible by looking at the performance of leading organisations.

Benchmarking can also:

- provide specific, evidence based information to enable organisations to improve quality, efficiency and outcomes
- facilitate continuous improvement leading to improved service capacity and viability
- lead to new and innovative ideas
- improve an organisation's accountability and transparency to all stakeholders (clients, staff and other community, funders and partners)
- identify that an organisation is a leader in an area of practice
- assist organisations to learn from one another about effective practice
- contribute to the broader pool of practice knowledge.

Benchmarking also assists organisations in making effective use of data they collect by:

- identifying data quality issues and implementing strategies to improve data quality, such as standardised operational processes and clearer definitions for data entry
- identifying what fields of data are needed and refining data collection to only include what will be actually used
- enabling services to develop and use indicators for specific quality improvement activities and make use of existing data to guide and evaluate service improvement activities
- clearly linking data that provides the evidence of effective practice to those practices.

1.3 APPROACHES TO BENCHMARKING

Benchmarking can be approached in a variety of ways. The key considerations are:

- who drives and controls the setting of benchmarks and the use of a benchmarking project
- whether the benchmarks are internal (within the organisation) or external (comparison with other organisations or industry benchmarks)
- what type of benchmarking is used (performance, process or both).

1.3.1 Who drives and controls benchmarking

Benchmarking can be driven by:

- individual organisations for their own use
- industry groupings to establish sector wide benchmarks
- other stakeholders such as funding bodies as part of managing performance agreements or funding formula.

Benchmarking that is driven by an individual organisation for its own use is a valuable process. It enables the organisation to identify its strengths and weaknesses and implement improvements in selected weaker areas. If the organisation then wants to see how it is performing in comparison to its peers, it can measure selected processes or practices against compatible benchmarks of other organisations from within the same industry.

Benchmarking that is industry driven is conducted by members of that industry to look for processes or practices that are valid and comparative across the sector. The process involves establishing best practice and identifying:

- industry benchmarks for particular activities and outcomes
- organisations that perform well at particular activities and have processes or practices that are adaptable to other organisations.

Organisations within the sector can then compare their performance with their peers, see the average level of performance of their peers, and look at how they can improve areas of their own performance. Industry driven benchmarking can aid efficiency, enable organisations to share innovative ideas and stimulate continuous improvement at a sector level.

Benchmarking that is driven by other stakeholders such as funding bodies is usually conducted at a sector level, but the main purpose may be to inform funding formula, clinical practice guidelines or other sector concerns.

A sector wide benchmarking program that is driven from industry (such as a peak body) or an accountability stakeholder (such as a funding body) may raise concerns about how the benchmarks are set. Do they reflect the diversity of organisations and the types of services they provide. Do benchmark averages of organisations correlate with best practice and whether there is the potential for benchmarking results to be utilised like a league table that reduces diversity across the sector.

This is particularly the case where accountability stakeholders, such as funding bodies, drive a benchmarking process and set benchmarks as part of funding requirements or use benchmarks as an evaluation tool.

1.3.2 Internal or external benchmarks

Internal benchmarking is a way for an organisation to compare similar processes or operations within itself and determine best practices. Internal benchmarking is relatively easy to research and to implement and can provide a good introduction to benchmarking for staff and management.

However, because it is only referring internally, it is limited. If an organisation's practices or performance are poor, then benchmarking internally will identify and measure improvement, but not necessarily assist the organisation to identify or aspire to best practice.

For external benchmarking, non-government drug and alcohol sector organisations may choose to benchmark against:

- their peers in the sector
- against public sector or government agency data
- performance in another industry altogether.

External benchmarks based on the performance of peer organisations or on an industry average can also be limited in that they may not necessarily represent best practice.

Table 1: Levels of internal and external benchmarking

INTERNAL	EXTERNAL
Activity level	**Inter-organisation**
A comparison is made between how similar activities or processes (e.g. intake and assessment) are carried out within the one organisation or at different points in time.	A comparison is made between different organisations carrying out similar processes in the same sector (e.g. intake and assessment in a number of drug and alcohol services).
Division level	**Industry standards**
A comparison is made between two or more different outlets or services within an organisation performing the same processes.	A comparison is made between industry wide performance benchmarks or quality standards and the organisation's performance or processes.
	Out-of-industry benchmarking
	A comparison is made of similar processes being carried out by organisations in different industry sectors (e.g. case management practices in drug and alcohol services and mental health services).

To identify best practice, external benchmarking needs to measure an organisation (or part of its operations) against an outside standard (such as those used in quality accreditation) rather than against average performance scores. When benchmarking looks to external best practices, it uses industry or sector standards or performance standards set by industry leaders as guidelines for internal performance.

In the non-government drug and alcohol sector, there are challenges in establishing external benchmarking for treatment practices and outcomes in particular because of the diversity in the sector in terms of:

- philosophical approaches to addiction
- treatment interventions and outcomes
- views on what is a positive treatment outcome.

These differences may have an impact on the design and development of sector benchmarks. If an organisation attempts to benchmark against organisations with significantly different resources or treatment interventions then adjustments would need to be made to ensure that the benchmarks were valid and meaningful.

Currently there are no specific industry benchmarks for the non-government drug and alcohol sector. However there are clinical guidelines and standards, and within each formal quality improvement program there are general governance, management and operational standards.

1.3.3 Types of benchmarking

There are two broad types of benchmarking that are relevant to non-government drug and alcohol services, performance benchmarking and process benchmarking.

1. **Performance benchmarking** is concerned with the measurable performance levels for a specific process. It makes use of 'hard data' to identify which processes produce the best outcomes, how effectively a particular process is working, the impact of changes to the process, and to set performance targets.

