Review of the Public Health Function

Health Improvement and Knowledge Management Subgroup

Interim Report

January 2006

Prepared by Dr A Jordan on behalf of the Health Improvement and Knowledge Management Subgroup

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1. Background

1.1 The Review

The Department of Health, Social Services & Public Safety (DHSSPS) commissioned a review of the Public Health Function in Northern Ireland in July 2003. The recommendations from the Review were agreed by the Minister in December 2004.

1.2 Implementation of the Recommendations

An Implementation Group, chaired by the Chief Medical Officer was established in February 2005 to oversee implementation of the recommendations. The recommendations fall into four broad areas:

- health protection;
- health improvement & knowledge management;
- workforce planning, training & education; and
- service development.

The Implementation Group established a subgroup for each area to consider the recommendations in detail and identify the steps needed to achieve successful implementation.

2. Health Improvement and Knowledge Management Subgroup

2.1 Terms of reference

The Health Improvement and Knowledge Management Subgroup is chaired by Professor Colin Boreham. The Terms of Reference given were:

> *To consider the recommendations contained in the Summary of the Review of Public Health Function in Northern Ireland relating to Health Improvement and Knowledge Management and provide to the Implementation Group:*
>
> - *A project plan by end of September 2005;*
> - *An Interim Report by the end of December 2005; and*
> - *Final Action Plan/Report by end of March 2006.*
>
> *The Review recommendations are high level and in drawing up the Action Plan and Reports the sub-group will:*
>
> - *Consider the review recommendations and determine how best they might be achieved, identifying a range of short, medium and longer term actions; identify the timetable, resource requirements, barriers to implementation and actions needed to ensure effective achievement of the review recommendations for Health Improvement & Knowledge Management.*

The recommendations in relation to Health Improvement and Knowledge Management were identified as recommendations 3 (b), 4(3), 5 (c) & (d) and 8 (b). They are:

- **Recommendation 3 (b)** DHSSPS should establish an integrated approach to health improvement including health promotion and the management of public health intelligence by combining regional elements of these functions within a single organisation to:
    - o provide regional leadership and support for activities relating to health improvement and health promotion;

- develop a Public Health Intelligence resource;
- support and co-ordinate population screening services;
- contribute to the training and development of multidisciplinary professionals in all aspects of health improvement and knowledge management including opportunities for secondment; and
- support the development of Public Health networks within Northern Ireland, nationally and internationally**.**

- **Recommendation 4 (3)** District Councils should be given a new general power of competence to promote well being similar to that available to local authorities in England, Scotland and Wales.

- **Recommendation 5 -**

  (c) Build and strengthen Public Health multi-disciplinary contribution at local, community and neighborhood levels through established initiatives such as Investing for Health, HAZ and other initiatives.

  (d) The range of community-driven initiatives should be effectively co-ordinated with shared local objectives based on local needs and regional objectives.

- **Recommendation 8 (b)** – There is a need to enhance current existing cross-border links for example, with the Department of Health & Children and Co-operation and Working Together and foster new ones in order to enhance the practice of Public Health across the island of Ireland.

2.2 Work of the Subgroup

The Subgroup meet for the first time in July 2005. Due to the wide-ranging nature and complexity of the task the group decided to split into three working groups to consider the following areas;

- health improvement - led by Prof C Boreham
- knowledge management - led by Dr D Stewart
- screening – led by Dr M Boyle

The remit of the working groups was to gather relevant information on each of the areas to inform the subgroup and aid their decision-making.

A project plan was agreed by the subgroup and is attached (Appendix 1).

In addition Mr McMahon agreed to consider recommendation 4 (3) concerning the powers of District Councils.

A workshop was also held by DHSSPS on 5th October 2005. A session at this allowed the subgroup to ascertain the views of a wide range of stakeholders on the following questions;

1. What are the gaps in current systems for Public Health knowledge management?
2. How can we build an effective Public Health network?
3. What would be the role of a new regional body in terms of health improvement, knowledge management and screening?

2.3 Report Structure

The outcome of the Review of Public Administration (RPA) which was announced in November 2005 will have a major impact on both the Department and the Health and Personal Social Services and on the implementation of the Review of the Public Health Function. To facilitate

implementation of the RPA the Department has established a Reconfiguration Programme Board and a number of Project Teams including one for Public Health Functions. Following this, in late December 2005, all four subgroups were asked by the CMO to produce an interim report on their work to date to feed into the work of the Public Health Function Project team. The subgroups were also advised that further work should be put on hold.

This report represents findings from the workshop and the work carried out by the Health Improvement and Knowledge Management subgroup from July 2005 to December 2005. It is important to realise that this work was carried out, as outlined above, by three working groups and that each of these working groups were at various stages of development of their particular project.

