

Report 23a: A review of knowledge management and evidence-based practice activities and networks in adult social care in the North West of England



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Your comments

This report and accompanying strategy, primarily aimed at the North West Joint Improvement Partnership (NW JIP) and Social Care Institute for Excellence (SCIE), was circulated to a wide range of stakeholders during May–June 2009, and their feedback incorporated into this final version.

If you have any additional comments to make, please send them to:

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Executive summary

This document reviews current knowledge management (KM) and evidence-based practice (EBP) activities and networks in adult social care in the North West of England.

By KM, we mean:

The creation and subsequent management of an environment that encourages knowledge to be created, shared, learnt, enhanced, organised and utilised effectively and efficiently for the benefit of adult social care practice. (Based on a definition by TFPL, Knowledge and Information Management Services, 2008)

By EBP, we mean:

Asking challenging questions about our practice and using the best available evidence (e.g. research findings, practitioner expertise and user views) to inform our decision-making. (Based on a definition by Research in Practice, 2002).

The specific objectives of this review are:

1. To provide a clear regional picture of KM and EBP activity and its effectiveness in adult social care.
2. To make recommendations for improving and sustaining regional KM and EBP systems and activities.
3. To inform a regional KM and EBP strategy for adult social care.

The primary target audience for this review is the North West Joint Improvement Partnership (NW JIP), but the report is of interest to a wide range of stakeholders and interested parties.

The report is divided into five sections:

1. [Section 2](#) sets the context for the review by providing an overview of KM and EBP and highlighting their importance in the field of adult social care.
2. [Section 3](#) describes the methods used to inform this review.
3. [Section 4](#) presents the main findings and recommendations of the review.
4. [Section 5](#) discusses the findings in the context of the five guiding principles of KM.
5. [Section 6](#) draws conclusions and summarises the recommendations that form the basis of the accompanying regional strategy for KM and EBP.

The key messages emerging from this review are:

- The terminology used (KM and EBP) remains confusing and inaccessible for some people.

- Much KM activity is uncoordinated and undertaken as part of other agendas, in particular, performance. The focus should be on raising the profile of KM and coordinating existing activities, rather than necessarily creating new systems and processes.
- Consideration needs to be given to the specific KM and EBP requirements of the NW JIP.
- Cultural issues are a major barrier to taking forward KM and EBP within individual organisations.
- There are already multiple sources of evidence; the challenge is to coordinate these and make best use of them regionally.
- There is considerable overlap and duplication of effort with existing regional networks and 'communities of practice'.
- Formal KM tools and techniques (e.g. after action reviews and lessons learned) appear to be underutilised within the region.
- There is a strong collaborative social work research community in the region, led by several specialist research departments at higher education institutes (HEIs).
- Multiple approaches to evidence dissemination are required. SCIE and Research in Practice for Adults (RIPFA) have a valuable role to play in summarising, quality assuring and disseminating evidence, both nationally and regionally.
- Although much of the technology and infrastructure to support KM and EBP depends on individual organisations, there is potential to apply and extend regionally national mechanisms such as the Athens pilot and chief knowledge officers (CKOs).
- There is a need to improve the KM skills of the adult social care workforce, both regionally and nationally.

The report makes the following recommendations for the NW JIP:

1. To collate and disseminate examples of KM strategies, organisational structures and activities within the region. The publication of this report helps in this respect.
2. To clarify the longer-term remit of the NW JIP's 'evidence' workstream, as well as investigate further its own requirements for KM (e.g. having a dedicated KM person).

3. To work with SCIE to develop an introductory guide to KM and an accompanying toolkit, with regional case studies. This will include tips on addressing the cultural issues associated with KM.
4. To facilitate the collation and dissemination of good practice examples in the region in line with the NW JIP workstreams (i.e. personalisation, commissioning, early intervention and prevention, workforce and leadership, etc.). Ideally, these examples should be accessible regionally (e.g. via the NW JIP web site), nationally (e.g. via the SCIE website) and via subject-specific sites (e.g. via the relevant Department of Health Care Networks).
5. To use the Good Practice Framework currently being developed by SCIE to inform the collation and dissemination of regional good practice examples.
6. To investigate further the potential of using the Department of Health Care Networks to facilitate knowledge sharing within the region. This is in preference to the NW JIP setting up its own separate networks.
7. To review its current networks and group membership to maximise their effectiveness and efficiency.
8. To support the piloting and evaluation of SCIE's KM e-learning resource within the region.
9. To support and promote the roll-out of the SCIE Athens pilot to all 23 local authorities in the NW.
10. To encourage all local authorities in the region to identify a CKO, in line with developments in the NHS.

1 Introduction

This document reviews current knowledge management (KM) and evidence-based practice (EBP) activities and networks in adult social care in the North West of England.

By KM, we mean:

The creation and subsequent management of an environment that encourages knowledge to be created, shared, learnt, enhanced, organised and utilised effectively and efficiently for the benefit of adult social care practice. (Based on a definition by TFPL, Knowledge and Information Management Services, 2008)

By EBP, we mean:

Asking challenging questions about our practice and using the best available evidence (e.g. research findings, practitioner expertise and user views) to inform our decision-making. (Based on a definition by Research in Practice, 2002).

A more detailed background to KM and EBP is provided in [Section 2](#) below.

The work has been undertaken as part of the North West (NW) Joint Improvement Partnership (JIP)'s 'One plan' (Section 8.1 'Developing the evidence base'), in conjunction with the Social Care Institute for Excellence (SCIE), to explore models of KM and EBP that will enhance the performance of local authorities and their partners in the region. This is in direct response to the [The status of social care review](#) (Platt, 2007). Further details about the NW JIP and SCIE are available in [Appendix A](#) and [Appendix B](#). The 'One plan' recognises that social care practitioners, managers and commissioners must have access to the best available evidence on effective social care interventions and practices in order to deliver transformed, personalised social care services. In addition, social care professionals need to be able to interpret and apply this evidence to their practice.

This review informs an accompanying strategy that sets out an overarching plan for managing and using knowledge and evidence to improve adult social care practice in the region. The focus of the strategy is on how the NW JIP can act as an enabler in this process.

1.1 Aims and objectives

The overarching aim of this work is to enhance the development and application of KM and EBP in the region, and in particular to support the priorities identified in the NW JIP 'One plan'.

The specific objectives of this review are:

1. To provide a clear regional picture of KM and EBP activity and its effectiveness in adult social care.
2. To make recommendations for improving and sustaining regional KM and EBP systems and activities.
3. To inform a regional KM and EBP strategy for adult social care.

1.2 Target audience

The primary target audience for this review is the NW JIP, including Richard Jones, Chair of the NW JIP and Executive Director of Adult and Community Services at Lancashire County Council; Bernard Walker, Director of Adult Services at Wigan Metropolitan Borough Council; David Jones, Deputy Regional Director of Social Care and Local Partnerships at the Department of Health; and the NW JIP workstream leads. Other stakeholders and interested parties include:

- SCIE
- Research in Practice for Adults (RIPFA)
- Care Quality Commission (CQC)
- Association of Directors of Adult Social Services (ADASS)
- Skills for Care
- Adult social care practitioners, managers, commissioners and policy makers at local authorities
- Adult social care practitioners, managers, commissioners and policy makers at provider organisations
- Improvement and Development Agency (IDeA)
- North West HEIs
- NHS North West
- Service users and carers.

1.3 The North West region and the benefits of a regional approach

The North West (NW) is one of the nine official regions of England. It has a population of 6.9 million (Office for National Statistics, 2007) and comprises five counties (Cumbria, Lancashire, Greater Manchester, Merseyside and Cheshire). It has two major conurbations centred on the cities of Liverpool and Manchester. Despite at least 10 years of action to address health inequalities, the gap in life expectancy is still widening in many local authority areas across the region, as well as between the region and England as a whole (Government Office for the North West, 2008).

As of 1 April 2009, there are 23 local authorities with adult social care responsibilities in the NW. A full list of these authorities is provided in [Appendix C](#). In addition, the NW Improvement and Efficiency Partnership (NWIEP) recognises five subregions:

1. Cheshire (including Warrington)

2. Merseyside
3. Greater Manchester
4. Lancashire
5. Cumbria.

In contrast, NHS North West identifies three subregions:

1. Cheshire and Merseyside
2. Greater Manchester
3. Lancashire and Cumbria.

There is an increasing recognition by central government that greater improvement and efficiencies can be delivered on a regional and subregional level. The challenge is to recognise where national, regional, subregional or local activity is most appropriate, results in the greatest efficiencies, and reduces unnecessary duplication of time and effort. It is essential to ensure that the recommendations in this report are seen as 'enabling', rather than as a mandate for individual organisations to follow.

1.4 Structure of this report

This report is divided into five sections:

1. [Section 2](#) sets the context for the review by providing an overview of KM and EBP and highlighting their importance in the field of adult social care.
2. [Section 3](#) describes the methods used to inform this review.
3. [Section 4](#) presents the main findings and recommendations of the review.
4. [Section 5](#) discusses the findings in the context of the five guiding principles of KM.
5. [Section 6](#) draws conclusions and summarises the recommendations that form the basis of the accompanying regional strategy for KM and EBP.

2 Background and literature review

2.1 Definitions

2.1.1 KM

There are many different definitions of KM (Bates and Ross, 2008; National Library for Health, 2008). In simple terms, KM can be thought of as ensuring that the right information is available to the right people in the right format at the right time (Beverley, 2007). This is in line with the definition adopted by the National Library for Health Knowledge Management Specialist Library:

Knowledge management is a conscious strategy for moving the right knowledge to the right people at the right time to assist sharing and

enabling the information to be translated into action to improve the organizational performance. (O'Dell and Grayson, 1997)

As noted in [Section 1](#), the following definition of KM has been used throughout this review:

The creation and subsequent management of an environment that encourages knowledge to be created, shared, learnt, enhanced, organised and utilised effectively and efficiently for the benefit of adult social care practice. (Based on a definition by TFPL, Knowledge and Information Management Services, 2008)

This definition recognises the importance of the 'environment' to facilitate KM, all the possible actions (creation, sharing, learning, enhancement, organisation and utilisation) associated with knowledge, as well as its impact on the effectiveness and efficiency of practice.