Example of performance benchmarking
A service using data from its Client Outcomes Management System (COMS) could identify where and when in the organisation's service delivery the best average scores were achieved at particular stages (such as exit or follow up). This would then form their benchmark to compare future scores against, or to compare with data from similar services.

2. **Process benchmarking** is concerned with the analysis of the processes themselves rather than just the performance or activity levels. Performance benchmarking can be used to identify practices and processes that are most effective, and then process benchmarking used to identify the components of an effective practice, why a practice is effective and what factors contribute to its effectiveness.

   Quality standards (such as EQuIP, QIC etc.) provide process 'benchmarks' at a generic organisational level by identifying good practice for running the organisation and delivering services. Clinical studies and other research literature provide information about processes (approaches and practices) for the delivery of drug and alcohol treatment programs that can be used to guide the analysis of practices and processes in benchmarking.

Example of process benchmarking
Having used the average from its COMS data to identify where the best score had been achieved, a service could investigate in more detail how this score was achieved. By comparing processes with another similar service, the service could also identify whether there were different approaches that yielded better results that could be adopted and incorporated into its own processes.

2. How to benchmark

2.1 THE BENCHMARKING PROCESS

The process of benchmarking consists of five stages:

- **Preparation:** identifying what will be benchmarked and the data needed
- **Data collection and comparison:** collecting and analysing the data and identifying 'best practice' results
- **Investigation:** analysing what makes a particular practice effective
- **Implementation:** identifying the standard or target being sought and making necessary improvements to current practices and processes
- **Monitoring and review**

2.2 BENCHMARKING – YOU'RE PROBABLY ALREADY DOING IT

Looking at the diagram of the benchmarking process, many organisations will see that they are already involved in some form of benchmarking. Any time an organisation takes a piece of data and compares it with the same data from an earlier time, or from another service area, they are using a form of benchmarking.

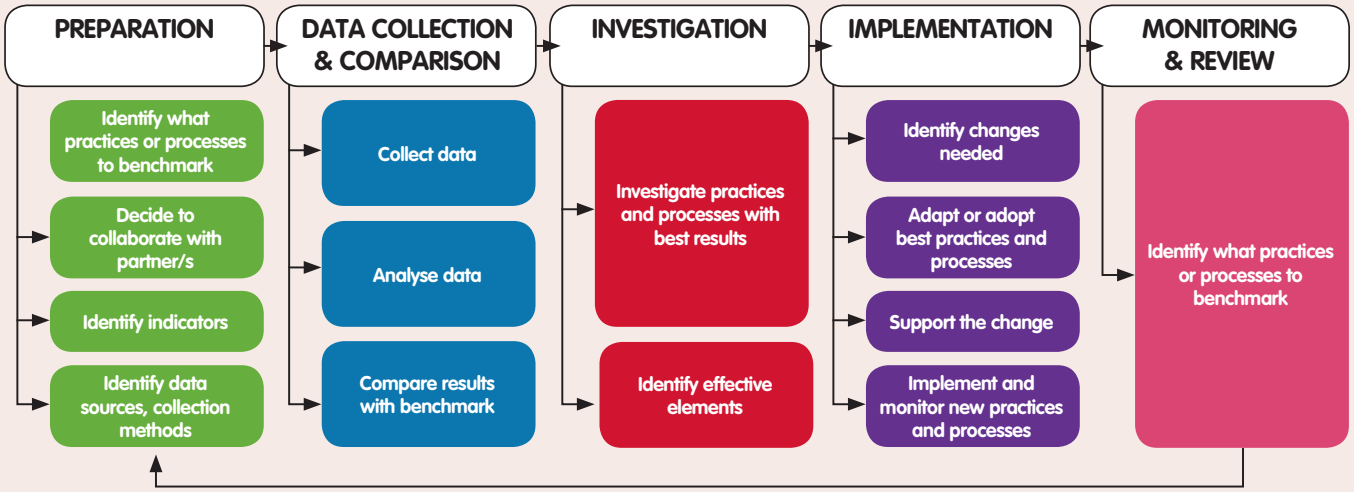
Simple, internal benchmarking occurs any time an organisation:

- takes data they have collected (such as client demographics, presenting issue, waiting time, referrals, outcomes and outputs) and uses this to identify whether there have been changes or improvements in results over time
- analyses the processes that produced the best results
- develops new processes or alters existing practices and processes in response.

Effective benchmarking does not necessarily require an organisation to collect new or additional data. Often, effective benchmarking simply involves a better use of existing data.

Data collection and analysis is a part of the required funding and reporting system for non-government alcohol and other drug services. Most organisations keep treatment outcome data for individual clients, provide summary analysis of outcomes as part of their internal reporting and/or use the information for service planning and internal evaluation. Start your benchmarking by looking at what you have already and see how it can be used.

Diagram 2: Overview of the benchmarking process



Source: Adapted from NSW Health *Using the HoNOS in Clinical Benchmarking and Performance Reporting* and *National Health Ministers Benchmarking Working Group (1996)*

The most important data sources will be the data provided as part of Minimum Data Set (MDS) reporting and your organisation's own treatment outcome data. Organisations entering data through the Client Outcomes Management System (COMS) on NADAbase will have access to reports of average scores across their client groups for the outcome measures they collect, and this provides ideal data for benchmarking.

2.3 ESTABLISHING A BENCHMARKING PROJECT

Establishing a benchmarking project is a good way of introducing benchmarking to an organisation and of ensuring that existing data is being used effectively to drive good practice. If an organisation is ready to expand its benchmarking activities, then a benchmarking project can be used to coordinate benchmarking with one or more partner organisations.

The steps involved in conducting a benchmarking project are described in detail in Section 4 of this resource, and a project planner is provided to guide you through the process.