The work is presented as the views of stakeholders, gathered at the workshop and a summary of the outputs from each of the working groups. Full papers produced by each of the working groups have been included in the appendices – these contain background information, results from "fact finding exercises" and more details on how the recommendations from the Review of the Public Health Function could be implemented. The working groups however were not at the stage to produce full action plans at the point when they put on hold.

3. Views of Stakeholders

The following were highlighted as gaps in the current systems for managing Public Health knowledge;

- Ability to access knowledge as there is no central holding point/organisation
- Lack of awareness of what knowledge is available
- A lack of, or lack of use, of wider sources of knowledge outside the HPSS
- Lack of evaluation of policy
- No system to decide and support the research agenda and identify priorities? No clear link between research and policy makers and ‘on ground’ staff
- Lack of capacity to analyse some of the information we do have
- Lack of skills – need to train people to develop a mix of information within PH
- Poor communication of knowledge between professional/agencies and to the public

Stakeholders also indicated that it was important to be clear who was using the knowledge, as solutions may be different for different groups and to differentiate between information management and knowledge management. It was also emphasised that any new systems should be linked to, or at least aware of, systems developed internationally and nationally e.g. Public Health Observatories.

In order to build an effective Public Health network stakeholders felt it was essential to;

- Scan what is already available and connections
- Define who is eligible for network

- Define who the network is expected to support or what it is expected to deliver
- Identify adequate resources to maintain the network
- Engage with organisations outside H&SSs who have a Public Health role
- Look at and learn from existing networks e.g IPH work on evaluating networks
- Include not only information sharing but sharing decision-making

Possibilities were discussed about linking or having a network of current networks. An important point was also raised that the ministerial group on Public Health could be an effective high level network and if commitment is given at this level then it will help facilitate networks below this.

It was also noted that in Northern Ireland we are currently weak in engaging the private sector at Ministerial level on PH issues e.g. obesity, and that we need to look to Europe for good examples.

Stakeholders felt that the new regional body should;

- Support the networking strategy development
- Advise on policy
- Evaluate or commission research on policy
- Build capacity/deliver training
- Engage other sectors in PH e.g. housing, transport, education
- Set standards – hold people accountable
- Drive the vision for health improvement, give leadership and set priorities.
- Develop process and pathways for implementation of policies and to allow a bottom-up approach from community.
- Develop systems to manage/access to Qualitative research.
- Engage/lobby/advocate with politicians
- Communicate with the public on PH issues.

4. Findings from the Working Groups.

4.1 Knowledge Management

The knowledge management working group, chaired by Dr D Stewart, met three times. It was comprised of providers and users of Public Health knowledge in Northern Ireland and an external expert from Scotland.

In considering how the recommendations of the review in relation to health improvement and knowledge management could be implemented the working group felt it was important to;

1. Clarify the concept of knowledge management in relation to Public Health.

2. Review developments in the management of Public Health knowledge nationally and internationally

3. Undertake a limited knowledge audit determining the major sources of Public Health knowledge in Northern Ireland, funding and the current availability to professionals and public.

4. Review the key elements a Public Health information system needed to provide to be effective.

A detailed paper was produced on this work (Appendix.2).

This information was utilised to produce a set of functions for a new regional health improvement and knowledge management body in terms of developing knowledge management (see below).

1. Lead and co-ordinate the development of a knowledge-based approach to the delivery of Public Health practice in Northern Ireland.

2. Link to developments in Public Health knowledge management nationally and internationally and ensure consistency and links with the Republic of Ireland.

3. Build communities of practice (including academic/research and service Public Health) to facilitate a systematic sharing of knowledge across Public Health practitioners and organisations within and outside the HPSS.

4. Identify sources of explicit knowledge and take a lead role in ascertaining how these could be developed and enhanced to underpin Public Health activity.

5. Ensure practitioners and policy-makers have access to up-to-date sources of evidence and "experts" as well as guidance on the best way to translate this evidence into practice and opportunities to build capacity to enable this to be achieved.

6. Co-ordinate the surveillance of health trends and support risk assessment of threats to health and well-being and health impact assessment of new policies and developments.

4.1.1 Knowledge management in the context of the Review of Public Administration

A lead person needs to be identified at senior level to "champion" knowledge management for Public Health and ensure the development of the above functions during the proposed structural reorganisation.

This individual should harness the relevant expertise currently available across the Public Health community and lead the development of the proposed system for knowledge management for Public Health in Northern Ireland.

The new regional body on health improvement and knowledge management would be best placed within the proposed Strategic Health Authority alongside Regional Health Protection Functions. Hence the Strategic Health Authority will eventually provide the leadership role for health improvement and knowledge management.