It is acknowledged that some people believe that the term KM is unhelpful because knowledge is not a 'thing' that can be 'managed' (Malhotra, 2002; CSIP, 2006). However, the term KM is commonly used in the private sector and is increasingly being adopted within public services, including the NHS and local government.

Knowledge is derived from information, but is richer and more meaningful than information. In organisational terms, knowledge is generally thought of as being 'know how', 'applied information', or 'information with judgement' (Beverley, 2006).

There are two types of knowledge: explicit and tacit (De Brún, 2005). **Explicit knowledge** is knowledge that has been documented and stored in paper and/or electronic format (e.g. reports, procedures, books, journal articles). **Tacit knowledge** is the knowledge that individuals have gained through experience, and tends to be stored in their heads.

KM is mostly concerned with tacit knowledge, with harvesting knowledge from individuals, presenting it in a format that can be shared with others, and encouraging people to build on what has already happened and learning from past events (De Brún, 2005). In contrast, information management refers to the retrieval, collation, storage and dissemination of explicit knowledge (De Brún, 2005). Inevitably the two concepts are interlinked and often considered as one.

People are at the heart of KM, but KM must be supported by appropriate **processes** and **technologies** to ensure the successful transfer of both explicit and tacit knowledge. Examples of processes and technologies include communities of practice, intranets, extranets, message boards, blogs, wikis.

KM can be thought of as an extension of **EBP**, or EBP as an extension of KM (Beverley, 2006).

2.1.2 EBP

EBP requires individuals to ask searching questions about their practice and the services they provide, for example, why are we doing this?, does it have to be this way?, does it work?, is there a better way?, how can we make this happen? Questions such as these can be answered by making good use of all available knowledge, including research, service user feedback, practitioner expertise and performance data. It may also be necessary to generate new evidence by conducting local research. In light of all the evidence gathered, decisions about policy and practice can be made that will improve outcomes for service users, carers and staff (Research in Practice, 2002).

The EBP model comprises five different stages (Sheffield City Council, 2008):

- Identifying the need for evidence
- Locating the evidence
- Appraising the evidence
- Adapting and applying the evidence
- Evaluating the outcome.

[Research in Practice for Adults](#) (RIPFA), a national research utilisation organisation that promotes the use of evidence in the planning and delivery of adult social care services, advocate using the term **evidence-informed practice** instead of EBP. This recognises that decisions are informed by evidence from a range of sources, including:

- Practice knowledge and experience (including professional wisdom and values, law and policy, knowledge from and about the community, the opinions of colleagues and other professionals, as well as 'gut feelings')
- The wishes and experiences of service users and carers
- Evidence from research.

Glasby and Beresford (2006) provide a similar argument, i.e. that the practice wisdom of practitioners and the lived experiences of services users are just as valid as knowing the world as formal research. However, they favour the term '**knowledge-based practice**'.

For the purpose of this review, the term EBP has been used because EBP is the favoured and understood term across the health, social care and local government sectors. The following definition of EBP, introduced in [Section 1](#) and which draws upon the RIPFA definition, has, therefore, been used:

Asking challenging questions about our practice and using the best available evidence (e.g. research findings, practitioner expertise and user views) to inform our decision-making. (Based on a definition by Research in Practice, 2002).

2.1.3 Types of knowledge and evidence

In 2003, SCIE undertook a review of the types and quality of knowledge in social care (Pawson, Boaz, Grayson, Long and Barnes, 2003). This yielded a classification scheme based on the different sources of social care knowledge, namely:

1. Organisational knowledge
2. Practitioner knowledge
3. User knowledge
4. Research knowledge
5. Policy community knowledge.

This classification scheme, like RIPFA's definition of EIP, recognises the diverse evidence base in social care, i.e. research findings, practitioner expertise, the views of service users and carers emerging from user surveys, performance data, etc. All of the above sources have a vital role to play in building up the social care evidence base, with there being no hierarchy implied in the above list. This is in contrast to the NHS, where the traditional "hierarchy of evidence" (SchARR, 2001) and research evidence, in particular systematic reviews, meta-analyses and randomised controlled trials (RCTs) dominate.

2.1.4 Best practice

The concept of **best practice** derives from a belief that organisations and individuals can learn from the successful experiences of others and thereby improve their own performance (Centre for Local Governance, 2008a).

The terms 'best practice' and 'good practice' are difficult to define formally, mainly because they depend on the specific practices, organisations and individuals involved. Similarly, although best practice has become a popular concept and is seen by central government as a means to stimulate widespread improvement in local government, there is actually very little critical analysis of either the theory or practice of sharing best practice (Centre for Local Governance, 2008a).

A number of assumptions are implied by the concept of best practice (Centre for Local Governance, 2008a):

- That successful outcomes can be identified and attributed to particular practices and that the factors in success can be isolated from the context in which they have occurred.
- That these practices are appropriate in other contexts, are replicable, and are likely to have similar results.
- That the mechanisms are in place to enable the sharing and transfer of practices from one context to others.
- That the adopting organisations are receptive to the new practice and able to implement it.

SCIE is currently working with RIPFA on behalf of the Department of Health to develop a method to assist social care practitioners to reflect upon and share practice developed. This has been termed the **Good Practice Framework**. It does not seek to impose an external judgement on practice but encourages internal self-audit with a view to sharing the process of practice delivery more widely. The focus is on good practice as a process involving a series of staged activities:

1. Stage One – the identification of the 'good idea', to be supported by both relevant evidence and a rationale from service users.
2. Stage Two – detail of what is done, including the contacts made with different stakeholders, further supporting evidence, and detail of acceptability to service users.
3. Stage Three – examination of outcomes achieved to date and how they correspond with the intended outcomes.
4. Stage Four – achievement of good practice with the meeting of outcomes and the completion of a summary template. This will include sections on the feasibility of the initiative being implemented elsewhere and information, where available, about affordability.

A web-based self-audit tool is being developed by SCIE that will allow the 'posting' of the relevant information for each stage into a standardised template. It is acknowledged that not all ideas will progress to the fourth stage; the interest is in the learning from the process and how far the idea progresses.

2.1.5 Learning organisations

Finally, the term '**learning organisation**' is frequently used in the context of KM. By this, we mean:

An organisation that views its success in the future as being based on continuous learning and adaptive behaviour, and where its workforce are skilled at exploiting, appraising and contributing to the knowledge base. (National Library for Health, 2008, based on a definition by Senge, 1990)

2.2 The importance of KM and policy imperatives

The 2008 Audit Commission report, *In the know*, helped to raise the profile of KM within the public sector (Audit Commission, 2008). People often waste time and resources by repeating the same practices and developing methods over and over again, rather than sharing what they know through reliable local, regional, national and international networks (Beverley, 2006). Learning from others is widely seen as a means of avoiding 'reinventing the wheel' and may, therefore, provide a 'shortcut' to the development of successful programmes and policies and require less time and creativity, and fewer resources, to develop solutions 'from scratch' and with a reduction of risk

(Centre for Local Governance, 2008a). In addition, sharing knowledge of lessons learned is thought to result in improved patient and service user care, safety and satisfaction, increased staff motivation and learning opportunities, improved opportunities for practice-based research and innovation, as well as better communication and IT systems (De Brún, 2005).

Recent promotion of sharing and adopting best practice by central government can be considered within the context of several dominant themes in New Labour's policy agenda (Centre for Local Governance, 2008a):

- Evidence-based policy and practice in which policy making is a '... "continuous learning process" that will use evidence-based research, pilot schemes and evaluation of policies and programmes to learn from success and failure and stimulate innovation' (Hartley and Allison, 2002).
- The encouragement of innovation and experimentation, particularly within a less prescriptive performance management framework that tolerates a diversity of approaches provided they adhere to minimum standards.
- Partnership and collaboration in which co-operation produces additional benefits in terms of outcomes.

There is a vital need for improved KM in order to deliver the transformative goals of recent policy directives in adult social care, such as [Putting people first](#), [Transforming adult social care](#), [Valuing people now](#), the national [Carers' strategy](#), the national [Dementia strategy](#), i.e. a whole-systems approach based on collaboration across sectors and organisations; workforce development; service redesign and improvement; and a central focus on empowering service users through personalised services (IRISS and NHS Education for Scotland, 2009).

Putting people first, for example, is unique in establishing a collaborative between central and local government, the sector's professional leadership, providers and the regulator. It seeks to be the first public service reform programme that is co-produced, co-developed, co-evaluated and recognises that real change will be achieved only through the participation of users and carers at every stage.

KM provides essential underpinning infrastructure to support these developments and ensure that the best possible outcomes for service users, carers and staff are achieved (IRISS and NHS Education for Scotland, 2009).

2.3 The guiding principles of KM

There are generally considered to be five guiding principles of KM (Cooke, 2004). These are:

1. Establishing top level management support for knowledge management ('**commitment**')
2. Developing a reflective learning culture ('**culture**')
3. Facilitating access to the 'knowledge' base ('**content**')

4. Providing employees with the skills to find, share, evaluate and organise knowledge, as well as undertake research ('**skills**')
5. Ensuring that the appropriate infrastructure and networking opportunities are in place to support KM ('**infrastructure**')

All five principles must be addressed in order for KM and its benefits to flourish.