In undertaking a benchmarking project, it is important to work within the organisation's limitations and to be clear about:

- The scope of the project and the specific objectives.
- The approach and methodology that will be used.
- The resources required and where these will come from – all organisations have some resources relevant to benchmarking. Most important are those staff with experience in data collection and analysis (i.e. the people who collect, enter or analyse the organisations statistics), and the data they collect.
- Project tasks and responsibilities, and who will be responsible for coordinating these.
- Whether the project will be internal or will involve external partners.

It is also critical that the organisation has fostered a culture of review and reflection, and that people have a positive attitude towards identifying ways of improving results and outcomes, and using benchmarking as a developmental tool.

There are several factors that might also affect the success of a benchmarking project:

- The level of support from, and involvement of, senior management or leadership within the organisation.
- The integration of the project with existing quality management processes.
- The willingness of people to share and compare performance data and to critically analyse the way they work.
- Consistency and continuity of staff involved and their ability to promote knowledge within the organisation.
- Capacity of the organisation to review findings, identify areas for improvement or change, set priorities and implement change.

Conducting an organisational benchmarking project (benchmarking aspects of the service against the organisation's own internal data or against external data), is a good way of starting out. It is simpler than a collaborative benchmarking project with a partner or partners as there are no external negotiations involved and no risk of the organisation feeling exposed.

If your organisation chooses at a later stage to collaborate with another organisation you can use the findings from the internal program to inform the next process.

2.4 COLLABORATIVE BENCHMARKING

2.4.1 To collaborate or not

An organisation needs to consider a range of issues if it is thinking about collaborating with other organisations. The main consideration is whether the collaboration will benefit the organisation and its clients.

The questions that should be considered regarding collaboration include:

- What level of resources will be required?
- Will collaboration reduce the impact of benchmarking on the organisation's resources as the load will be shared?
- Will the organisation be exposing itself to any risks in sharing data or information? If so, do the benefits of collaboration outweigh the risks, and how could the risks be mitigated or eliminated?
- What type of external benchmarks will benefit the organisation to review itself against?
- Is collaboration likely to result in new developments in the areas being benchmarked?
- Will collaboration offer the organisation new ideas, skills and expertise?
- Will there be an identifiable benefit to clients such as improved service quality or outcomes?
- Will the project provide the organisation with an opportunity to document and model good practice?

2.4.2 Selecting benchmarking partners

There are obvious benefits in collaborating with a service from the non-government drug and alcohol sector. However, there may be other benefits in collaborating with a government drug and alcohol service or with another organisation from a different service sector.

The decision will vary depending on what areas the organisation selects as the ones they want to benchmark. For example, if an organisation identified governance as an area to benchmark then they may choose a non-government organisation from another service sector but if they were interested in benchmarking clinical management then they could consider another non-government alcohol and drug organisation or another health service.

It is also important to make clear decisions about the similarities or differences of benchmarking partners, or in the case of sector or industry benchmarks, the factors that will affect different benchmarks. These include:

- **Service location** – city, suburban, regional centre or rural
- **Service size** – number of service types (e.g. health promotion prevention, day program, counselling and/or residential rehabilitation) number of staff, number of locations (including fixed or mobile services)
- **Service type** – Case management, withdrawal management non-medicated, withdrawal management medicated, rehabilitation day program, residential rehabilitation, drug and alcohol health promotion and prevention – information and education, drug and alcohol health promotion and prevention – community development program, aftercare program etc.
- **Service hours** – general business (9am – 5pm), 24/7, after hours etc.
- **Client populations** – gender specific, age specific, cultural or language based, dual diagnosis
- **Complexity of service provision** – multi faceted (e.g. provides information, education, assessment, referral, counselling and treatment) or predominantly single focus (e.g. telephone information and referral or residential treatment service)
- **Data collection** – what existing data the service has access to (e.g. COMS etc.).

2.5 WHERE TO START OUT IN BENCHMARKING – LEVELS YOU MIGHT WORK AT

Organisations may make their benchmarking as simple or as sophisticated as they choose. When starting out, keep things simple and manageable. As an organisation becomes more experienced in performance monitoring generally, and benchmarking in particular, they may progress to more sophisticated levels of benchmarking.

Table 2: Levels of benchmarking

LEVEL	DESCRIPTION
Exploring	• Establishing simple benchmark projects. • Focus on internal benchmarking. • Trialling benchmarking with one or two partner organisations.
Integrated	• Developing a set of benchmarks to be used as ongoing measures, including use of any industry benchmarks. • Reviewing and streamlining data collection to integrate benchmark data. • Integrating benchmark reports into usual performance reporting. • Implementing continuous improvement with benchmark data as a core component.
Leadership	• Having a fully integrated benchmark system for internal benchmarking and reporting. • Working with several partner organisations to identify shared benchmarking data and processes. • Contributing to the development of industry benchmarks. • Mentoring organisations starting out with benchmarking.

2.6 CHALLENGES ASSOCIATED WITH BENCHMARKING

There are several challenges that organisations may face in benchmarking but there are also strategies which can be used to address these challenges.