It will however be important that the Strategic Health Authority links with the Public Health Observatory currently being developed across Ireland. This will allow strong links to be maintained and enhanced with the Observatories in the UK and ensure consistency and clear links with the Republic of Ireland. It may be appropriate for some of the functions of the new health improvement and knowledge management body relating to knowledge management to be taken forward by the Observatory.

4.2 Screening

The screening working group, chaired by Dr M Boyle, was comprised of Public Health physicians from the four Health and Social Services Boards and the DHSSPS and a representative from the Health Promotion Agency. It considered the future development of screening services in Northern Ireland.

4.2.1 Screening in relation to the Review of Public Administration

This group put forward proposals for roles and functions in relation to screening of each of the new structures outlined by the Review of Public Administration. The role of Public Health in population screening programmes was also outlined and an accountability framework proposed to accompany the new structures. A detailed paper was produced on this work (Appendix 3)

4.3 Health Improvement

The Health Improvement Working Group, chaired by Professor Colin Boreham, met on several occasions. This group considered the functions a new regional body would undertake in relation to health improvement. In

doing this the group considered the current functions of other similar organisations locally, nationally and internationally.

The group proposed the following functions for a new regional body in relation to health improvement.

To provide regional leadership and co-ordination across the following functions:-

1. Provide advice to Northern Ireland Departments on all aspects of health improvement.

2. Develop and deliver health improvement programmes to both the public and professionals consistent with "Investing for Health" and current Public Health priorities in Northern Ireland.

3. Co-ordinate input to, and evaluation of, health improvement programmes and policies.

4. Develop and support partnerships with a range of stakeholders, including Northern Ireland Departments, the HPSS, local government, and community, voluntary, academic and business sectors and the media to promote health improvement.

5. Support the development and maintenance of Public Health networks within Northern Ireland, regionally, nationally and internationally.

6. Co-ordinate and provide multi-disciplinary professional training and development in health improvement.

7. Exercise the DHSSPS functions under Article 71(1), (2) and (3) of the Health and Personal Social Services (Northern Ireland) Order in relation to voluntary organisations.

This was supplemented by specific functions in relation to knowledge management and screening as outlined above (sections 4.1 and 4.2) which would also be taken forward by the same regional body.

4.4 Environmental Health

Mr McMahon considered recommendation 4 (3) - a new general power of well-being for District Councils, similar to that available to local authorities in England, Scotland and Wales.

A detailed paper was produced (Appendix 4).

4.4.1 The Power of well-being in relation to the Review of Public Administration

The Review of Public Administration (RPA) in Northern Ireland appears to support the introduction of such a power of well being for councils and states it is likely that the introduction of the necessary legislation would be a matter for DOE. The introduction of a general power to promote well-being should be introduced as a matter of urgency and certainly in advance of the general implementation of the RPA.

Appendix 1

REVIEW OF PUBLIC HEALTH FUNCTION – IMPLEMENTATION

HEALTH IMPROVEMENT& KNOWLEDGE MANAGEMENT SUB-GROUP

DRAFT PROJECT PLAN

Background

The Review

The Department of Health, Social Services & Public Safety (DHSSPS) commissioned a review of the Public Function in Northern Ireland in July 2003. The recommendations from the Review were agreed by the Departmental Board and the Minister in December 2004.

Implementation of the Recommendations

An Implementation Group, chaired by the Chief Medical Officer was established in February 2005 to oversee implementation of the recommendations. The recommendations fall into four broad areas:

- health protection;
- health improvement & knowledge management;
- workforce planning, training & education; and
- service development.

The Implementation Group has established a sub group for each area to consider the recommendations in detail and identify the steps needed to achieve successful implementation.

Terms of Reference

The Terms of Reference for the Health Improvement & Knowledge Management Sub-Group are:

To consider the recommendations contained in the Summary of the Review of Public Health Function in Northern Ireland relating to Health Improvement and Knowledge Management and provide to the Implementation Group:

- *A project plan by end of September 2005*
- *An Interim Report by the end of December 2005; and*
- *Final Action Plan/Report by end of March 2006.*

The Review recommendations are high level and in drawing up the Action Plan and Reports the sub-group will:

- *Consider the review recommendations and determine how best they might be achieved, identifying a range of short, medium and longer term actions; identify the timetable, resource requirements, barriers to implementation and actions needed to ensure effective achievement of the review recommendations for Health Improvement & Knowledge Management*.

Project Scope

The Sub-Group, which is chaired by Professor Colin Boreham, is tasked with considering recommendations 3 (b), 4(3), 5 (c) & (d) and 8 (b). They are:

- **Recommendation 3 (b)** DHSSPS should establish an integrated approach to health improvement including health promotion and the management of public health intelligence by combining regional elements of these functions within a single organisation to:
    - provide regional leadership and support for activities relating to health improvement and health promotion;
    - develop a Public Health Intelligence resource;
    - support and co-ordinate population screening services;
    - contribute to the training and development of multidisciplinary professionals in all aspects of health improvement and knowledge management including opportunities for secondment; and

- support the development of Public health networks within Northern Ireland, nationally and internationally**.**

- **Recommendation 4 (3)** District Councils should be given a new general power of competence to promote well being similar to that available to local authorities in England, Scotland and Wales.

