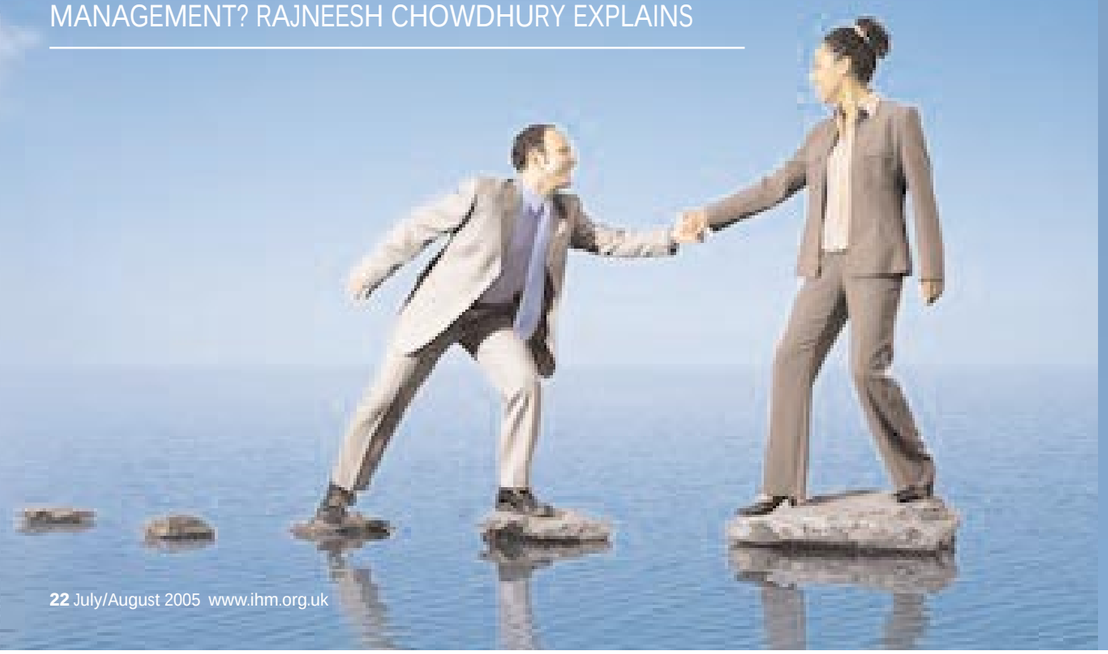
22-23_knowledgeman_des2 2/6/05 1:01 pm Page 22

knowledge management

Making the leap

HOW CAN WE MAKE THE MOVE FROM INFORMATION MANAGEMENT TO THE MUCH MORE USEFUL KNOWLEDGE MANAGEMENT? RAJNEESH CHOWDHURY EXPLAINS



Healthcare is changing constantly. At the present time, power to address medical conditions seems to lie in the amount of information the clinician has and the knowledge that comes from this information. The more informed we are, the more empowered we are believed to be.

Does overemphasis on information technology (IT) mean underemphasis on user perspective and intuition? How can we make a leap from managing information to managing knowledge?

As far as quality healthcare service provision is concerned, information plays a significant role. This has been recognised in the Coronary Heart Disease (CHD) National Service Framework[1], which places information in the list of 'fundamental values and guiding principles'. The Coronary Heart Disease Information Strategy[2] followed, which sets out the rationale for such a strategy to support modern, co-ordinated cardiac care, including the policy and strategic context, and suggested the implementation and monitoring of the strategy. The objectives of the CHD information strategy are to develop and support access to consistent, integrated and robust information for all concerned stakeholders.

Information has therefore appeared as a buzzword and the 'modern' NHS has witnessed dominant faith in strategies (documents and resources) like Our Information Age[3], Information For Health[4], the British National Formulary[5], the National Electronic Library for Health[6], among others, to deliver better healthcare services. Most importantly, today we are part of a £6.2 billion management information systems mega-project – the National Programme for Information Technology (NPfIT) – which is set to redefine the face of medical informatics in the UK as the most advanced system in the world.

However, overemphasis on technology can lead to the lack of appreciation of human intuition and opinion. Unless attention is paid to end users, an information strategy may quickly become a mere technology strategy, with disastrous consequences. In Information Systems Strategic Management[7], Clarke cites a high-profile example in the health sector: the failure of the computer-aided dispatch system of the London Ambulance Service in 1992, where problems in the system were treated as technical, rather than political or social.

Quite recently, when I asked a key player in the NPfIT programme, of a particular Cluster, about who the client of the systems design is, they replied that it was the people that specify the design. However, it is the clinicians, administrators and patients – end users – who ought to be the clients. When I asked them what representation and power the affected stakeholders – the patients – have on the programme, they replied that in the national level, patients have representation and they do play a role; however, in the local level, although they ought to, it is not always possible. No wonder, when the Radio 4 File On 4 survey was conducted, only 7% of the 500 GPs and hospital doctors felt they had been "adequately consulted"; and a further three quarters of doctors were not confident that the system will succeed[8].