The European Committee for Standardization (2004) provides a guide to good practice in KM. This has five parts:

1. KM framework, which sets the overall context for KM at both the organisational and personal levels.
2. Culture and KM, which explains how to create the right cultural environment for introducing KM.
3. Implementing KM in small and medium-sized enterprises (SMEs), which provides a project management methodology to help organisations get started in KM.
4. Measuring KM, which helps organisations assess their progress in KM.
5. KM terminology, which summarises the key KM terms and concepts.

2.4 KM tools and techniques

A wide range of KM tools and techniques exist (Watson, 2007; Centre for Local Governance, 2008a; National Library for Health, 2008). These include:

- KM strategies
- KM self-assessment tools, such as
 - > Collison and Parcell's KM tool, and variations of this (Collison, Parcell and Cooke, 2008)
 - > Centre for Local Governance KM self-assessment tool (Centre for Local Governance, 2008b)
- KM skills assessment tools
- Approaches to measuring knowledge, such as:
 - > intellectual capital
 - > knowledge audit
 - > mapping
 - > social network analysis
- Approaches to capturing knowledge, such as:
 - > after action reviews
 - > exit interviews
 - > knowledge harvesting
 - > lessons learned
 - > best practice guides, toolkits, and case studies
- Approaches to mobilising knowledge, such as:
 - > '**communities of practice**', i.e. groups of people who share a common interest in a specific area of knowledge or competence and are willing to work and learn together over a period to develop and share that knowledge
 - > networks

- > knowledge translation
- > organisational learning
- > peer assists
- > storytelling
- > technology (e.g. websites, intranets, extranets, blogs, wikis)
- > conferences, seminars and workshops
- > awards
- > champions
- > open days and site visits
- > mentoring
- > secondments.

It is beyond the scope of this review to consider each of these tools in more detail here. However, further information, including examples from the NHS, are available via the [National Library for Health Knowledge Management Specialist Library](#). It should also be noted that there has been little analysis of the effectiveness or appropriateness of these mechanisms (King and Ollerearnshaw, 2000).

2.5 KM in health and social care

KM has its origins in the business sector, where the focus is on improving efficiency. Karl-Erik Sveiby is often cited as the founding father of KM in the 1980s. However, KM is now seen increasingly within the public sector, particularly the NHS and social care.

2.5.1 KM in the NHS

There is a strong emphasis on KM and EBP in the NHS. The [NHS National Knowledge Service](#) (NKS), for example, was created in 2002 as part of the government's response to the Kennedy Report on paediatric cardiothoracic surgery in Bristol (NHS National Knowledge Service, 2007). The mission of the NKS, set out in the strategy of [NHS Connecting for health](#), was to ensure that every decision made by a patient or a healthcare professional could be supported by best current evidence.

The [National Library for Health Knowledge Management Specialist Library](#) is part of the NKS. This aims to provide the bridge between knowledge and practice by providing the best available evidence and practical examples of health professionals successfully sharing and applying knowledge and experience to their daily activities.

In response to the Darzi report, *High quality care for all* (Department of Health, 2008), the KM Specialist Library will be transferred to [NHS Evidence](#), hosted by the National Institute for Health and Clinical Evidence ([NICE](#)). NHS Evidence was launched on 1 April 2009 as a web-based service to help people find, access and use high-quality clinical and non-clinical evidence and

best practice. It is built around a powerful search engine and consolidates information from a wide range of sources into one central portal.

The Hill report, *From knowledge to health in the 21st century* (Hill, 2008), recommended that, at a regional level, Regional Directors of Public Health should be designated the responsibilities of the CKO for their strategic health authorities; each NHS organisation should have someone at board level entrusted with the role of **CKO** for that organisation; and every clinical or management team in the NHS should identify someone in the team as '**Team Knowledge Officer**', responsible for ensuring the effective input of evidence to enable the team to function properly.

2.5.2 KM and EBP in social care

In May 2008, SCIE undertook a review of existing national and local KM strategies, models and toolkits in the social care sector (Bates and Ross, 2008). The overall aim of this review was to highlight the feasibility of having a portal on the SCIE web site linking to KM resources in the field. However, the paucity of evidence in the social care sector resulted in the scope being expanded to cover the public sector more generally, but with a specific emphasis on the NHS and local government.

The concept of EBP is less prevalent in social care than in the NHS, but most social work degree programmes now include core modules on finding and appraising evidence, as well as undertaking small-scale research projects.

NHS Education for Scotland and the Institute for Research and Innovation in Social Services (IRISS) are currently developing a three-year Knowledge Management Strategy and Action Plan for Social Services in Scotland, entitled *Sharing knowledge, improving practice, changing lives* (IRISS and NHS Education for Scotland, 2009). This strategy aims:

To equip and empower organisations, staff and service users with the resources, skills and confidence to seek, access and share knowledge and put it into practice, when and where it is needed. This will be a vital part of day to day work in social services, resulting in more integrated, consistent care and better outcomes for service users, based on reliable evidence and good practice. (IRISS and NHS Education for Scotland, 2009).

The approach in Scotland is still under development, but it is likely to involve creating a national infrastructure to support access to knowledge (e.g. by establishing a Social Services Managed Knowledge Network, developing Social Services Knowledge Scotland, and creating an information literacy and KM training and development programme). It may also set out specific actions to be developed on the ground by organisations, teams and individuals, such as producing and facilitating use of tools, systems and processes to support organisations in planning, implementing and evaluating KM strategies and building 'communities of practice'.

3 Methodology

A variety of approaches has been used to establish what KM and EBP activities and networks already exist in the region, as well as to ascertain the views of a wide range of relevant stakeholders on future priorities. This has included:

- A comprehensive Internet and literature search using a wide range of resources (e.g. Social Care Online, National Library for Health, Google Scholar, Google, IDeA, CSIP, CSED, Department of Health, Skills for Care, RIPFA, ADASS, CSCI).
- A group discussion, informed by a topic guide, with Directors of Adult Social Care at an NW JIP away day.
- A workshop and/or individual discussions with Heads of Social Care Research (or equivalents) at North West HEIs.
- A workshop with regional local authority KM and EBP leads.
- A discussion, informed by a topic guide, at a regional personalisation leads network.
- Individual telephone and face-to-face discussions, informed by a topic guide, with representatives from health, social care and local government organisations, including the NW JIP, SCIE, ADASS, CSCI, Skills for Care, RIPFA, IDeA, individual local authorities within the NW, NHS North West and the regional Public Health leads network.
- Individual telephone and email discussions, informed by a topic guide, with a service user and a carer.
- Individual telephone and email discussions, informed by a topic guide, with provider organisations.

Detailed notes made during each of the above discussions were subsequently typed up to act as an aide-memoire.

A full list of all the people and organisations contacted as part of this review can be found in [Appendix D](#).

4 Findings

4.1 Overview

Before looking at the findings in more detail, it is helpful to highlight a few key issues that emerged during the course of this review.

First, the need to maintain a specific focus on adult social care was prominent throughout all the discussions and workshops. Although it was acknowledged that much could be learnt from other sectors (e.g. the NHS, local government, private industry), it was felt that adult social care had its own unique features that could become lost if the KM agenda was seen simply as an extension of work already being undertaken in the health sector, for example. That said, it will be important to ensure that, where opportunities for joint working do exist (e.g. via NHS NW research networks, the evidence base for integrated care, hospital discharge, long term care pathways), then these should be utilised in order to avoid duplication of time and effort.

Second, it was also clear that local authorities cannot operate in isolation, but instead need to recognise the KM needs, skills and resources of the independent sector, and the NHS, as well as of service users and carers. At its most basic level this means ensuring that any of the resources associated with the recommendations in this report are accessible and understandable to everyone.

Finally, in order to make the recommendations in this report more achievable, it was suggested that the approaches should initially be focused in one area and evaluated. Commissioning was widely suggested as the pilot area, with the aim of making the NW a centre of excellence for world-class commissioning.

4.2 Definitions of KM

A common theme that emerged related to concerns about the use of the term 'knowledge management'. This was particularly prevalent among participants at the workshop of regional local authority KM and EBP leads. The literature, as noted in [Section 2.1](#), supports this viewpoint, in particular that the concept of actually managing knowledge is an 'oxymoron' (Malhotra, 2002). Several individuals at the workshop expressed a preference for an alternative term to be used and for the concept to be explained in a more meaningful and accessible way. No alternative terms were suggested, however; instead definitions relating to using 'evidence' to improve performance and outcomes for service users and carers were advocated.

One group at the workshop also questioned using the term 'EBP', instead favouring 'evidence-informed practice', in line with RIPFA, and as described in

[Section 2.1](#). However, as noted previously, EBP is now the favoured and accepted term within the public sector.

Given these concerns about definitions, it was interesting to find that the service user and carer consulted as part of this review appeared to experience no difficulty in understanding the phrases and definitions used and recognised the importance of KM. Similarly, contributors from HEIs were familiar and comfortable with the terminology used.

It was clear that various KM-type activities, particularly in relation to performance improvement and information management, were being undertaken but not under the umbrella of KM, or EBP. Examples given included collating qualitative evidence for inspections; involvement in numerous local, regional and national networks; undertaking of local research in conjunction with HEIs; learning from complaints; and organisational development initiatives. As the Directors attending the NW JIP away day acknowledged, although KM and performance are inextricably linked, it is important to recognise KM as a separate entity.

Since KM and EBP are now accepted terms in the public sector, it is recommended that the NW JIP continue to use these terms. However, greater emphasis should be placed on illustrating the relevance of KM and EBP to frontline practitioners and how KM and EBP can improve outcomes for service users and carers (e.g. through the use of case studies).