Table 3: Challenges in benchmarking

CHALLENGES	STRATEGIES
Lack of understanding within the organisation of how benchmarking works or the benefits it can offer	• Develop a clear and simple briefing for the organisation that explains how a benchmarking process will work, how it fits with existing evaluation and quality management activities and the expected benefits. • Address the concerns that people may have about benchmarking e.g. being exposed to external scrutiny, risks associated with collaboration, impact on funding. • Present the briefing to the Board/management committee and staff.
Lack of engagement from staff or lack of commitment and support to the process from senior staff and management	• Ensure that the benchmarking team is led and championed by a senior manager and key staff from areas across the organisation. • Include strategies for engaging relevant staff and promoting the benchmarking process as a positive shared goal with benefits for clients. These might include staff development sessions exploring the benefits of benchmarking or engaging key individuals to act as group leaders in benchmarking exercises.
Finding suitable collaborative partners	• Don't just look locally for partners. Current technology enables easy discussion and negotiations so distance should not be a barrier to collaboration.
Data – standardisation; quality; difficulties in finding comparable data; capacity to access data	• When considering partnering, look for organisations with similar services and data sets e.g. COMS, NSW Health Minimum Data Set. • Investigate how other services manage their data and if they have any more efficient processes that would work for your organisation.
Staff with expertise in quality management and data	• Seek advice and support from NADA or other drug and alcohol services that have implemented benchmarking, or consider mentoring or assistance from a university.
Resource constraints – not sure what impact it would have on staff time	• Start small. Keep the project targeted – choose a few key indicators and plan the resource allocation.

3. Guide to conducting a benchmarking project

3.1 HOW TO ESTABLISH A BENCHMARKING PROJECT

The following table provides a suggested outline of a benchmarking project from the start of forming a team through to implementing changes identified as a result of benchmarking.

Diagram 3: Steps in a benchmarking project

The following table elaborates on the diagram above and details the suggested benchmarking project steps.

Table 4: Detailed steps in a benchmarking project

CHALLENGES	STRATEGIES
Select a benchmarking team	• Look for people with an interest or expertise in benchmarking and quality improvement. • Identify staff with resources to bring to the process (e.g. data collection and analysis). • Include process stakeholders (e.g. team leaders, data analysts). • Ensure the work of the team is communicated to the rest of the organisation to get their 'buy in' and reduce any concerns.
Identify issues and practices or processes to benchmark	• Don't benchmark too many areas. Look for practices or processes with significant impacts on the organisation: – management of waiting lists – file management – client outcomes, staffing levels and stakeholder relationships – funding/budget areas of difficulty – challenges, constraints – areas of opportunity.
Research and document the practices or processes selected and identify performance measures or indicators	• Determine how work is organised and flows through the organisation by: – examining internal documents such as budgets, policies, procedures and reports – conducting internal interviews – identifying the procedures that have to be done well for the process or practice to succeed and look for measures of quality, impact, and cost – identifying problem areas. • Look for existing performance measurement practices in the industry and consider collecting data that is likely to be comparable. If the organisation has existing performance measures, look at the data that may be used as a basis for comparison.

Table 4: Detailed steps in a benchmarking project *(continued)*

CHALLENGES	STRATEGIES
Select benchmarking partners (for collaborative projects)	• Identify other organisations whose work you respect in the aspects of service that you want to benchmark. • Take time to discuss and plan the project, identifying responsibilities and agreements. • Establish a formal agreement, such as a Memorandum of Understanding.
Plan data collection and collect the data	• List what the organisation wants to find out about practices, processes, performance measures and problem areas. • Identify what data the organisation already collects. • Formulate questions to uncover the information wanted (for example – how are client problems handled, how are waiting lists managed). • Choose the data collection methods and collect the data (for example – interviews, surveys (on-line or hard copy), focus groups, publications, site visits).
Compare performance and identify processes that produce results	• Document the findings and display them in a concise manner (e.g. diagram comparisons in charts and tables). • Identify practices or processes with the best performance levels. • Analyse and identify the factors that support best practice.
Select areas for improvement and set targets	• Don't try and implement too many changes - select a realistic improvement program related to your organisation's resources. • Assess potential improvements or changes: – Which better/good practices or processes could work in our organisation? – What would the organisation have to change to adopt new practices or processes from other organisations? – What are the resource implications? (e.g. budget, staff, office/clinic space.)
Develop, document and implement strategies for change	• Develop a plan for implementation: – What needs to be done to successfully implement change? – How can we get the necessary resources? – Who will be affected by the changes? How will they be consulted and informed about the changes? – Who else needs to be kept informed about the plan? – Who in the organisation has responsibility and accountability for managing the changes? • Select and prioritise specific areas for improvement and identify goals, targets, milestones, timeframe and resource allocations. Be realistic with goals and allow sufficient time and resources for the implementation. • Document identified improvements and implemented actions in a quality improvement register or log.

After implementing changes set a time frame (e.g. 12 or 24 months) to re-measure performance and repeat the process steps from the collection and analysis of data through to development and implementation of strategies for change. Benchmarking is part of the continuous improvement process, and benchmarking activity should be recorded along with other quality improvement activity.

3.2 FROM IMPLEMENTATION TO INTEGRATION

The first part of integrating benchmarking into the organisation's evaluation and continuous improvement practices is the implementation of changes in response to the findings of a benchmarking project. The organisation should have a clear framework for using benchmarked data and creating action plans to convert the results and benchmarking efforts into new improved practices, processes and organisational change. Benchmark data should also become a regular part of organisational reporting and should inform the organisation's service planning.

It may be helpful to document the following if the organisation does not already have a clear framework for performance monitoring and quality management.

1. Establish who in the organisation has the overall responsibility for performance and quality management. It should be this person's role to integrate benchmarking as a tool within the organisation's ongoing continuous improvement processes.
2. Document the processes for performance monitoring and quality management within the organisation, and how benchmarking data will be used within these processes.
3. Decide whether specific benchmarking projects will be conducted in the future, and document the parameters for these (how a project is proposed, assessed and approved). Conducting benchmarking exercises as a regular part of organisational evaluations will contribute to the evidence base for an organisation's practice.

3.3 SELECTING AREAS AND INDICATORS

3.3.1 Areas for benchmarking

There are many aspects of an organisation's activities that could be considered for benchmarking, with service delivery being the most critical. It is also possible to apply benchmarking to general organisational governance, management and operations, and to external relationships.