PEOPLE POWER

The people element mustn't be under-played just because the technology element is overplayed. Information strategy projects should pay equal importance to people and technology and realise that people do not exist for technology to work efficiently, but technology does exist for people to work effectively.

Getting the people and technology indices right is a challenge, but brings its rewards. The starting point is the realisation that strategising with IT should not be the sole organisational mission, but the effort ought to be towards recognising how availability of information may enable members to maximise on their understanding and engage in conscious action for improvement. In other words, information should be used as a raw material to create knowledge. Information, per se, has no relevance unless it instigates an informed perception to yield results.

There should be a leap from information management to knowledge management (KM). Without it the former remains restricted just at the level of availability and accessibility of required meaningful data, and won't result in creative action. KM is the ability to harness the existing and potential capabilities of the organisation and its members and use them to build a competitive advantage. KM entails not only working at the level of the 'what' and 'how' of doing things, but the 'why' as well. The perception and world view of stakeholders become paramount here because strategies are worked upon to give meaning to work. This understanding not only results in the reworking of strategies, but also their redefinition.

In the recent past, I have used specialist techniques in management systems to understand how strategies are perceived and accepted within a core cardiac team. My application of a systems approach called Soft Systems Methodology indicated that information is available, but what is not available is the information about what to do with that information. This is where the 'why' question comes in. My application of a systems methodology called Critical Systems Heuristics indicates the requirement, but the inability, to include patient representation at the local level for the NPfIT programme. This is where the question of the actual clients of the programme arises. In my opinion, the clients significantly include the patients. For successful implementation of any project, stakeholder participation is vital and there should exist a strategic meaning of why a project is envisioned. The key to this lies in taking a whole systems approach, where knowledge is cherished and benefits maximised.

> "OVEREMPHASIS ON TECHNOLOGY CAN LEAD TO LACK OF APPRECIATION OF HUMAN INTUITION"

A holistic approach entails considering the boundary issue critically. Effective KM is only possible when established boundaries are critiqued and learning cascades across paradigms. We have a lot to gain by breaking rigid administrative and political boundaries and taking part in dynamic cross-fertilisation of ideas and perspectives.

AS A WHOLE

Let us see what a holistic KM approach can teach us. Northern Ireland, Scotland and Wales turned down the offer of joining NPfIT[9]. This will clearly create problems in healthcare for people living in border areas. NHS Scotland is going ahead with the Generic Clinical System, simultaneously with NPfIT, but not necessarily compatible with it[10]. Much could have been gained by developing compatible IT systems rather than two, similar, yet incompatible ones.

Northern Ireland has a successful Virtual Partnership body for patients, hosted by Wellnet, where patients can have discussion forums[11]. Learning from this project should cascade into NHS patient forums across boundaries to improve patient representation and participation, and should not just be confined to Northern Ireland.

A holistic approach to KM can serve significantly to overcome unseen blocks commonly arising from mere technological glitches, non-participative decision making, unstrategic mundane planning, isolative development initiatives and detachment from learning opportunities. At a time when there is massive IT investment in the health sector and a push towards new strategies for delivering high-quality results, there is always a danger of duplication of effort and the possibility of being left out from potential learning from similar initiatives.

As I have indicated, there is valuable learning to be achieved by systemic considering and cross-learning of initiatives in England, Scotland, Wales and Northern Ireland. Adopting a holistic approach to KM sooner rather than later will enable maximum benefits for a sustainable competitive advantage in healthcare. ■

Rajneesh Chowdhury is Associate in the Knowledge Transfer Partnership programme between the University of Hull and the NHS. He can be contacted at R.Chowdhury@hull.ac.uk. *He is grateful to Alan Nobbs, Ruth Butler and Amanda Gregory for reviewing this paper and for their valuable suggestions*

References

1. National Service Framework for Coronary Heart Disease (2000), Dept of Health
2. Coronary Heart Disease Information Strategy (2001), Dept of Health
3. Our Information Age (1998), HMSO
4. Information for health: an information strategy for the modern NHS 1998-2005 – executive summary, Dept of Health, NHS Executive, 1998
5. The British National Formulary: www.bnf.org/bnf/
6. The National Electronic Library for Health: www.nelh.nhs.uk/
7. Clarke, Steve (2001), Information Systems, Strategic Management: An integrated approach, Routledge, London
8. 'GPs 'doubtful' about IT upgrade' http://news.bbc.co.uk/1/hi/health/3750474.stm
9. 'MPs told Wales, Scotland and NI passed on NPfIT' www.e-health-insider.com/news/item.cfm?ID=752
10. 'NHS Scotland begins national EPR procurement' www.e-health-insider.com/news/item.cfm?ID=850
11. News, Editor: Sue Kinn www.bcsnsg.org.uk/itin16/VOL16-2news.pdf