4.3 KM strategies and structures

Although the NW JIP away day in January 2009 indicated a high level of interest in KM and EBP among regional Directors of Adult Social Care, this review has identified that only a handful of local authorities in the NW have resources dedicated specifically to KM and EBP. Instead much KM and EBP activity comes under other, often disparate, functions, such as Performance, Workforce Development, Organisational Development, Corporate Research and Policy, Communication and Public Information. Although it is acknowledged that KM is 'everybody's business', the local authority workshop also indicated that it is beneficial for KM activities to be coordinated locally (e.g. by a dedicated person or team). A list of KM and EBP contacts at each local authority is provided in [Appendix E](#).

Of the 23 local authorities in the NW, only six (Cumbria, Lancashire, Liverpool, Warrington, Wigan and Cheshire East) are currently partners of [RIPFA](#), a national research utilisation organisation that promotes the use of evidence in the planning and delivery of adult social care services. Nationally, there are 46 RIPFA partners, which indicates that, given that there are nine regions in England, the NW is slightly above average in terms of membership. It is acknowledged that the high cost of membership (about £14,000 per annum) is prohibitive for some local authorities, but there are numerous benefits of joining, including access to free evidence-based learning events, a wide range of publications, one-to-one research support, an email and online

discussion forum, as well as the opportunity to participate in practice-based change projects. Interestingly, one of the groups at the workshop with local authority KM and EBP leads wanted to see all local authorities in the region becoming partners of RIPFA, thereby increasing the number of learning events held in the NW, improving access to contacts in the region (e.g. via the discussion forum).

Cumbria County Council Adult Social Care, for example, has a Knowledge Management Team and a three-year KM strategy endorsed by its Corporate Director of Adult and Cultural Services. Further details are provided in Case Study 1 below.

Lancashire County Council Adult and Cultural Services, led by its Training and Development Department, is re-launching its 'Carry on learning' initiative, which is concerned with leading and managing the way staff learn about the people they service and the best way staff can do their work. Further details are provided in Case Study 2 below.

Stockport Metropolitan Borough Council subscribes to a web-based portal for social care organisations called CareKnowledge; this delivers best practice, research and other information directly to individuals' desktops. The Council, led by the Consultation and Performance Manager, is now looking to develop a more strategic approach to KM. Further details are provided in Case Study 3 below.

Recommendation 1

The NW JIP should collate and disseminate examples of KM strategies, organisational structures and activities within the region.

There are several examples of EBP strategies in local authorities outside the NW (e.g. Sheffield, North Yorkshire, Gloucestershire, Royal London Borough of Kensington and Chelsea) but most of these focus on children's services. For the NW JIP, although there is currently an 'evidence' workstream, clarification is required about its longer-term remit and the extent to which the work becomes embedded within other workstreams, as well as its links with the performance workstream. Consideration also needs to be given to whether the NW JIP requires its own dedicated KM resource, responsible for identifying, coordinating and disseminating regional evidence. It was also evident from the local authority workshop that it would be helpful if KM was clearly incorporated within the remit of the NW JIP in order to ensure visible leadership of the regional strategy.

Recommendation 2

The NW JIP needs to clarify the longer term remit of its 'evidence' workstream, as well as investigate further its own requirements for KM (e.g. having a dedicated KM person).

Case study 1

Cumbria County Council – Knowledge Management Team and Strategy

The KM team at Cumbria County Council has been in existence since 2004. In April 2009, the team moved from the Care Governance Team to the Performance Team. The team currently comprises 4.25 WTE staff, including a Knowledge Manager, Research and Information Officer, Research and Information Assistant, Document Control Officer and Administrative Assistant. The KM team is responsible for:

- Managing an electronic library (e-library).
- Ensuring that all policy statements, procedures and practice guidelines are produced in a standard 3P format and kept up to date.
- Identifying and disseminating key social care documents via an Essential and Supporting Information (EASI) system.
- Ensuring employees have access to relevant library and information resources, such as via the Social Care Specialist Library Collection at Carlisle Public Library.
- Undertaking literature/ Internet searches on behalf of employees.
- Obtaining journal articles for employees that support practice and/or research.
- Implementing the Department of Health's *Research Governance Framework for Health and Social Care* to ensure that all research conducted by or involving social care employees, service users, their families and/or their carers in Cumbria is of high quality and is ethically sound.
- Undertaking and supporting research activity (e.g. by undertaking annual service user surveys, coordinating regular research support group meetings).
- Linking with RIPFA.
- Maintaining a Knowledge and Interest Database (KID).
- Collating outcomes and evidence examples across the directorate.
- Promoting evidence-informed practice to employees.

Cumbria has a three-year [KM strategy](#) (2007–10) and a separate three year (2007–10) research strategy. Both strategies are endorsed and supported by the Directorate's Management Team. There were plans to have an overarching health and social care KM strategy for Cumbria from 2010 onwards, but this is now likely to be in the form of a set of agreed KM principles.

In summer 2008, the KM team undertook a survey of its users (and non-users) and found very high levels of satisfaction with its services. However, the survey also revealed that many staff were still not aware of KM and EBP and how the team could help them.

Case study 2

Lancashire County Council – 'Carry on learning' initiative

The 'Carry on learning' initiative is currently in proposal form and aims to ensure that:

- Research results, policy developments, views from the public and learning from practice are made available to appropriate staff.
- People in all corners of the directorate are encouraged to continue to learn techniques and ideas that might help them to be more effective in their work.
- Efforts are made to seek out learning that is needed across the hierarchy to improve the services on offer.
- Adult and Community Services contribute to learning and evidence regionally and nationally.

In order to meet these requirements, it is recognised that staff need to:

- Both seek out and capture data, evidence and feedback.
- Seek answers to their questions about what works and does not work.
- Store this information in a useable form in an accessible place.
- Communicate it to people in a targeted and effective way.
- Put in place arrangements to précis and abridge material.
- Listen to ideas from all staff about what works best, what does not work, and how people can be helped to continue learning.
- Discuss what is new, i.e. ideas, findings, proposals, and encourage and facilitate such discussion.
- Make sure learning and evidence are used in practice.

Although not labelled as such, this initiative is clearly concerned with KM and EBP.

Case study 3

Stockport Metropolitan Borough Council – KM workshop and strategy

A KM workshop was held with key stakeholders, including representatives from the Adult Social Care Senior Management Team (SMT), at Stockport Metropolitan Borough Council in February 2009. The aim of this workshop was to raise the profile of KM, as well as to identify key priority areas for KM in Stockport in the future.

It emerged from this workshop that the focus should be on coordinating existing KM-type activities, rather than creating new systems and processes. The emphasis should also be on embedding KM within other related strategies (e.g. information management, communication, learning and development), rather than necessarily creating a separate KM strategy. Those people attending the workshop felt that, in terms of the five guiding principles of KM (refer to [Section 2.3](#)), Stockport should focus its efforts on encouraging a reflective learning culture. Suggestions included including KM and EBP in job descriptions and conditions of employment, on team meeting agendas, and in appraisals and supervision. In addition, it was important for senior managers to show commitment by modelling behaviour and encouraging middle managers to promote KM and EBP. It was also clear that senior managers were keen to collaborate with colleagues in the NHS to develop a common approach to KM.

4.4 Organisational readiness for KM

A major theme that emerged throughout this review was the cultural issues associated with adopting KM and EBP within individual organisations. This is also reflected in the literature (e.g. Austin, Claasen, Vu and Mizrahi, 2008). Although the local authority workshop indicated that most authorities were now committed to the concept of a 'learning organisation', various cultural barriers still need to be overcome, such as managers not viewing reading and reflection as a valid work activity. The following suggestions to encourage the embedding of KM into practice were made:

- Writing KM and EBP into job descriptions
- Having specific service plan, team plan, appraisal and supervision targets relating to KM and EBP
- Including knowledge-sharing activities on team meeting agendas
- Giving staff half a day a month as reflective learning time, in line with practice in the NHS
- Improving the co-ordination and dissemination of research undertaken by post-qualifying and Masters students
- Linking in with the current review of social work courses in the NW, led by Manchester Metropolitan University (MMU) to encourage a shift from values-based practice to EBP.

In addition, Petch (2008) presented the following eight laws for evidence-informed practice in integrated working, which could be applied to organisations in the NW:

1. Make sure there is a common understanding of what EIP policy and practice means.
2. Establish expectations at all levels of partner organisations that policy and practice will be evidence informed.
3. Highlight evidence-informed practice as an essential component of continuing professional development.
4. Identify and nurture a network of evidence-informed champions.
5. Identify and disseminate simple examples of evidence-informed practice – 'evidence stories'.
6. Ensure in-house intranets and newsletters routinely feature details of EIP.
7. Have a regular discussion spot for an evidence example at integrated team meetings.
8. Use supervision and appraisal sessions for routine discussion of the evidence base for specific decisions and actions.

Existing publications by Research in Practice may also help in this respect, such as *Firm foundations*, which provides a guide to organisational support for the use of research evidence (Barratt and Hodson, 2006), and *Leading evidence informed practice* (Hodson and Cooke, 2007). Part 2 of the *European guide to good practice in knowledge management* (European

Committee for Standardization, 2004) also provides tips on how to create the right cultural environment for introducing KM.

Recommendation 3

The NW JIP should work with SCIE to develop an introductory guide to KM and an accompanying toolkit, with regional case studies. This will include tips on addressing the cultural issues associated with KM.

4.5 Sources of evidence

It was clear from all the discussions and workshops that people used a wide variety of sources in order to access the evidence and knowledge they needed. This included:

- National databases (e.g. Social Care Online, Research Register for Social Care)
- General national websites (e.g. Department of Health, IDeA, RIPFA, SCIE, CSED, SSRG, INVOLVE, CQC, Audit Commission, Government Office North West)
- Subject specific national websites (e.g. Rowntree Foundation, MENCAP, Valuing People, Age Concern, In Control, Impower)
- Regional websites (e.g. CSIP, RIEP, Making Research Count, NW Commissioning Roadmap)
- Subscription services (e.g. CareKnowledge, RIPFA)
- National networks (e.g. RIPFA)
- Regional networks (e.g. Skills for Care, regional carers networks, regional personalisation leads network, regional commissioning leads network, regional performance leads officers group)
- Subregional and local networks (e.g. Greater Manchester Research Governance Group, LINKs, colleagues at the same or different local authorities)
- Electronic discussion forums, chatrooms, blogs, podcasts, etc.