Service delivery

- Procedures involved in service delivery (intake, screening and assessment, case management and coordination, program completion and exit, follow up and aftercare).
- Treatment approaches and client outcomes.
- Continuity of care (short term, long-term treatment and external supportive care as well as transition and referral to other services).
- Procedures involved in providing other service types (preventative health programs, early intervention, telephone information, referral and advice).
- Community development, practice consultations, running forums and events.

Organisational

- Organisational governance and accountability practices (board and management practices, strategic direction; financial management, external reporting to funding body).
- External quality standards (the extent to which the organisation meets external sets of standards).
- Program operations (general organisational factors that foster or inhibit comprehensive, high-quality service provision e.g. adherence to clinical practice guidelines, practices for client/treatment record documentation).
- Staffing (recruitment practices, knowledge, skill and qualification level; staffing levels; staff supervision and support).
- Internal communications.

External relationships

- Collaboration (partnerships and networks with related services and organisations).
- Reputation and profile (how the organisation is perceived by clients, peers, local community, referring agencies and funding bodies).
- Communication practices.

3.3.2 Performance measures and indicators

Having selected areas to benchmark, the organisation needs to select the performance measures it will use for each of these, and what indicators it will use to measure. There are essentially three types of performance measures[1]:

- How much did we do? A measure related to effort (quantitative data).

> ***Example:*** *An indicator might be the number of clients treated for alcohol problems or the number of group sessions provided.*

- How well did we do it? A measure related to the quality of what was done.

> ***Example:*** *An indicator might be the percentage of clients admitted within two days of contact or percentage of staff with qualifications or quality improvement program accreditation.*

- Is anyone better off? A measure related to the effect on skills/knowledge, attitude/opinion, behaviour and circumstance.

> ***Example:*** *An indicator might be the percentage of clients with decreased opiate use or Severity of Dependence Scale (SDS) score.*

The following chart provides a range of examples of measures and indicators that your organisation might use for benchmarking.

Table 5: Examples of benchmarking measures and indicators

AREA	EFFORT How much did we do?	QUALITY How well did we do it	EFFECT Is anyone better off?
Service delivery			
Service delivery procedures (intake, screening and assessment, case management and coordination, discharge, follow up).	Number of applications for service weekly. Number of assessments conducted weekly. Number of cases being managed per FTE staff position.	Average wait time to access the service.	Percentage of clients accessing appropriate treatment.
Treatment approaches and client outcomes.	Number of current, new and closed episodes.	Percentage of clients completing treatment programs.	Average scores for groups of clients on validated client outcome measure tools (e.g. SDS score, NADA COMS, WHO Quality of Life etc.).
Continuity of care.	Number of clients receiving ongoing care planning.	Percentage of clients satisfied with continuity of care.	Percentage of clients accessing required care without disruption.
Procedures involved in providing other service types (preventative health programs, early intervention; telephone information, referral and advice).	Number of programs or sessions provided. Number of people reached. Number of people seeking information.	Percentage of program participants rating sessions highly. Percentage of other stakeholders providing positive feedback about programs. Percentage of callers successfully referred.	Percentage of program participants indicating change in attitude, understanding or likely behaviour. Percentage of people having needs met with information, referral or advice.

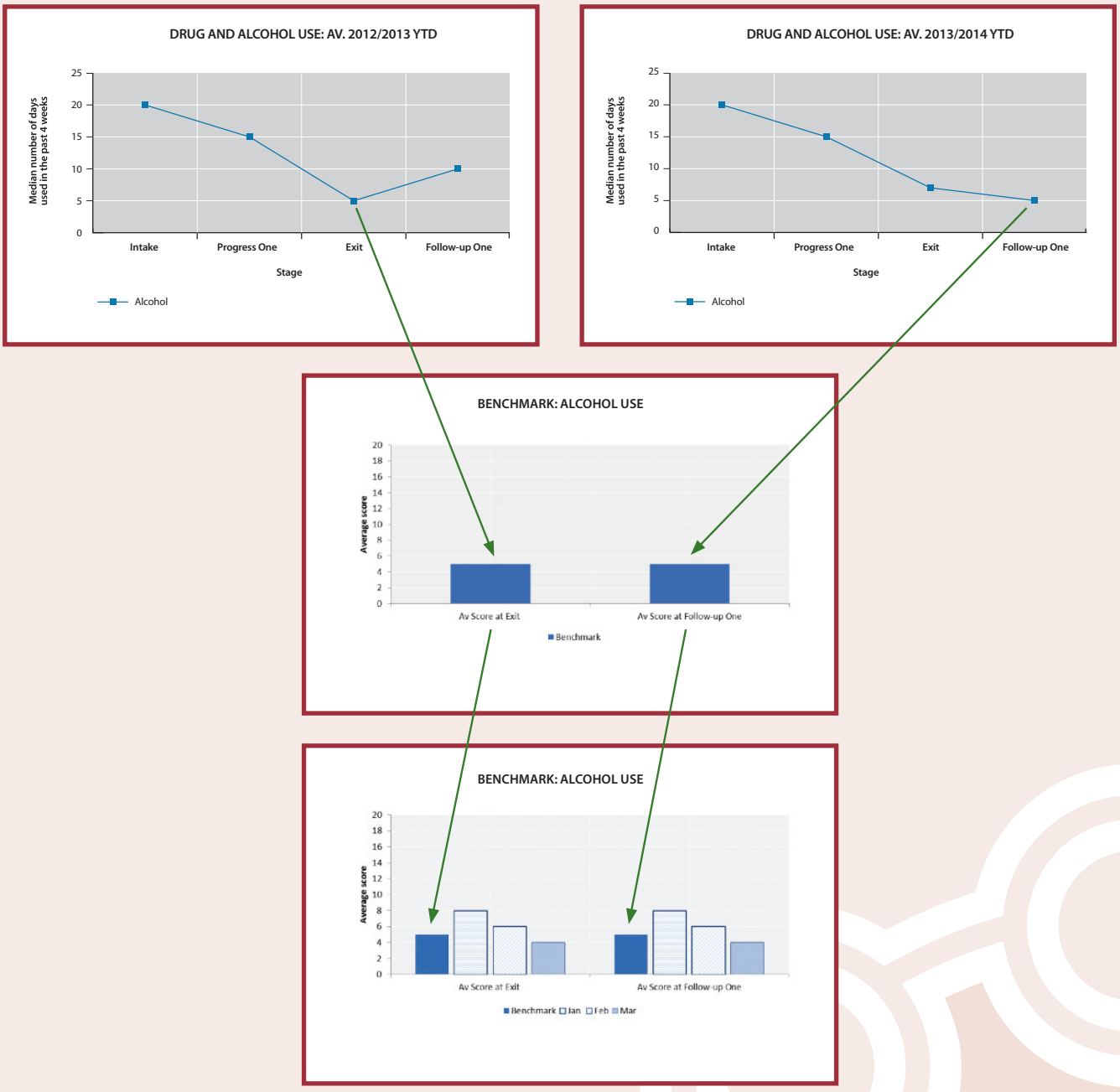
[1] Results Based Accountability framework

