

Abstract

*"The NHS in the UK is constantly going through change. In this case study, **Józefa Fawcett** highlights how Knowledge Management principles were applied within the Public Health Sector during 2000 – 2003 as a mechanism to help support individuals manage the change process. Using an organic KM infrastructure she describes how a county-wide project in the UK laid the foundations upon which the health economy could build better cross-organisational working by listening their own workforce and in so doing, lead the way towards improved communication, understanding and developments in service provision and care for patients."*

About the author

Józefa Fawcett works as an independent specialist practitioner who utilises her expertise to enhance personal and organisational learning and development. She has a particular interest in leaders and managers and in enabling them to understand how to value the wealth of knowledge within their teams, which she sees as fundamental to individual and organisational performance development.

She has over 28 years experience of training and knowledge development, joining the NHS in 1990 after spending 14 years in the private sector, her last substantive post was Head of Workforce Development in an NHS Shared Service Centre up until 2002.

She has published a number of articles on Knowledge Management (KM) and is an enthusiastic and experienced speaker on the subject, both at conferences across UK and Europe but also in her capacity as visiting lecturer at University of Westminster, London. Józefa is due to join the ECLO Board and bring her particular brand of expertise and humour to future meetings.

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Listening to Learn..

Let me briefly introduce you to the National Health Service in the UK, some of the current changes impacting on healthcare provision, clinical development & training and present a case study of how a Knowledge Management Centre(nhs) Network across on English county could be used to encourage a new way of organisational learning, collaborative working and knowledge-sharing across professional, organisational and sector boundaries.