Case study 4 below describes in more detail one regional source of evidence that was highly regarded – the North West Commissioning Roadmap.

Many people expressed concern at the sheer number of different sources, the duplication of information, as well as the time needed to search effectively and find the required information. The terms 'information overload' and 'death by email' were commonly used. Evidence summaries, such as those produced by RIPFA, and policy briefings (e.g. produced locally by Lancashire County Council) were, therefore, favoured. There was also a clear desire for a single coordinated and maintained site where people could access all the evidence that they needed. There was not agreement about the extent to which this should be national versus regional, general versus subject-specific, or all evidence versus "good practice" examples. People attending the regional personalisation leads meeting, for example, expressed a preference for a dedicated regional personalisation website for sharing case studies, whereas

those attending the HEIs workshop and local authority workshop saw the benefits of developing a regional focus on a national website (e.g. SCIE).

Recommendation 4

The NW JIP should facilitate the collation and dissemination of good practice examples in the region in line with the NW JIP workstreams (i.e. personalisation, commissioning, early intervention and prevention, workforce and leadership, etc.). Ideally, these examples should be accessible regionally (e.g. via the NW JIP website), nationally (e.g. via the SCIE website) and via subject-specific sites (e.g. via the relevant Department of Health Care Networks).

Case study 4

North West Commissioning Roadmap – www.northwestroadmap.org.uk/

The North West Commissioning Roadmap is aimed at commissioners of adult health and well-being services in local authorities and primary care trusts in the NW. It provides a means of sharing practice around the region by offering advice, case studies, summaries of national guidance, comprehensive resources sections, with links to other websites, as well as regional contact details. The website supports joint strategic commissioning the NW, but does not give detailed guidance on contracting. The Roadmap has three sections:

1. Commissioning in the North West, which includes a common definition, glossary of terms and principles of commissioning endorsed by regional leadership, as well as commissioners' contact details and regional case studies
2. Commissioning practice, which provides advice and guidance about commissioning, including self-directed support, practice-based commissioning and strategic commissioning. This section offers commissioning models, tools, good practice guidance and materials, and signposts to other sources of help.
3. National themes and guidance, which summarises key national guidance and policy direction that health and well-being organisations need to implement, and signposts to other sources of help.

The Roadmap has been developed by the Institute of Public Care for ADASS North West, NHS North West, North West JIP, and the Regional Director of Public Health. The leadership in the North West aims to use this web site to encourage more consistent commissioning practice across the region. In the future, it is hoped to expand the Roadmap to provide an interactive site for regional commissioners.

It was also evident that people wanted some kind of quality assurance of the 'evidence', i.e. to indicate its reliability, validity and applicability.

Recommendation 5

The NW JIP should utilise the Good Practice Framework currently being developed by SCIE to inform the collation and dissemination of regional good practice examples.

Despite the comments made above, many people, particularly those attending the HEIs' workshop, felt that much regional knowledge and evidence (e.g. individual case studies, small-scale local evaluations) remained 'hidden', with findings not being published and disseminated formally. It was evident from the local authority workshop that some authorities were tackling this issue by developing in-house 'evidence banks' or 'knowledge-sharing banks'. Further details are provided in Case Study 5 below. In addition, most authorities have databases of research projects that have been reviewed through research governance arrangements. Although such information should be submitted to SCIE's national Research Register for Social Care, it is evident that only a handful of local authorities regularly do so.

Case study 5

Local authority knowledge-sharing banks

RIPFA undertook a review of knowledge sharing banks for successful outcomes in adult social care, in October 2008. This was at the request of two Partner organisations in the NW (Cumbria County Council and Wigan Metropolitan Borough Council).

Cumbria, for example, has developed an electronic system called the '**Outcomes and Evidence Library**' for collating and sharing examples of individual cases and/or working practices that demonstrate how agencies support service users to achieve desired outcomes. The purpose of this system is to share good practice across the local adult social care and health community, as well as to provide evidence for formal inspections. At present, examples are collected using a detailed pro-forma that is subsequently uploaded to the Council's e-Library. A simple listing of projects is provided in an Excel spreadsheet, with hyperlinks through to more information. It is acknowledged that front-line practitioners need to be more engaged in both contributing to the 'Outcomes and evidence library' and in using the evidence that has already been collated.

Wigan has recently developed a similar system called an '**Evidence Bank**', which is available on the local authority's intranet site. This system allows evidence to be provided in a wider variety of media (e.g. CD, DVD, paper, PDF, Word). Like Cumbria, all examples submitted tend to be included, i.e. there is no formal selection or screening process.

The RIPFA review identified three more local authorities in the current RIPFA network, but outside the NW, (Birmingham, Cornwall and Bristol), that have or are about to develop similar knowledge-sharing banks. In addition, RIPFA identified eight further national (e.g. Sandwell Metropolitan Borough Council's storyboard project) and international examples (e.g. the Canadian Health Services Research Foundation).

At a regional level, the NWIEP has launched its own evidence base project, designed to collate evidence in support of the performance agenda. Further details are provided in Case Study 6 below.

Case study 6

NW Improvement and Efficiency Partnership (NWIEP) – Evidence base project

The Centre for Local Governance at the University of Manchester has recently been developing an evidence base for the NWIEP (Centre for Local Governance, 2009). This will help to inform NWIEP decisions and review the impact of improvement activities. The aims of the project are to:

- Review the current performance of the sector
- Consider the political and contextual issues that currently, and may in the future, impact upon the performance of the sector and its ability to improve
- 'Future proof' the current performance and contextual issues and their impact on the sector
- In line with the above, identify the areas of future focus for sector improvement and efficiency.

Theme 6, drawn from the National Performance Indicators, relates to 'health and social care'. The focus of this project is on chart analysis of quantitative evidence in line with performance indicators.

4.6 Networks and 'communities of practice'

Perhaps one of the most striking findings of this review is the overwhelming number of networks, both physical and electronic, that exist both regionally and nationally and which span the social care, health and local government fields. Regional examples include:

- NW JIP workstream leads networks (e.g. personalisation, early intervention and prevention, commissioning)
- NW Adult Social Care Performance Lead Officers Group
- NHS NW research networks, including Comprehensive Learning and Research Networks, Mental Health Research Network, Dementia and Mental Disorders Network
- Local communities of practice involving people from a wide range of disciplines, such as those set up by Lancaster University.

National examples include:

- The Department of Health Care Networks (e.g. integrated care, personalisation, prevention and early intervention, housing, telecare, dignity champions, commissioning, dementia, and care services efficiency delivery)
- [IDeA communities of practice](#) for local government which supports collaboration across the local government and the public sector
- [CHAIN](#), an online network for people working in health and social care
- [eSpace](#), a community-based online collaboration tool dedicated to improving health care and wellness by sharing knowledge and experiences of technology-enabled change

- [Knowledge exchange](#), covering the health services.

It was evident, however, that there was no coordinated approach to these networks, with much duplication of effort, and people attending multiple similar meetings and events.

There was a feeling that 'communities of practice' should be enabled to emerge from the bottom up and develop counting on the creativity and curiosity that people naturally have.

Further details about the Department of Health Care Networks, which have perhaps the greatest potential for application in the NW, are provided in Case Study 7 below.

Case study 7

Department of Health Care Networks – www.dhcarenetworks.org.uk

Department of Health (DH) Care Networks take the lead for *Putting people first* in the DH around integration and whole system reform, housing with care, assistive technology and partnership working. The work is led by Jeremy Porteus, National Programme Lead. Current DH Care Networks include integrated care, personalisation, prevention and early intervention, housing, telecare, dignity champions, commissioning, dementia, and care services efficiency delivery). They have a collective membership of over 26,000 people in health, social care, the third sector and academia.

The objectives of the DH Care Networks are:

- To promote whole system reform and partnership working
- To improve commissioning to better facilitate health and social care delivery and practice
- To support change in the delivery of housing and telecare services for older and vulnerable people
- To encourage multidisciplinary team working and effective collaboration

DH Care Networks provide a range of services (e.g. regular e-newsletters, web links to resources, events, best practice examples) to their members to help keep them informed of the latest policy and service developments in their area of interest.

DH Care Networks previously worked through CSIP's nine regional development centres on specific locally driven programmes of work, linking in with the regional government offices and often in partnership with other service improvement bodies to assist in local service design. The networks also link with national public and private sector organisations, other improvement and standards agencies, as well as academic institutions to develop a comprehensive knowledge base on good policy and practice. There is, therefore, potential to link with Local Involvement Networks (LINKs) and support regional work in terms of user-led organisations.

Recommendation 6

The NW JIP should investigate further the potential of using the Department of Health Care Networks to facilitate knowledge sharing within the region. This is in preference to the NW JIP setting up its own separate networks.

Recommendation 7

The NW JIP should also review its current networks and group membership to maximise their effectiveness and efficiency.