Table 5: Examples of benchmarking measures and indicators *(continued)*

AREA	EFFORT How much did we do?	QUALITY How well did we do it	EFFECT Is anyone better off?
Organisational			
Organisational governance and accountability practices (board and management practices, strategic direction, financial management, external reporting to funding body).	Number of board meetings, internal and external reports.	Percentage of reporting deadlines met. Percentage of stakeholders finding reports or planning documents useful.	Proportion of strategic key performance indicators met. Improvement in financial situation (e.g. increase in revenues, decrease in costs, improved balance sheet).
External quality standards (the extent to which the organisation meets external sets of standards).	Number of internal and external audits conducted.	Percentage of quality standards fully met.	Scores against key performance indicators for standards.
Program operations (general organisational factors that foster or inhibit comprehensive, high quality service provision e.g. adherence to clinical practice guidelines, practices for client/treatment record documentation).	Number of practices or processes reviewed or audited within the last year.	Proportion of non-compliant practices or processes identified.	Refer to client or program outcomes.
Staffing (knowledge, skill and qualification level, staffing levels, staff supervision and support).	Number of FTE staff per client. Number of hours staff development per FTE staff.	Percentage of staff with specified qualification levels. Percentage of staff expressing high levels of satisfaction.	Staff turnover rates/average length of service.
External relationships			
Collaboration (partnerships and networks with related services and organisations).	Number of contacts with other practitioners or service providers. Number of collaborative ventures or agreements.	Percentage of stakeholders providing positive feedback on activities.	Percentage of collaborative activities meeting targets or outcomes.
Reputation and profile (how the organisation is perceived by clients, peers, local community, referring agencies and the funding body).	Amount spent on promotional activities. Staff hours spent on presentations or similar interactions.	Percentage of stakeholders providing positive feedback on activities.	Percentage of key stakeholders/referring agencies rating the organisation highly.

Benchmarking Example

The XYZ service has been tracking the average levels of drug and alcohol use across its client groups and is using this to benchmark treatment outcomes in each substance. Using COMS on NADAbase, they generate reports in graph form showing the annual average scores at each stage of treatment for alcohol.