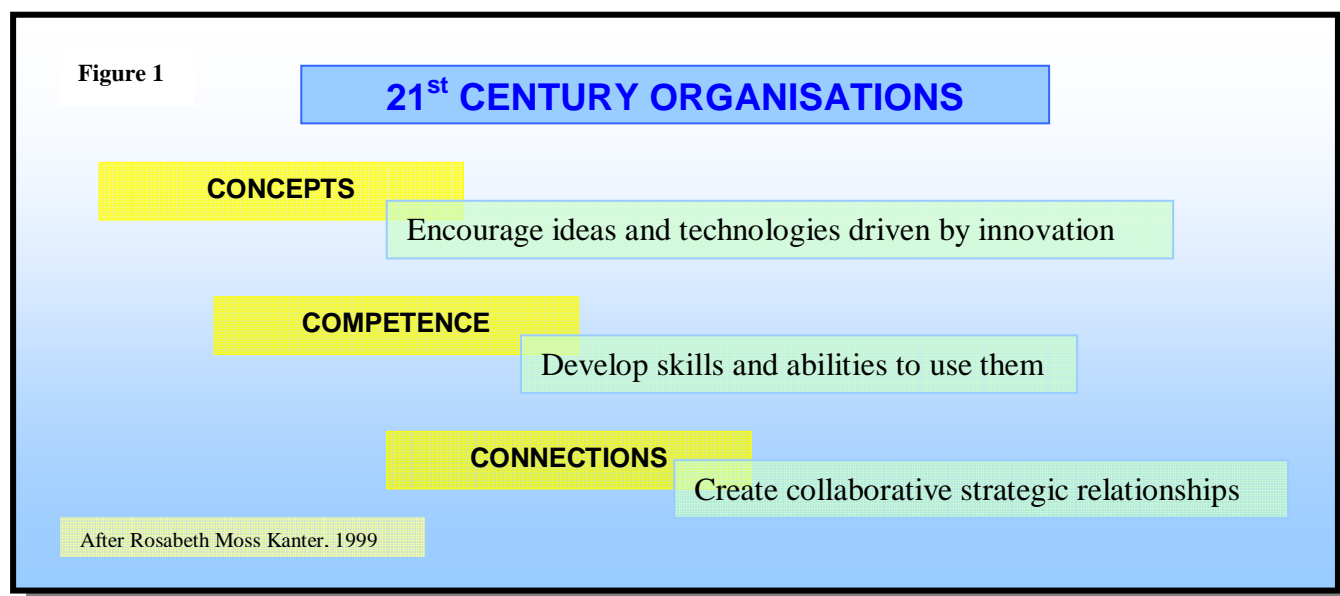
Modernising the NHS

The UK National Health Service became a reality on 5th July 1948, and over the last 56 years there have been constant changes in Health Care provision, some of which have caused major organisational headaches and ongoing Human Resource problems. Financial constraints over the years have made it impossible to accurately predict the day-to-day costs of running the NHS as more expensive and more frequently used drugs are constantly being developed and public expectations grow. These tensions continue to challenge senior management and indeed successive governments. The current government's answer to this was in its White Papers in 1997¹ and 1998² making clear the aim to build a modern and dependable health service that provides a fast responsive and high quality service across all parts of the country. The NHS Plan³ further outlined a five-stage improvement programme, which included breaking down barriers between different parts of health and social care and investing in staff, buildings, equipment and information. The restructure of the NHS started on 1st April 1999 with the creation of 481 Primary Care Groups each responsible for the co-

ordination of healthcare provision. After only five months, two fifths of these were aiming to become Primary Care Trusts with further responsibilities for developing partnerships in commissioning *and* provision. This case study area is made up of 6 Primary Care Trusts, one Mental Health & Learning Disabilities Trust, one Ambulance Trust and two General Hospitals.

Changes in the provision of healthcare

The whole of the NHS is working towards an 'Interface' model of health care, a fundamental principle of which is to encourage and enable different relationships between the patient, the clinician and other clinical professionals. This new relationship - based upon consensus teams, integrated practice, blended roles, management integration, mutual acceptance and support for the good of the whole patient/client - also means a change in leadership and management styles. Many writers have focused on the strategic issues around consensus building, integration and collaboration, Rosabeth Moss-Kanter (1999)⁴ highlighted that to create world class 21st Century organisations, what is needed are a range of skills that allow the organisation to operate either with a 'collaborative advantage' or as a 'collaborative ambassador', these skills are categorised within three important elements, **CONCEPTS; COMPETENCE & CONNECTIONS**. (see figure 1 below)



To those in the NHS, this model of collaborative and consensus working between the professions might seem like an impossible dream, but it is from this starting point that the idea for the Knowledge Management Centre(nhs) Network originated.

Various KM approaches in the NHS

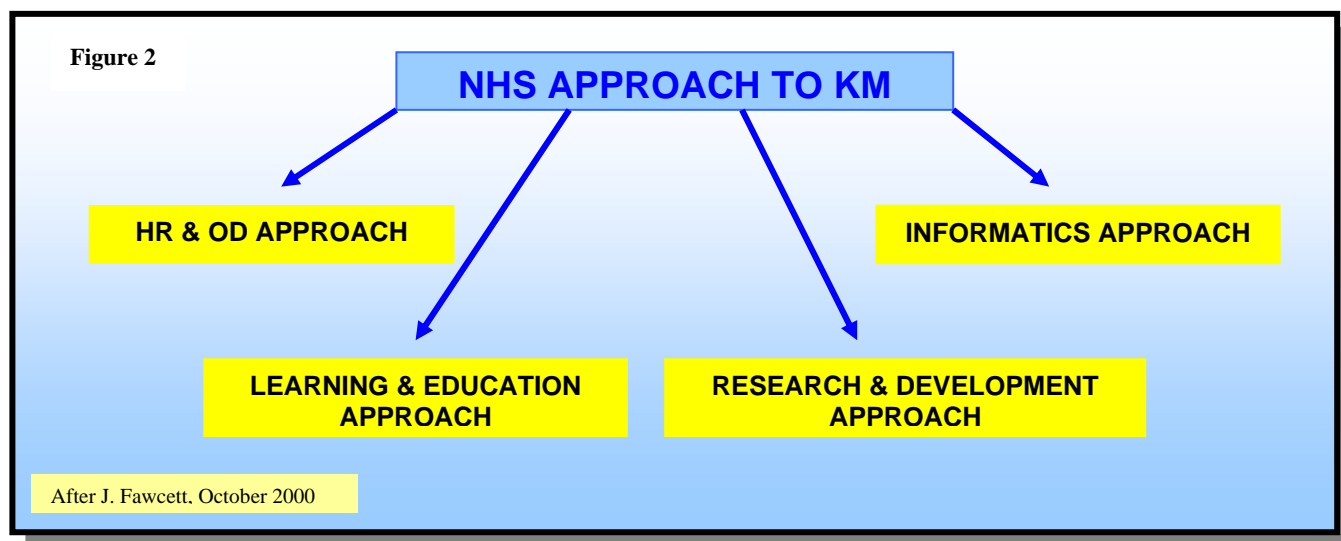
One definition often quoted is from the Swedish writer Karl-Erik Sveiby (1999), he says:

"...Knowledge Management is an organisation's capacity to influence and create value from its intangible assets"

While others have described KM as managing both explicit and tacit knowledge, what is clear is that few activities depend on knowledge as much as healthcare management, clinical practice and patient choice. To date the NHS has spent more energy managing buildings and money than managing its knowledge. This is now changing, and there is a major shift to embrace both strands of Knowledge Management. The traditional

strand offering a *scientific* approach where the emphasis is on the *management of information and the speed and accuracy of data storage, retrieval and dissemination* and the increasingly popular European strand, concentrating on a more *organic* approach and the *management and mobilisation of people and their knowledge* utilising this for creativity and innovation within an organisation. There is however, growing confusion between *Information*, which is embedded in tools for processing data quickly and *Knowledge*, which is embedded in the minds of the workforce and depends on a variety of social interactions to encourage "knowledge harvesting/creation". The key to any successful KM strategy is to apply a blended KM approach adopting the best fit for the organisation and its context - no longer does "one size fit all".

Over the last few years the NHS has attempted four distinct KM approaches (see figure 2) with varying degrees of success.



The HR/OD approach (most likened to the organic model)

Regular forums were held to raise awareness of how to support change initiatives through the Human Resource and Organisational Development professionals. These now are no longer being rolled out.

The Informatics approach (most likened to the scientific model)

A considerable amount of work has been undertaken with NHS librarians across the UK in how to adapt and influence this new environment, there is also a National Electronic Library for Health a wonderfully rich resource library online.

The Research & Development approach (a mix of the scientific and organic)

A national tool was designed to identify ways to increase individual and organisational research and development capacity and promote systematic take up of research evidence. This is now no longer operating.

The Learning Network approach (a mix of the scientific and organic models)

Regional Learning Networks offered leadership and management development programmes for non-executive directors and clinical leaders, learning centres, learning partnerships and beacon sites for sharing intelligence. This has now been disbanded.