4.7 KM tools and techniques

As noted in [Section 2.4](#), a wide range of KM tools and techniques exists. It was, therefore, surprising to find that only a handful of such tools, mainly networks and communities of practice (see [Section 4.6](#)), case studies, conferences/ workshops and reciprocal visits, were explicitly mentioned throughout the course of this review. Cumbria County Council Adult Social Care, for example, used Collison's KM self-assessment tool to provide a benchmark in 2006/7 (Collison, 2006). Several local authorities, but mainly outside the NW, have developed EBP questionnaires to audit where their organisation currently is in terms of EBP and where the focus of future efforts should be. More formal processes, such as knowledge transfer partnerships, whereby knowledge is transferred between an academic institution and a host organisation (e.g. a local authority, primary care trust), although recognised by HEIs, were not commonly used in the region. It appears that this is because of the restrictive cost implications and paperwork associated with this approach. The adoption of SCIE's social care subject taxonomy could aid knowledge sharing in the region by encouraging the use of a consistent vocabulary. Formal KM techniques, such as after action reviews and lessons learned, did not appear to be widely used. There is, therefore, clearly potential for greater promotion of KM tools and techniques in the region, supported by case studies of their use in practice. This could be done via the KM guide and toolkit referred to in Recommendation 3.

It should be noted, however, that the effective use of these tools and techniques depends on the appetite of individuals for knowledge and their personal ability to use such resources. This latter point is elaborated on in [Section 4.10](#).

4.8 Research capacity

There is a very strong social work research community within the NW, led by various specialist research departments at regional HEIs, including the Personal Social Services Research Unit (PSSRU) at the University of Manchester, the Applied Social Science Unit for Research and Evaluation (ASSURE) at Lancaster University, and the Salford Centre for Social Work Research at Salford University. The latter is also the regional centre for [Making Research Count](#), a national collaborative research dissemination initiative.

The PSSRU at Manchester is also part of the intramural group of the National Institute for Health Research (NIHR)'s new **School for Social Care Research**. The aim of this school is to increase the evidence base for adult social care practice by undertaking high quality primary research and providing a focus for applied research in social care within the NIHR. In addition, the PSSRU has strong links internationally that will become increasingly important with an ageing population where lessons can be learnt and knowledge transferred from elsewhere.

A list of all the HEIs undertaking social work research in the region is provided in [Appendix F](#). The [North West Universities Association](#), which represents these 14 HEIs, potentially provides a mechanism for coordinating regional activities and identifying opportunities for collaborative action. Further details about the HEIs that specifically contributed to this review can be found in [Appendix G](#).

During the HEIs workshop, two key proposals emerged:

1. An alignment of the research priorities of the Department of Health, the NW JIP and HEIs.
2. The identification of a regional budget to fund pilot projects.

One suggestion was for each local authority to contribute in the region of £10,000 to fund collaborative research to be undertaken by the HEIs, NW JIP and ADASS against two or three regionally agreed priorities. Another proposal was for each local authority to provide £3,000–£4,000 to fund three or four regional practitioner-based research projects, supervised by HEIs. Although laudable suggestions, the likelihood of this happening, particularly given the current financial climate, is questionable. There are also many practical issues to consider, such as how the research will be commissioned, who will lead and manage the process, whether funding contributions should be made on the size of the local authority, how full economic costings will be handled, how HEI management would view this approach in light of the new Research Excellence Framework, etc. An alternative approach would be to map and promote the skills and expertise of existing social work research departments in the NW, as well as to encourage the collaborative approach demonstrated by HEIs at the workshop. There was also a strong desire from local authorities that the focus in the region, at least in the short term, should be on sharing the existing knowledge and making this more accessible, rather than generating yet more evidence.

The possibility of establishing a NW Social Care Research Group comprising representatives from HEIs, local authorities, third sector organisations, the JIP, SCIE, RIPFA, INVOLVE, etc. was also discussed at the HEIs workshop. Although this was generally well-received, it may be more appropriate to tie this in with the proposals for other regional networks and communities of practice (see [Section 4.6](#)), rather than create a separate group.

4.9 Evidence dissemination

A key feature of all the discussions and workshops was the need to focus on the dissemination of evidence, in particular the research outputs of the HEIs. Although it was acknowledged that peer reviewed journals have their place, it was agreed that multiple approaches (e.g. workshops, web site promotion, videos, CDs, podcasts, toolkits, working with journalists, using 'evidence champions') need to be used in order to increase the chances of evidence being used in practice. Interestingly, Bellamy, Bledsoe and Traube (2008) found a paucity of studies testing and validating implementation and dissemination strategies in social care. SCIE, and RIPFA, have a key role to play in dissemination at a national level (Platt, 2007), but the NW JIP can also assist in this process; for example, by using regional workshops to disseminate research findings. As noted in [Section 4.1](#), any outputs associated with the NW JIP should be accessible and understandable to everyone, including service users and carers.

During the review, it was evident that many individuals were already regularly using evidence in practice. Examples include the national evaluation of the Partnerships for Older People Projects (POPPs), the evaluation of the individual budgets pilot programme, and care services efficiency delivery efficiency solutions. However, it was also clear that there was no systematic process for the identification and implementation of such evidence. This was particularly noticeable at the NW JIP itself, where individual workstream lead were responsible for keeping up to date in their field, rather than there being a central current awareness/information service. It was evident that potentially useful publications produced by organisations, such as SCIE and RIPFA, were being overlooked. This links back to Recommendation 2 and whether there is a need for the NW JIP to have its own dedicated KM resource.

4.10 KM skills

There is an ongoing debate in the literature and practice about where the focus of KM and EBP training should fall, i.e. whether investment should be on developing the skills of a few individuals who then seek out, appraise and/or generate evidence, or whether all staff should be equipped with the necessary skills to do this themselves. In reality, as highlighted at the local authority workshop, most front-line staff do not have the time to do this activity themselves. Even if staff do receive training in KM, the cultural issues of their organisation (e.g. non-acceptance of taking time out to read and reflect) are likely to prevent them from being able to use these skills in practice. As noted in [Section 4.1](#), it is also important to recognise that service users and carers will increasingly need to develop KM skills, particularly in response to the personalisation agenda.

Multiple approaches are, therefore, required to improve the KM skills of the adult social care workforce. These include:

1. Providing formal KM skills training to KM and EBP leads at local authorities and other organisations providing adult social care (see Recommendation 8).
2. Providing a basic introduction to KM that is accessible to all, i.e. including service users and carers (see Recommendation 3).
3. Promoting the use of pre-evaluated and summarised sources of evidence, such as those produced by SCIE and RIPFA, to all staff.

SCIE is currently developing an e-learning resource on KM. The NW, in particular those local authorities that have already indicated an organisational readiness for KM (e.g. Cumbria, Lancashire, Liverpool, Wigan, Warrington and Knowsley) would be ideally placed to pilot and evaluate this resource.

Recommendation 8

The NW JIP should support the piloting and evaluation of SCIE's KM e-learning resource within the region.

4.11 Technology and infrastructure

In terms of technology to support KM, most of this is the responsibility of national organisations (e.g. the provision of Social Care Online by SCIE, the provision of CareKnowledge by OLM) and individual organisations (e.g. the IT systems of local authorities). Stockport Metropolitan Borough Council, for example, is increasingly using new technologies (e.g. video blogs, Twitter) to improve internal (and external) communication. These approaches could easily be adapted to facilitate KM by encouraging and enabling people to share knowledge effortlessly.

In Salford, a pilot project entitled Information Technology for Service Users (ITSU) is under way to improve IT access and knowledge sharing amongst provider organisations. Further details are provided in Case Study 8 below.

Case study 8

Salford Care Training Partnership – Information technology for service users (ITSU)

Each of a pilot group of 10 organisations in Salford (including mental health, housing, domiciliary care and residential care), received a laptop, with a broadband subscription for 12 months, one-to-one bespoke training on IT, communication, provision of information, etc., a resource/starter pack to make best use of the technology, a template for recording data, including usage statistics and one-to-one support to enable individuals to share their experiences with others.

The intended outcomes of this project are:

- To involve service users in the delivery of their own care and to ensure that they are not socially excluded from using IT to support their lifestyle and interests. including better communication/networking and access to leisure facilities via the Internet.

- For organisations to have access to up to date and portable IT.
- For organisations to have access to the Internet and associated resources.
- To enable organisations to upskill staff in IT, communication with service users, provision of information advice and guidance, coordination of activities, etc.
- To promote the wider use of IT within the care sector.
- To promote the wider use of e-learning to offer a broader range of methods to meet training requirements.
- To promote the use of IT to improve business systems and processes.
- To promote the use of IT as a method of communication and staff involvement.
- To promote the use of the Salford Care Training Partnership web site to share good practice with other organisations.

Access to social care electronic journals and databases is being opened up by a pilot project involving SCIE. Further details are provided in Case Study 9 below.

Recommendation 9

The NW JIP should support and promote the roll-out of the SCIE Athens pilot to all 23 local authorities in the NW.

Case study 9

Social Care Athens Pilot – www.scie-socialcareonline.org.uk/help/athens.asp

SCIE and Skills for Care are currently leading a ten-month pilot to provide local authority social care staff with access to a wide range of electronic journals and databases free of charge via a system called Athens. The pilot covers five regions, including the NW. At present, access in the NW is administered by Cumbria, and is limited to RIPFA partners, i.e. Cumbria, Lancashire, Liverpool, Warrington, Wigan and Cheshire East.

As previously mentioned in [Section 2.5](#), there is now a requirement in the NHS for each Trust to have a CKO at board level, and for each team to have a team knowledge officer. CKOs are responsible for leading the development, management and sharing of knowledge within their organisation to maximise their use in supporting the improvement of care. A role description for a CKO is provided in [Appendix H](#). It has been suggested that Adult Social Care should adopt a similar model to help raise the profile of KM within the sector. Cumbria County Council, for example, has already identified a CKO and is taking part in regional CKO events.

Recommendation 10

The NW JIP should encourage all local authorities in the region to identify a CKO, in line with developments in the NHS.