- **Recommendation 5 -**

  (c) Build and strengthen Public Health multi-disciplinary contribution at local, community and neighborhood levels through established initiatives such as Investing for Health, HAZ and other initiatives.

  (d) The range of community driven initiatives should be effectively co-ordinated with shared local objectives based on local needs and regional objectives

- **Recommendation 8 (b)** – There is a need to enhance current existing cross-border links for example, with the Department of Health & Children and Co-operation and Working Together and foster new ones in order to enhance the practice of public health across the island of Ireland.

Project Desired Outcomes

1. **Interim report to Implementation Group December 2005**
2. **Costed Action Plan to Implementation Group March 2006**

The Sub-Group agreed, at its first meeting in July 2005, that given the complexity of the recommendations, and in particular recommendation 3 (b), that the task should be taken forward in four stages. It also recognised that there were areas of overlap with other Sub-Groups and discussions would need to take place throughout the life of the project.

Stage 1 – Development of Project Plan

Target date – 30th September 2005

Stage 2 – Consideration of recommendation 3 (b)

This recommendation falls into three main areas – health improvement, knowledge management and screening. The Sub –Group agreed to set up three smaller working groups to gather relevant information on each of the areas to inform the Sub-Group and aid in their decision making. The working groups are:

- health improvement - led by Prof C Boreham
- knowledge management - led by Dr D Stewart
- screening – led by Dr M Boyle

The working groups are to consider recommendation in detail, gather relevant information and identify steps/actions to achieve implementation. These will be considered by main Sub- Group, although it was acknowledged that consideration of the other three recommendations may also impact on this recommendation.

Target date - November 2005

Stage 3 – consideration of recommendations 4 (3), 5 (c) & (d) & 8 (b)

Group to consider remaining recommendations, including any impact on recommendation 3(b) and identify steps/actions to achieve implementation.

Target date - December 2005

Stage 4 – Action Plan

Group to consider steps/actions identified in stages 2 & 3 and develop a costed action Plan.

Target dates - Interim Report to Implementation Group by December 2005

Action Plan for submission to Implementation Group by March 2006

Risk(s)

A number of risk(s) have been identified with this project. These are:

Review of Public Administration - new administrative structures incompatible with review recommendations.

Project Tasks/ Timescales

The recommendations are complex but to ensure that the task is completed on time a number of milestone dates have been identified and these are attached at Annex 1. A project plan for each of the working groups considering recommendation 3 has also been developed and are attached:

Health Improvement - Annex 2

Knowledge Management – Annex 3

Screening – Annex 4

ANNEX 1

PROJECT PLAN

MILESTONE DATES

	2005						2006		
	July	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Initial Sub Group meeting	↔								
Project Plan	↔	↔							
Consideration of Rec. 3	↔	↔	↔	↔	↔	↔	↔	↔	
Second Sub-Group meeting			**19th Sept**						
Third Sub-Group meeting					**14th Nov**				
Fourth Sub-Group meeting (to agree steps identified for Rec. 3)						**TBC for Early Dec**			
Interim Report						↔			
Fifth Sub-Group meeting (consideration of remaining recs.)							↔	↔	↔
Sixth Sub-Group meeting (to consider draft action plan)								↔	↔
Final meeting of Sub-Group (to finalise action plan)									**TBC Mar**

ANNEX 2

HEALTH IMPROVEMENT WORKING GROUP

Introduction

A health improvement working group, comprising of professionals from Boards, Health Promotion Agency, Health Scotland, Institute of Public Health, Environmental health and the Department has been established to identify actions to achieve successful implementation of Recommendation 3 (b). A Working Group on Knowledge Management and a Working Group on Screening have also been established.

Project Plan

The Working Group has agreed a number of tasks to be undertaken and issues clarified before agreeing actions for consideration by the Health Improvement Sub-Group.