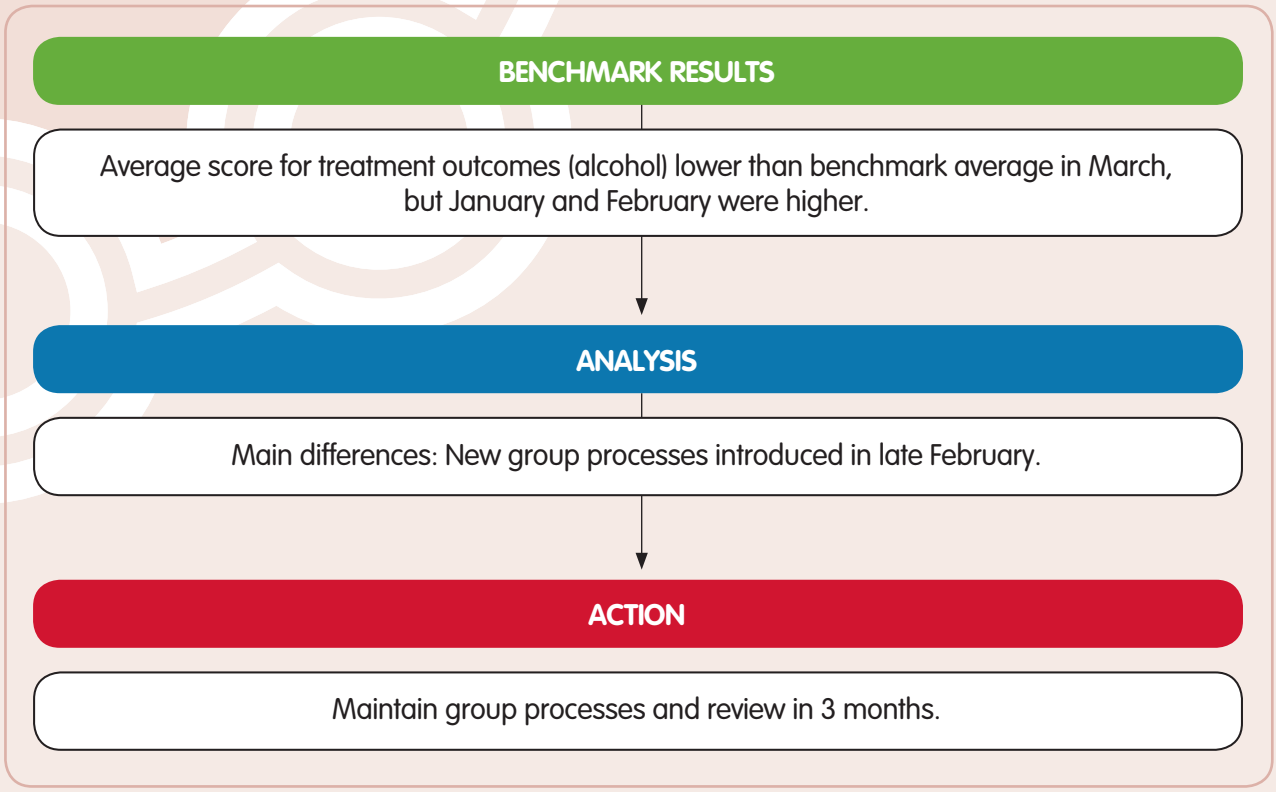


Selecting the best results for **Exit** and **Follow-up One** stages as the benchmarks, the organisation monitors future results against these.

Using the benchmarked data

Once indicators are identified and benchmarks set, benchmarking can then be used to drive improved practices, processes and organisational change.

The following example takes the result of the benchmarking of treatment outcomes on the previous page, analyses what may have contributed to improved results and then applies this to ongoing practice.



4. Benchmarking tools

4.1 BENCHMARKING PROJECT PLANNER

BENCHMARKING PROJECT PLANNER		
Project title:		
Project coordinator:		
Team members:		
Time frame:		
Areas considered for benchmarking	**Priority**	**Notes**
Service delivery		
Service delivery procedures		
Treatment approaches		
Continuity of care		
Procedures for other (non-direct) services or programs		
Other		
Organisational		
Governance and accountability		
External standards		
Program operations		
Other		
External relationships		
Collaboration		
Reputation and profile		
Other		
Issues and concerns:		
INTERNAL BENCHMARKING		
Selected indicators	Data available	Data needing collection
EXTERNAL BENCHMARKING		
	Data available	To be researched

SELECTING BENCHMARKING PARTNER/S		
Potential partner:		
Characteristic	**Information**	**Notes**
Service location	City, suburban, regional centre or rural	
Service size	Number of service types (e.g. health promotion prevention, day program, counselling or residential rehabilitation) number of staff, number of locations (including fixed or mobile services)	
Service type	Case management, withdrawal management non-medicated, withdrawal management medicated, rehabilitation day program, residential rehabilitation, drug and alcohol health promotion and prevention – information and education, drug and alcohol health promotion and prevention – community development program, aftercare program etc.	
Service hours	General business (9am – 5pm), 24/7, after hours etc.	
Client populations	Gender specific, age specific, cultural or language based, dual diagnosis	
Complexity of service provision	Multi-faceted (e.g. provides information, education, assessment, referral, counselling and treatment) or predominantly single focus (e.g. telephone information and referral or residential treatment service)	
Data collection	Existing data the service has access to (e.g. Client Outcomes Management System (COMS) etc.)	

4.2 DEVELOPING A MEMORANDUM OF UNDERSTANDING

If you are participating in a collaborative benchmarking project it is advisable to enter into a written agreement with your collaboration partners that outlines the limits of the project, obligations of each partner and a general code of conduct to minimise any difficulties and avoid misunderstandings.

In developing the details of this agreement, keep in mind:

- **Equality of exchange:** Ensure that partners will be disclosing similar information at the same level of detail to one another. Discuss and agree on expectations with regard to the exchange early in the process.
- **Confidentiality:** Partners should agree to treat information they receive from one another as confidential. Depending on the information that will be exchanged, you may also want to consider entering a non-disclosure agreement with your benchmarking partner.
- **Use of information:** Ensure that the agreement specifies that any benchmarking information exchanged cannot be used for any purpose other than that to which you have agreed.
- **Commitments:** Ensure that each partner's undertakings are clearly identified and that you are clear about what action will be taken if a partner does not meet their commitments.

The following pro forma provides a template for developing a Memorandum of Understanding.

[Insert organisation name/logo] [Insert partner organisation name/logo]

MEMORANDUM OF UNDERSTANDING TEMPLATE

A commitment to partnership between

[Insert organisation name]
[Insert organisation address]

and

[Insert partner organisation name]
[Insert partner organisation address]

commencing

[Insert month and year]

SECTION 1. BACKGROUND

[Insert a background to the partnership, for example: when and why it commenced, achievements, etc.]

1.1 About [insert organisation name]

[Insert a summary of the organisation such as aim, services provided, website, etc.]

1.2 About [insert partner organisation name]

[Insert a summary of the organisation such as aim, services provided, website, etc.]

SECTION 2. PURPOSE

The purpose of this Agreement is to [insert details].

SECTION 3. EXPECTED OUTCOMES

The partnership between [insert organisation name] and [insert partner organisation name] expect to achieve the following outcomes:

» [Insert outcome]
» [Insert outcome]
» [Insert outcome]

Note*

Some outcomes examples could include:

» improved referral processes for clients of our service
» increased communication and information sharing between organisations

* Delete when document is completed

SECTION 4. GOVERNANCE

The partnership between [insert organisation name] and [insert partner organisation name] is governed by:

» [insert details of governance]
» [Insert details of governance]
» [insert details of governance]

Note*

Some examples of governance information to include above could include:

» Who in each organisation holds authority in relation to this Agreement?
» How are activities going to be undertaken and monitored?
» Is this activity/MOU overseen by a particular group or committee?