5 Discussion

It is clear from this review that there is already considerable KM and EBP activity within the NW. However, it is also evident that there are gaps and areas for improvement, as illustrated by the various recommendations in this report. The following section briefly considers the main findings of this review in the context of the five guiding principles of KM, introduced in [Section 2.3](#), i.e. commitment, culture, content, skills and infrastructure.

5.1 Commitment

Regionally, there does seem to be a real commitment to KM and EBP, as illustrated by the funding of this review and accompanying strategy, and the opinions expressed by Directors of Adult Social Care at the NW JIP away day. The importance of KM is already starting to be recognised by individual local authorities, particularly in view of the changing evidence requirements of CSCI, and now the Care Quality Commission (CQC). A few local authorities have dedicated resources for KM and have written, or are in the process of writing, KM and EBP strategies. Having a regional KM and EBP strategy should help individual organisations to gain support for taking forward such activities. The identification of CKOs at each local authority should also help in raising the profile of KM within the region. Although several Chief Executives of provider organisations came forward expressing an interest in this review, the extent to which this permeates across the sector remains uncertain.

5.2 Culture

As noted in [Section 4.4](#), cultural issues are potentially the most significant barrier for taking forward KM and EBP within individual organisations. Although the NW JIP cannot force organisations to adopt certain approaches, it does have a role to play, alongside SCIE, in challenging and dispelling these negative cultural beliefs. It can do this by developing and promoting a KM guide and toolkit, with regional case studies of how implementing evidence in practice has resulted in improved outcomes for service users, carers and/or staff. There is also the potential to link more closely with the 'workforce and leadership' workstream of the NW JIP to encourage the embedding of evidence into practice. Although not a main finding of this particular review, 'evidence champions' within individual organisations may help to overcome some of the cultural issues by acting as a knowledge transfer channel.

5.3 Content

It is very clear that there is already a large range of evidence sources, both regionally and nationally. The desire for collaboration from the HEIs bodes well for further practitioner-based research in the future. Any further developments should focus on adding value to and co-ordinating existing

resources, however, rather than creating yet more. That said, it is acknowledged that much evidence still remains 'hidden' (e.g. local good practice examples). The NW JIP has a role to play in making this more accessible. SCIE can help by providing a mechanism for quality assuring this evidence (e.g. via the Good Practice Framework). As noted previously, it will become increasingly important to ensure that all evidence produced is accessible and understandable to everyone, i.e. including service users and carers.

5.4 Skills

There is considerable research experience within the region, as demonstrated by the number of specialist social work research departments. However, there is clearly a need to improve the KM skills of the adult social care workforce, both regionally and nationally. This is also supported by the literature, e.g. Booth, Booth and Flazon (2003). Although it is not a realistic expectation that all staff should be trained in KM and EBP, it is appropriate to use the NW JIP as a vehicle for raising awareness of KM (e.g. through the use of a guide and toolkit) and in piloting national KM training, such as SCIE's KM e-learning package. Again, as noted in [Section 5.3](#), ultimately such training will also need to be made available to service users and carers.

5.5 Networking and infrastructure

Finally, it is evident that a wide range of networks already operate both regionally and nationally. The focus should be on consolidating and improving the effectiveness of existing networks (such as the Department of Health Care Networks) at a regional level, rather than creating new networks. Much of the infrastructure, particularly in terms of IT, required to support KM is dependent on individual organisations. There is potential for the NW JIP to improve some infrastructure, however, e.g. by promoting the role of CKOs within local authorities, and supporting the SCIE Athens pilot.

5.6 Limitations of this review

Although this review has yielded some useful findings, it is important to note some of the limitations associated with it. First, the timescale (five months) and resources (one part-time person) for the review were limited and, therefore, not all contacts and initiatives could be investigated in detail. Second, it is acknowledged that much KM activity is 'hidden' and not explicitly identified as KM. This is particularly the case in the independent sector. The short timeframe and limited resources also meant it was not possible to adopt formal research methods (e.g. tape recording and transcribing of interviews, undertaking of formal qualitative analysis of interview data). Finally, because of delays in obtaining permission to use existing KM self-assessment tools, a formal audit of KM activities has not been possible. On reflection, however, the use of such tools is likely to be more meaningful at an individual organisation level, rather than at a regional level.

Despite these limitations, the review has identified various recommendations for policy and practice; these are summarised in [Section 6](#) below.

6 Conclusions and recommendations

6.1 Conclusions

To conclude, the key messages emerging from this review are:

- The terminology used (KM and EBP) remains confusing and inaccessible for some people.
- Much KM activity is uncoordinated and undertaken as part of other agendas, in particular, performance. The focus should be on raising the profile of KM and coordinating existing activities, rather than necessarily creating new systems and processes.
- Consideration needs to be given to the specific KM and EBP requirements of the NW JIP itself.
- Cultural issues are a major barrier for taking forward KM and EBP within individual organisations.
- There are already multiple sources of evidence; the challenge is to coordinate these and make best use of them regionally.
- There is considerable overlap and duplication of effort with existing regional networks and 'communities of practice'.
- Formal KM tools and techniques (e.g. after action reviews and lessons learned) appear to be underused within the region.
- There is a strong collaborative social work research community in the region, led by several specialist research departments at HEIs.
- Multiple approaches to evidence dissemination are required. SCIE and RIPFA have a valuable role to play in summarising, quality assuring and disseminating evidence, both nationally and regionally.
- Although much of the technology and infrastructure to support KM and EBP depends on individual organisations, there is potential to apply and extend national mechanisms, such as the Athens pilot and CKOs, regionally.
- There is a need to improve the KM skills of the adult social care workforce, both regionally and nationally.

6.2 Summary of recommendations for policy and practice

For convenience, the recommendations made in this report are listed below.

1. The NW JIP should collate and disseminate examples of KM strategies, organisational structures and activities within the region. This report helps in this respect.
2. The NW JIP needs to clarify the longer term remit of its 'evidence' workstream, as well as investigate further its own requirements for KM (e.g. in terms of having a dedicated KM person).
3. The NW JIP should work with SCIE to develop an introductory guide to KM and an accompanying toolkit, with regional case studies. This will include tips on addressing the cultural issues associated with KM.
4. The NW JIP should facilitate the collation and dissemination of good practice examples in the region in line with the NW JIP workstreams (i.e. personalisation, commissioning, early intervention and prevention, workforce and leadership, etc.). Ideally, these examples should be accessible regionally (e.g. via the NW JIP website), nationally (e.g. via the SCIE website) and via subject-specific sites (e.g. via the relevant Department of Health Care Networks).
5. The NW JIP should utilise the Good Practice Framework currently being developed by SCIE to inform the collation and dissemination of regional good practice examples.
6. The NW JIP should investigate further the potential of using the Department of Health Care Networks to facilitate knowledge sharing within the region. This is in preference to the NW JIP setting up its own separate networks.
7. The NW JIP should also review its current networks and group membership to maximise their effectiveness and efficiency.
8. The NW JIP should support the piloting and evaluation of SCIE's KM e-learning resource within the region.
9. The NW JIP should support and promote the roll-out of the SCIE Athens pilot to all 23 local authorities in the NW.
10. The NW JIP should encourage all local authorities in the region to identify a CKO, in line with developments in the NHS.

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You can get a copy of this document in different formats, such as large print, Braille, audio, or in a different language, by contacting Publications at SCIE on 020 7089 6840, email: publications@scie.org.uk

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Appendices

Appendix A North West (NW) Joint Improvement Partnership (JIP)

The NW JIP is an alliance of agencies in the region that has, in discussion with local government and partners at regional tier, agreed a number of improvement priorities that address adult social care, health and well-being.

The partnership has developed a 'One plan' proposition with multiple sign up to the improvement priorities, multiple investment from different sources and integrated and aligned delivery. The partnership is operating to a headline plan, being delivered separately and collectively, by partnership members. The plan is based on agreed priorities, and will avoid duplication and add value to the effective use of member resources. An important part of the plan is to build an alliance with subregional partnerships to support the development of subregional activity and facilitate some regional tier alignment. Most elements of the plan are being delivered through the resources available to member organisations; this includes the Department of Health and NHS resource, as well as some investment from the North West Improvement and Efficiency Partnership (NWIEP).

In 2008–9, there were nine 'One plan' programme objectives:

1. Efficient programme management and stakeholder engagement
2. Deliver personalisation/ self-directed support programme
3. Deliver early intervention programme and promote independence
4. Deliver whole system efficiency programme
5. Deliver intelligent commissioning and market development
6. Develop leadership and partnership
7. Support effective workforce planning and development
8. Develop the evidence base
9. Support performance.

Additional objectives for 2009–10 are likely to include:

1. Deliver the Valuing people now programme
2. Support the health and social care of offenders.

Current NW JIP Board members include:

- Representatives from ADASS NW
- Representatives from the Department of Health NW (e.g. Deputy Regional Director of Social Care and Local Partnerships, and Deputy Regional Director of Public Health)
- Representatives from the former Care Services Improvement Partnership (CSIP)
- Representatives from the Department of Health's Care Services Efficiency Delivery (CSED)
- Regional Director of the Care Quality Commission

- Representatives from Skills for Care
- Representatives from NHS North West
- Representatives from North West Employers Organisation
- Representatives from Improvement and Development Agency (IDeA)

Appendix B Social Care Institute for Excellence (SCIE)

SCIE was established by the Government in 2001 as a registered charity that works in England, Wales and Northern Ireland. It aims to improve the experiences of social care service users by advancing and promoting knowledge about good practice. SCIE's resources bring together policy and research with the opinions of practitioners, service users and carers. Its work covers the whole of social care, including services for adults, children and families, stakeholder participation, people management, social work education, e-learning, and the use of knowledge in social care.