1. Identify and consider which organisations, currently involved in regional health improvement (including health promotion), should be combined into one single organisation.
2. Identify and consider models from other jurisdictions.
3. Agree health improvement functions, role and responsibility of new organisation.
4. Identify steps to be taken to establish a new organisation e.g. legislation
5. Consider structure of new organisation.
6. Identify staffing requirements (health improvement only)
7. Consider accommodation needs (findings from other 2 WGroups will need to be taken into account)

Action Plan

1. Secure resources
2. Make legislation to establish new organisation

3. Make ‘Direction of Functions’ for new organisation

4. Accountability arrangements e.g. Financial Memorandum, Management Statement etc.

5. Recruitment/ transfer of staff including Terms & Conditions of Service

6. Identify accommodation (if necessary).

KNOWLEDGE MANAGEMENT

PROJECT DELIVERABLES

Product	Description	Timescale	Team members responsible for development	Quality Assurance
1 - Project Initiation Document	A short report defining the project and its management.	by 19th September 2005	Dr A Jordan	Project Board
2 – A review of the concepts of knowledge management and their potential	A report detailing the concepts of knowledge management and potential applications for enhancing the public health function in NI	by 30th November 2005	Dr P O Halloran Mr L McLean Ms J Neil	Dr d Stewart Project Board
3 – Audit of sources of knowledge management	An audit and summary report ascertaining the major sources of public health knowledge in NI (to include sources of funding and links)	by 30th November 2005	Dr A Jordan Mr M Mayock Mr D Kennedy Ms M Heaney Dr C Willis Mr T Doherty Dr K Balanda	Project Board
4 – A review of developments in knowledge management outside NI	A report detailing developments in knowledge management external to NI and actual or potential links which could be made to these (should include UK, Ireland, Europe and world wide web)	by 30th November 2005	Dr J Chalmers Dr K Balanda	Project Board
5 – Stakeholder event 1	A half day event (linked with the other working groups and subgroups) to garner views on current sources of knowledge management and future developments	5th October 2005	DHSSPS	Implementation Group Project Board
6 – Gap analysis	A short report detailing gaps in the	Week beginning 5th		Project Board

Product	Description	Timescale	Team members responsible for development	Quality Assurance
	current sources of knowledge management and potential for future development – this will be developed via a group meeting.	December 2005		
7 – Appraisal of options for development	A report detailing the options for the development and co-ordination of knowledge management within NI and an appraisal of these options. To include the working group's recommendation for their preferred option.	By 31st December 2005		Project Board
8 - Stakeholder event 2	A half day event (for stakeholders related to knowledge management, including producers and users) to present the options for development and harness views.	January 2005		Project Board
9 – Summary report	A summary report for the Project Board of the work and findings of the working group.	6th February 2005		Project Board

NB – Products 6 and 7 may be amalgamated together and developed over a 1 to 2 day project team event/meeting on 14th December 2005

ANNEX 4

HEALTH IMPROVEMENT AND KNOWLEDGE MANAGEMENT

SCREENING ELEMENT

Introduction

A screening sub-group comprising of public health physicians from the four Health and Social Services Boards and the DHSSPS and a representative from the Health Promotion Agency has been established to develop a Project Plan and Action Plan for screening.

Project Plan

The subgroup has identified a number of tasks which have to be undertaken and issues to be agreed before the Action Plan can be developed.

1. Define the Public Health Function in Population Screening Programmes.
2. Agree which functions should be carried out at Government, Regional and Local level.
3. Agree the functions, roles and responsibilities of a regional screening office.
4. Consider screening arrangements in other UK countries.
5. Outline the organisational structure of a regional screening office.
6. Identify the accountability issues which need to be addressed.
7. Identify Health Service staff who have a regional screening responsibility and who could transfer to a regional unit.
8. Identify what additional staff will be required.
9. Estimate the revenue consequences.
10. Develop a framework for a Regional Screening Network.
11. Assess ICT requirements.

Action Plan

1. Identify the resources required to establish a regional screening office.
2. Identify suitable accommodation.
3. Establish a regional screening office.
4. Transfer staff who currently have a regional screening responsibility to the regional office (it may be feasible/more appropriate for some staff to work from another location).
5. Recruit additional staff.
6. Define the accountability arrangements with the DHSSPS and HSS Boards and Trusts.
7. Establish a Regional Screening Network.

Appendix 2

1. Knowledge Management

1.1 Background

The Management of Public Health Knowledge was identified as a major theme within the original Capita report to DHSSPS. It was felt to be an essential component in supporting the overall objectives of improving the population's health and decreasing health inequalities. Areas for development focused on how Public Health is organised to manage information and how it uses information and research to assist in planning its activities

Key considerations were;

Health Information and Intelligence

- Develop a high quality, accessible knowledge management system which can draw from established evidence bases and measure impact and outcomes of Public Health activity over a period of time. It must also provide accurate, relevant and timely information on key Public health problems in order to improve public understanding and aid decision making.

Research and Development

- Achieve a balance between academic Public Health departments providing research to meet their overall research objectives and address the research priorities of the broader Public Health community.

Building the Evidence Basis

- Build capacity within Northern Ireland to make available evidence that addresses regional needs and local priorities.

Taken from the Review of the Public Health Function in Northern Ireland – Final report – 6 December 2004 – page 55.