* Delete when document is completed

SECTION 5. TERMS OF THE AGREEMENT

This Agreement is effective from the date of signature by both parties and remains so for a period of [insert time period] at which time a review on continued partnership shall be undertaken.

[Insert other relevant information, including confidentiality and release of information]

SECTION 6. DISPUTE RESOLUTION AND TERMINATION OF AGREEMENT

Disputes between the two parties are to be managed in the first instance by the identified officers. Where issues are not resolved at this level, either party shall refer to their organisations' external dispute management processes.

Either party may terminate the Agreement at any time in writing to the other party.

[Insert other details in regards to dispute resolution or termination of agreement]

SECTION 7. AGREED ACTIVITIES

Specific activities that will be undertaken to achieve the expected outcomes of this agreement.

7.1 Specific activities

NO.	ACTIVITIES	DESCRIPTION OF ACTIVITY
[insert No]	[activity name]	[brief description of activity ensuring sufficient detail so that the activity meets expectations and is valuable to both organisations]

7.2 Responsibilities and timeframes

NO.	ACTIVITIES	RESPONSIBLE/LEAD AGENCY/WORKER	DUE DATE
[insert No]	[activity name]	[Specify timeframe]	[Specify timeframe]

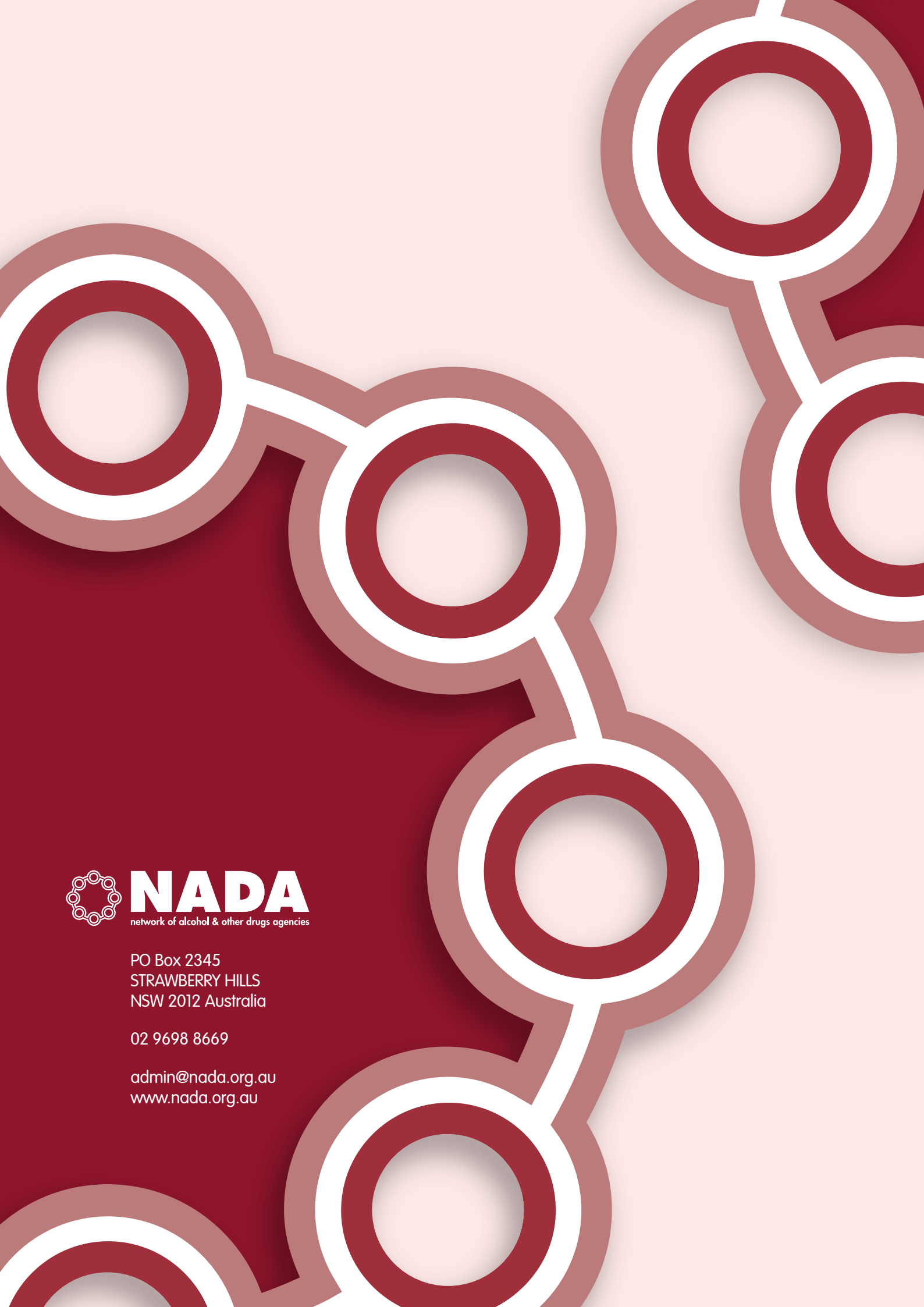
SECTION 8. CONTACT DETAILS

The identified personnel responsible for coordinating and/or undertaking agreed activities are:

CONTACT DETAILS	
[Insert organisation name]	
Name:	
Position:	
Phone:	**Mobile:**
Email:	
[Insert partner organisation name]	
Name:	
Position:	
Phone:	**Mobile:**
Email:	

SECTION 9. SIGNATURES TO THIS AGREEMENT

SIGNATURES TO THIS AGREEMENT	
[Insert organisation name]	
Name:	
Role:	
Signature:	**Date:**
[Insert organisation name]	
Name:	
Role:	
Signature:	**Date:**



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