SCIE aims to:

1. Capture and co-produce knowledge about good practice. It carries out and commissions research and work with other leading organisations to produce information and practical guidance about what works in social care.
2. Communicate knowledge, evidence and innovation. It shares knowledge about what works in partnership with sector partners, including improvement agencies, networks of providers, groups of people who use services, regulators and government departments.

Ultimately SCIE aims to be a catalyst for transformation of care services.

SCIE publish a wide range of resources which are freely available via their web site (www.scie.org.uk). These include:

- Online practice guides for social care managers and workers
- Practical tools to improve the way organisations manage and support their staff
- e-learning tools on key subjects for students, teachers, lecturers and trainers
- A comprehensive online database of social care ([Social care online](#))
- Discussion papers and position papers outlining the views of SCIE or other partners
- Brief summaries of existing research
- Guides to existing resources or information
- Detailed reviews of existing knowledge.

SCIE also carries out regional and international work. Increasingly SCIE will have a more regional focus for the dissemination of its work. This coincides with the development of regional JIPs.

Appendix C Local authorities in the North West with adult social care responsibilities

1. Blackburn with Darwen Borough Council
2. Blackpool Borough Council
3. Bolton Metropolitan Borough Council
4. Bury Metropolitan Borough Council
5. Cheshire East Council
6. Cheshire West and Chester Council
7. Cumbria County Council
8. Halton Borough Council
9. Knowsley Metropolitan Borough Council
10. Lancashire County Council
11. Liverpool City Council
12. Manchester City Council
13. Oldham Metropolitan Borough Council
14. Rochdale Metropolitan Borough Council
15. Salford City Council
16. Sefton Council
17. St Helens Metropolitan Borough Council
18. Stockport Metropolitan Borough Council
19. Tameside Metropolitan Borough Council
20. Trafford Metropolitan Borough Council
21. Warrington Borough Council
22. Wigan Metropolitan Borough Council
23. Wirral Metropolitan Borough Council

Appendix D List of people contacted

NW JIP

- Carey Bamber
- Alix Crawford
- Mike Houghton-Evans
- David Jones
- Tony Marvell
- Sue Ramprogus
- Stephen Rea
- David Whyte

SCIE

- Amanda Edwards
- Diane Gwynne-Smith
- Trish Kearney
- Ellie Layfield
- Colin Paton

Department of Health

- David Jones

ADASS and Regional Directors of Adult Social Care

- Charlie Barker
- Stephanie Butterworth
- Anne Higgins
- Richard Jones
- Patricia Jones-Greenhalgh
- Sue Lightup
- Ged Lucas
- John Rutherford
- Stephen Sloss
- Jill Stannard
- Bernard Walker

Skills for Care

- Alix Crawford
- Thea Seville

Research in Practice for Adults (RIPFA)

- George Julian
- Alison Petch
- Todor Proykov

CSCI/ CQC

- Alan Jefferson

IRISS/ HES

- Susan Linder
- Ann Wales

IDeA

- Dimple Rathod

NHS

- Rachel Cooke
- Lynda Cox
- Stuart Eglin
- Dominic Harrison
- Sheila Marsh
- David Stewart
- Maria Thornton

Local authorities

- Ian Jones, Bolton Metropolitan Borough Council

- Catherine Hammersley and Helen Moynihan, Bury Metropolitan Borough Council
- Catherine Beverley, Cumbria County Council
- Sharon McFarlane, Knowsley Metropolitan Borough Council
- Angela Esslinger and Jonny Keville, Liverpool City Council
- Nicola Gribben, Rochdale Metropolitan Borough Council
- Sarah Bullock, St Helens Metropolitan Borough Council
- Karen Kime and Julie Green, Stockport Metropolitan Borough Council
- Sandy Parkinson, Tameside Metropolitan Borough Council
- Jan Walker, Trafford Metropolitan Borough Council
- Amanda Brown, Warrington Borough Council
- Bridget Whittell, Wigan Metropolitan Borough Council
- Rachel Hughes and Chris Batman, Wirral Metropolitan Borough Council

HEIs

- Sarah Lyons, Edge Hill University
- Cheryl Simmill-Binning, Lancaster University
- Liz Pell, Manchester Metropolitan University (MMU)
- Debbie Brown, University of Central Lancashire (UCLAN)
- David Hughes and Jane Hughes, University of Manchester
- Hugh McLaughlin, University of Salford

Providers

- Via the Skills for Care provider network

Users and carers

- Via the NW JIP 'Personalisation' workstream Citizen Leaders group

Appendix E List of KM and EBP leads at NW local authorities

Local authority	KM/EBP lead
1. Blackburn with Darwen Borough Council	Marie Howard-Wright
2. Blackpool Borough Council	Seonaid Elliott
3. Bolton Metropolitan Borough Council	Ian Jones
4. Bury Metropolitan Borough Council	Catherine Hammersley
5. Cheshire East Council	John Wilde
6. Cheshire West and Chester Council	To be confirmed
7. Cumbria County Council	Catherine Beverley
8. Halton Borough Council	Katy Hansford
9. Knowsley Metropolitan Borough Council	Jean Perkins
10. Lancashire County Council	Angela Esslinger
11. Liverpool City Council	Brendan Doyle

12. Manchester City Council	Anna Smith
13. Oldham Metropolitan Borough Council	Tracey Mellor/Bronwen Holloway
14. Rochdale Metropolitan Borough Council	Nicola Gribben
15. Salford City Council	Sarah Griffiths
16. Sefton Council	Roger Robinson
17. St Helens Metropolitan Borough Council	Sarah Bullock
18. Stockport Metropolitan Borough Council	Karen Kime
19. Tameside Metropolitan Borough Council	Sandy Parkinson
20. Trafford Metropolitan Borough Council	Jan Walker
21. Warrington Borough Council	Amanda Brown
22. Wigan Metropolitan Borough Council	Bridget Whittell
23. Wirral Metropolitan Borough Council	Rachel Hughes

Appendix F HEIs potentially undertaking social care research in the NW

1. Applied Social Science Unit for Research and Evaluation (ASSURE), Lancaster University
2. Edge Hill University
3. Liverpool Community College
4. Liverpool Hope University
5. Liverpool John Moores University (LJMU)
6. Manchester Metropolitan University (MMU)
7. Open University
8. Personal Social Services Research Unit (PSSRU), University of Manchester
9. Salford Centre for Social Work Research, University of Salford
10. Stockport College of Further and Higher Education
11. University of Bolton
12. University of Central Lancashire (UCLAN)
13. University of Chester
14. University of Cumbria

Appendix G Further details about HEIs that specifically contributed to this review

ASSURE, Lancaster University	The Applied Social Science Unit for Research and Evaluation (ASSURE) has been in existence for 10 years. It works in partnership with local authorities, the NHS and third sector organisations to undertake evaluations and applied research. The unit is currently engaged in 55 projects and 86 different partnerships.
Edge Hill University	The University is increasingly focusing on research and knowledge transfers. There are currently eight research centres, including the Evidence Based Practice Research Centre, the Centre for Local Policy Studies and the Widening Participation Research Centre. The emphasis is on working collaboratively and developing local partnerships.
Manchester Metropolitan University (MMU)	The Research Institute of Health and Social Change is located within the Faculty of Health, Psychology and Social Care. The Chair is jointly funded by Manchester City Council and the University. The Institute is involved in a wide range of research and evaluation projects, including the evaluation of Partnerships for Older People Projects within Manchester.
PSSRU, Manchester University	The Personal Social Services Research Unit (PSSRU) has branches at three UK universities: Manchester, Kent and LSE. Its mission is to conduct high quality

	research on social and health care to inform and influence policy, practice and theory. The PSSRU at Manchester is part of the Faculty of Medical and Human Sciences and is based within the School of Medicine. The PSSRU is one of three social care research units that receive core funding for five-year programmes of work from the Department of Health. The others are the Social Policy Research Unit at the University of York, and the Social Care Workforce Research Unit at King's College London. About half of the unit's funding comes from other research commissioners.
Salford Centre for Social Work Research, University of Salford	The Salford Centre for Social Work Research is part of the Institute for Health and Social Care Research. It is a regional site for Making Research Count, a national collaborative research dissemination initiative designed to get evidence into practice. The Centre is involved in a wide range of research projects and collaborations (e.g. with Skills for Care, service user involvement).
University of Central Lancashire (UCLAN)	UCLAN has a research department focusing on social work. Key areas of interest include health and social care commissioning and community engagement. Nicky Stanley at UCLAN is involved in Making research count.

Appendix H Role profile of a CKO in an NHS organisation

Objective

To lead the development, management and sharing of knowledge within NHS and partner organisations to maximise its use in supporting the improvement of patient care.

Context

Knowledge management (KM) is required to ensure that strategic, operational and clinical activity is based on a combination of specialist knowledge, sound evidence, experience and data. Effective KM strategies maximise the efficient use of all these resources and ensure that knowledge is recognised, generated and transferred within a receptive learning culture, for the benefit of the whole health system.

Role

- To ensure relevant experience, evidence, research, information and data are available to all staff. This will enable knowledge-based strategic, operational and clinical planning and activity.
- To lead horizon scanning to ensure their organisation is prepared for future service needs.

- To participate in national/regional networks of CKOs to steer knowledge management in the NHS.
- To develop specific strategies to protect organisational knowledge, for example during times of major change.
- To work with people responsible for human resources, continuing professional development, information, innovation, library and related strategies to develop a knowledge-based culture.

Personal qualities

- Board level director. Personal skills and interests are more important than field of specialism.
- Passionate about the importance of making full use of an organisation's knowledge for the benefit of patient care and service improvement.
- Fully understands the complementary nature and value of data, information, research evidence and experience.
- Committed to creating and sustaining a knowledge-sharing culture by actively seeking to remove the boundaries of departmental and professional silos.
- Committed to the learning and development of all staff, thereby developing the organisation's knowledge.



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