1.2 Work undertaken

In considering how the recommendations of the review in relation to health improvement and knowledge management could be implemented the working group felt it was important to;

1. Clarify the concept of knowledge management in relation to Public Health.

2. Review developments in the management of Public Health knowledge nationally and internationally

3. Undertake a limited knowledge audit determining the major sources of Public Health knowledge in Northern Ireland, funding and the current availability to professionals and public.

Details of this are outlined below.

An exercise was then undertaken to determine the key elements a Public Health information system needed to provide to be effective.

This information was utilised to produce a set of functions for a new regional body developing knowledge management in NI.

2. Knowledge Management – concepts and application to Public Health

Dr Peter O'Halloran

2.1 Introduction and Background

Contemporary KM literature is primarily written in the commercial context, where company value is increasingly dependent on knowledge, intellectual capital and intellectual property, and learning organisations are seen to have a competitive advantage (Jashapara, 2004). However, more recently its

concepts and approaches have been explored as a means to managing the knowledge requirements of practitioners and decision-makers in health care (Bose, 2003).

KM is often described as a cycle, moving from creating knowledge, to structuring knowledge, to sharing knowledge, to applying or "leveraging" knowledge (Bose, 2003; Jashapara, 2004). There is a long tradition of creating and structuring knowledge in Public Health, so this summary concentrates on sharing and leveraging knowledge.

KM can be defined as:

> "the effective learning processes associated with exploration, exploitation and sharing of human knowledge (tacit and explicit) that use appropriate technology and cultural environments to enhance an organisation's intellectual capital and performance." (Jashapara, 2004, P. 12).

2.2 Tacit and explicit knowledge

The identification of knowledge as tacit ("knowing how") or explicit ("knowing that") is a key theme in the knowledge management literature. It appears to stem from a distinction made by Polanyi (1967) between knowledge that is difficult to express, and that is usually transferred (if at all) by demonstration rather than description – tacit knowledge; and knowledge that can be written down or codified, and can be transferred through formulae, or technical documents – explicit knowledge (Ahmed *et al,* 2002). More recently organisational knowledge has been characterised as being on a continuum between the tacit and explicit. So, for example, Blackler (1995) identifies knowledge that is "embrained," (in the minds of individuals) "embodied," (in the skilled actions of individuals) "encultured," (in the shared understanding of a group) "embedded," (in the systemic routines of an organisation) and "encoded" (in signs and symbols of various sorts). All these types of

knowledge are present in organisations but different types predominate in different types of organisation.

2.3 Data, information, and knowledge

Related to the ideas of tacit and explicit knowledge are the distinctions made between data, information and knowledge. Data are symbolic representations of facts; information is the arrangement of data in meaningful patterns; knowledge requires a "knower" who will take data and information and use it as a basis for action in a given context (Ahmed *et al,* 2002).

2.4 KM and the nature of knowledge

Knowing "who knows how to do what"

If knowledge requires a "knower," then it will be important to identify who the knower is. Only then can the knowledge manager intelligently organise to make sure the knower has the necessary knowledge. Furthermore, effective knowledge management means recognising that much vital knowledge is tacit – embodied or embrained in key individuals – and therefore KM is partly about effectively managing these individuals. Generally speaking, the more complex and contingent the process, the more likely it is that the necessary knowledge to carry out the process is embodied in people.

Of course KM is partly about making tacit knowledge explicit and consequently available to all who need it. However, not all tacit knowledge can be encoded and in a fluid and unpredictable environment, even explicit knowledge may require tacit knowledge to ensure successful application. Therefore, KM is also about *knowing who knows how to do what* and *how to gain access to them* and their embrained or embodied knowledge.

2.5 Managing knowledge or managing information?

KM must start from the knower, but in practice it seems that in health care we are inclined to start from the information that we have encoded – in research databases, guidelines or policies – and assume that our task is to make this accessible to all who could conceivably need it. In other words we see the task as information management, rather than knowledge management. If this is the task, then we need look no further than the UK *Public Health electronic Library* (PHeL) (http://www.phel.gov.uk/). The PHeL is in turn a partner of the *National Electronic Library for Health* (NeLH), which provides public access to seventy databases, most without subscription. If the goal is information management, then we have gone a very considerable way towards achieving it.

2.6 Applying Knowledge Management principles

In the last two decades there has been an exponential rise in the volume of information contained in scientific databases and a quantum leap in the technology enabling databases to be accessed and searched. Yet this has not been matched by a comparable step forward in the use of this information by those who might benefit. Certainly KM is concerned with effective training and optimising the use of databases - but to what purpose? A prior enquiry – whether by a practitioner or those facilitating practice - must determine the following:

- What are the problems to be addressed?
- Who is responsible (at various levels) for addressing these problems?
- How will this particular knower best be able to understand the available knowledge?
- What knowledge is needed to enable the responsible persons to effectively address the problems?
- What sort of knowledge (on the tacit – explicit continuum) is needed?