The County-wide KM project case study

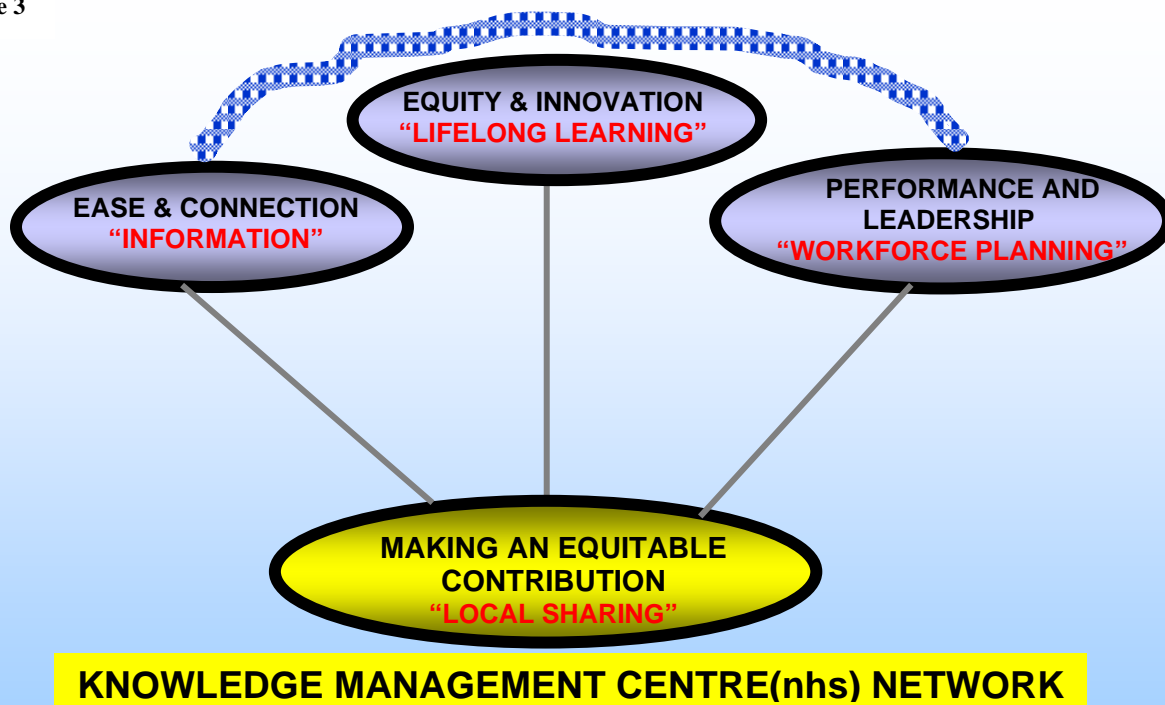
The Knowledge Management Centre(nhs) Network (KMC) was established May 2000, and its purpose was to encourage the sharing of knowledge across the health economy across its professional, organisational and sector boundaries; to build up working

partnerships for the future and provide a wide range of information regarding traditional and eLearning opportunities.

The project's key deliverables by March 2003, were to: -

- Set up KM Centres around across the county creating local '*Communities of Practice*' each with a '**learnirect**' eLearning access point
- Create an infrastructure (see figure 3) that aligns the KMC Network with other development going on around the County thus creating local internal working partnerships
- Market the provision of eLearning facilities to all health and social care staff in Berkshire
- Support eLearning study through the establishment of an eLearning Advisory Team
- Act as a 'signposting' service connecting people to other people so as to fully utilise the vast array of explicit and tacit knowledge held within Berkshire
- Facilitate cross boundary working relationships so as to underpin the next phase of health and social care changes post 2003.

Figure 3



"...Mobilising Knowledge in an ever changing Health Service"

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The 'parachute' analogy represents a vehicle through which staff on the ground can **access** national and other high level directives and information (guidelines, learning provision etc.), **share** expertise across **joined up** initiatives and find collaborative partnerships via their own local **supportive** framework. Through 'human portals' (the KM intermediaries, who run the Knowledge Management Centres) staff get advice on how to find information (electronic and paper), discover what county-wide initiatives are going on and encourage them to share their local learning (tacit knowledge). The role of these KM co-ordinators is to mobilise this knowledge, rather than manage it,

and ensure that those responsible for future decision-making and problem solving have access to their own talented workforce.

The health economy already had well established Post-Graduate libraries, a Corporate Intranet and various organisational and clinically specific websites. This *organic* KM approach aimed to build upon this by not only providing equity of access to all of this information to healthcare staff who had limited time or, in many cases, no access to computers in their day to day work but also provide a vehicle through which the organisations themselves could listen to the ideas from their workforce.

In July 2000, the KMC Network was invited by the health care regional office to promote a new UK-wide eLearning initiative - a partnership between the NHS and University for Industry (Ufi) - this led to the KM Centres becoming licensed '**learndirect**' sites for enrolment onto any of the 700+ products available. This brought much needed funding to progress the KM side of the project as well.