Only then can the knowledge manager ask the questions:

- How can this knowledge be made available?
- What combination of written/encoded information and embodied knowledge is needed, and how will the knower gain access to it?

2.7 Mind the gap

Even if an organisation accurately identifies its KM needs and devises a relevant strategy, a number of difficulties can arise in the implementation process. Ahmed *et al* (2002) identify a number of "gaps" that may undermine a KM strategy.

The technology gap occurs when an organisation assumes that linking people with each other and with information databases via e-communication is a substitute for developing a community of practice with a culture of sharing knowledge to gain deeper insights into effective working. *The implementation gap* occurs when organisations know what to do but do not do it. *The transfer gap* arises when an organisation fails to learn from other organisations; or where different parts of the organisation fail to learn from each other. *The integration gap* is seen when an organisation fails to identify and integrate the components of a comprehensive KM strategy. Organisations must think through their KM requirements, work out how the various parts fit together, prioritise key aspects, and effectively communicate with the relevant members of the organisation. This is not a "one-off" process but requires continued effort and attention to the changing organisational environment.

2.8 Applying KM principles to the organisation of Public Health

The application of KM principles to public health organisations is not without practical difficulties, largely stemming from the complexity of the public sector. On the other hand, the ethos of public service lends itself to the formation of the "communities of practice" described in the KM literature. (Communities of

practice are “groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.” [Snyder *et al,* 2004, P. 17]) But whatever the strengths and weaknesses of the sector, if we accept that public health work is knowledge-intensive work, then the literature suggests that it should be configured as a “learning organisation.” KM is not simply about organising information; it is about configuring an organisation (or organisations, or networks) to make optimal use of available knowledge. What sorts of organisations effectively manage knowledge-intensive work? This is a very big question for which multiple and complex answers are given. At the risk of over-simplifying the issues, a helpful summary is given in Table 1. (Iles and Sutherland, 2001, P. 65).

Ultimately, it is necessary to recognise that KM is a social process. Knowledge is created, organised, communicated, understood, applied and evaluated by people – invariably people living and working in communities of practice (see, for example, Gabbay and le May, 2004). The implication is that KM must take notice of how communities of practitioners are presently gaining knowledge, and, where possible, seek to work in synergy with these accepted practices. Otherwise, expensively constructed databases and KM strategies may be perceived to be irrelevant or unwieldy and consequently ignored by those for whom they are intended.

2.9 Conclusions - knowledge management and Public Health

Knowledge Management is an emerging discipline with its roots in the commercial sector. Whilst some confusion exists over key concepts, KM has the potential to identify and harness both explicit information and “embrained” knowledge for the benefit of the Public Health. Its application to public health organisations is not without practical difficulties, largely stemming from the complexity of the public sector, although the ethos of public service lends itself to the formation of the communities of practice described in the KM literature. Effective KM is more than simply providing access to information. It is about understanding how relevant communities of practice presently

manage their knowledge, and in the light of this, configuring the organisations within which they work to enable both practitioners and decision-makers to make optimal use of the knowledge, both explicit and embrained, that is available to them.

Table 1. ***The main characteristics of the Learning Organisation***	
Structure	Learning Organisations have flat managerial hierarchies that enhance opportunities for employee involvement in the organisation. Members are empowered to make relevant decisions. Such structures support teamwork, strong lateral relations, and networking across organisational boundaries both internal and external (e.g. project teams). These features promote systems thinking, information sharing and openness to information necessary for organisational learning. Temporary forms are favoured as they cater for current needs but can be shaped through experimentation to respond to future changes.
Information systems	Learning Organisations require information beyond that used in traditional organisations where information is generally used for control purposes (single-loop learning). Transformational change requires more sophisticated information systems that facilitate rapid acquisition, processing and sharing of rich, complex information that enables effective knowledge management.
Human resource practices	People are recognised as the creators and users of organisational learning. Accordingly, human resource management focuses on provision and support of individual learning. Appraisal and reward systems are concerned to measure long-term performance and to promote the acquisition and sharing of new skills and knowledge.
Organisational	Learning Organisations have strong cultures that promote

culture	openness, creativity and experimentation among members. They encourage members to acquire, process and share information, to nurture innovation and provide the freedom to try new things, to risk failure and to learn from mistakes.
Leadership	Like most interventions aimed at securing significant organisational change, organisational learning depends heavily on effective leadership. Leaders model the openness, risk taking and reflection necessary for learning and communicate a compelling vision of the Learning Organisation, providing empathy, support and personal advocacy needed to lead others towards it.
(Taken from *Organisational Change: A review for health care managers, professionals and researchers,* Iles and Sutherland, 2001, P. 65)	

3. **Developments in Knowledge Management nationally and internationally.**

Dr Jim Chalmers and Dr Kevin Balanda

3.1 Organising and sharing knowledge

As previously stated much of the present use of KM is based around the needs of big corporations. There are, however, examples of the use of KM concepts in Public Health in other countries. Of particular relevance to Northern Ireland are the development of infrastructure and processes to support KM. It seems that the work being done in the UK is as far ahead as anywhere else.