Project methodology

The plan was simple, to establish a network of KM Centres in at least 4 healthcare organisations across the county during the period 2000 - 2003. Local Implementation Teams (made up of partners from health, social, independent and voluntary care sectors and Borough councils) were brought together to oversee the introduction of each Centre for their own geographical area. An eLearning Advisory Team was established to address cultural issues associated with the development of the new learning technologies, and a Project Advisory Board that reported progress to the Department of Health via a National eLearning Action Group. As one of 16 eLearning pilot NHS sites across the UK, this particular health economy was unique in that it was attempting to introduce eLearning and knowledge-sharing across many sectors on behalf of a whole health economy that was itself embarking upon major organisational and structural change. Part funding came from the Department of Health, the regional office, the local Workforce Development Consortium and the local organisations themselves.

Lifelong Organisational Learning & KM

Each KM Centre was organised into KMzones, providing: -

- A **Reflection Zone** with dedicated '**learndirect**' computers for eLearning
- An **Information Zone** with Internet connections, books and journals and completed assignments, dissertations and general information donated by staff
- A **Networking Zone** for neutral-space for meetings and protected learning time
- The **Interprofessional Learning Exchange** - place to bring different professionals together

This last KMzone was the most exciting because put in place ways to further promote and encourage collaboration and cross boundary sharing, including ideas like:

- A Post-Graduate Advanced **Certificate in Change Management**
- **KM SHAREMATCH scheme** - offering staff an opportunity to workshadow any profession they like across sector boundaries
- **KM database** capturing information about the talented workforce in each geographical area
- **Development for Trainers Forum** - a supportive network through which members could reflect upon the latest learning practices and share professional knowledge
- **The KM Collaborative** - For those who are leading KM initiatives whether it be from a technological, management or social perspective. This new network wanted to look at how to apply KM principles to other organisational learning initiatives.

Challenges and Constraints

Working on a project of this scale, that was based upon collaboration and networking, during a period of such major multi-organisational restructuring, meant both exciting challenges and very practical constraints. There was the need to regularly energise some of the original project champions who, as part of the boundary changes, found themselves with other more immediate priorities, or in many cases losing their jobs.

There was also the need to constantly looking to identify new champions in the system to support the project – this was not always easy and often meant that there was NO local support for this work.

Of all the constraints, the most significant was defying the more traditional approach to cultural change – which was usually top down – and in total contrast to this bottom-up project that wished to inform some of the key decision making from a purely operational level.

Local resourcing of the project faltered towards the end of 2003 and, as a result, many of the innovative ideas were scrapped or fell into decline. The monitoring groups fell apart and the network administration and co-ordinating role disappeared with the lack of funds. The eLearning provision was retained, however, the KM side has all but gone, and with it the learning from within that could benefit the organisations in their improvement plans.

Finally, there was always a danger that as interest in KM grew in the NHS, the emphasis on classifying and codifying information and creating online 'library junk yards' would become more important than developing networking capability. This sadly has been the case, resulting in huge repositories of information that are kept for just-in-time (JIT) use, which is both costly and a huge strain on already creaking IT infrastructures and servers.

Key learning

For readers of this case study there will be many questions: Can you buck the cultural trend of an organisation from within – should you even try? How do you demonstrate the benefits of learning in real monetary terms, so that the organisation takes notice? Should you be looking to develop opportunities for innovative practice when there is little chance for staff to use this at their workplace? And what happens to the motivation of the workforce when their ideas and views are not valued or even known about?

I leave you to make up your own mind, but here are some of my concluding thoughts.

This project focused less upon the mechanics of managing knowledge and more on the challenge of how to mobilise and effectively share this knowledge across organisations. Innovations that enable the workforce to learn and share are hard to maintain, and if organisational learning is to be successful then the end result must be a change of culture at all levels. It is not enough to introduce a website or database, but also to have in place a plan as to how an organisation can learn to listen so that they can in turn learn how to change and build the skills needed to use the knowledge that is being created. This health economy took a first and important step in crossing what were once traditional NHS boundaries in learning, knowledge sharing and utilisation of local intellectual capital - and in so doing might still have a chance of creating opportunities for the workforce to influence and inform the future provision of health and social care services for patients.

Good luck with your own organisational learning initiatives.

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