The UK approach, which is particularly influenced by the work of Muir Gray, is applied in some significant public health resources, such as the National Electronic Library for Health and the Public Health Observatories.

The main issue for Public Health is that relevant knowledge resources tend to be distributed across a variety of organizations and locations. A key task for KM is to help organize and share these resources. The use of a central repository of relevant knowledge resources has been considered, but will inevitably be inefficient and likely to encounter a variety of problems related to ownership and control, and loss of specialist input. A more distributed solution is likely to be more efficient; and the recommended approach is one adopted in the UK. This approach involves networks of interoperable libraries that can be accessed across the internet.

This approach requires the following infrastructure to be established

- Agreed metadata standards that comply with the published eGov standards based on the “Dublin core” (http://www.govtalk.gov.uk/documents/eGovMetadataStandard%20 20040429.pdf).

- Agreed vocabularies to describe various metadata elements. For Public Health this includes using the National Public Health Language (NPHL) to describe the subject of a resource and the Public Health Resource Type Encoding Scheme (PHRTES) to describe the type of a resource.
- Governance arrangements to manage the implementation of these standards in the relevant libraries including standardized cataloguing and searching procedures.
- Relevant information and communication technology (ICT) to allow the knowledge resources in any library to be accessed easily from across the internet.

An example of this approach can be seen on the websites of the Association of Public Health Observatories (APHO) and in the National Electronic Library for Health (NeLH).

Ireland's population health observatory (INIsPHO) has made considerable progress towards building this infrastructure for its website, It includes metadata standards, adapting the NPHL so it can be used on the island, an online catalogue with the necessary administration tools, and interoperability with other observatories. As well as meeting specialist needs in Northern Ireland, the observatory is keen to share this infrastructure so it can be developed on an all-island basis

3.2 Translating knowledge into policy and practice

The technical developments described above are concerned with organizing and sharing knowledge. However to translate this knowledge into effective policy and practice there needs to be a parallel development of "communities of interest" – another concept which is widely used in the world of KM. Communities of interest are not constrained by professional or organizational boundaries but serve to draw together the professionals and others who share a similar interest. Within the field of Public Health, they can be particularly

important in bridging the gap between academic and service practitioners which was highlighted as an area of concern in the Review.

Like the Public Health Observatories in the UK, a key objective of the all-Ireland observatory is to support such communities of interest. Communities of interest also help build the knowledge base by sharing lessons about the effective implementation of knowledge

Although the organisation which takes responsibility for the roles discussed above will not necessarily be responsible for knowledge generation, it must be intimately linked to those who do, including academics, service practitioners and government.

3.3 Infrastructure and resources

It is important to realise the development and maintenance of the necessary infrastructure and communities of interest will require resources. There will be set-up costs, but also ongoing revenue costs for such activities as identifying and cataloguing knowledge resources, maintaining technology, and facilitating the communities of interest.

4. Knowledge Inventory

Dr A Jordan

The group undertook a limited exercise to begin developing a knowledge inventory of the main sources of (explicit) Public Health knowledge in Northern Ireland. Whilst collecting this information opportunity was taken to review accessibility to this information, funding sources and to explore sources of tacit knowledge or “knowers”.

Due to timescale it was impossible to detail every resource available to support the Public Health Function on the island therefore the focus at this point was on

A. Resources based in Northern Ireland
B. Resources which are regional

These were identified (in the main) via face to face meetings with organisations which the group felt (based upon their wide and varied experience) were most likely to have sources of Public Health knowledge. However not all sources of Public Health knowledge were covered; in particular smaller organisations were not included e.g. councils (air quality data) and community and voluntary groups.

The information obtained was stored on an excel database. It was categorised and presented under various themes/headings including type of resource, area of Public Health and organisation in a similar manner to the approach outlined above. The information gathered has been forwarded to the DHSSPS.

Whilst this represented only some of the information held within Northern Ireland it was clear that there was a wealth of information collected on the island. Some of this information was already held on excellent websites developed by organisations where sets of data had been amalgamated and presented in easily accessible ways e.g. NINIS website, public health matters website, INIPHO. However other information was less accessible. Indeed awareness of the availability of some information was limited amongst healthcare professionals and there were minimal resources to respond to queries. Individuals tended to access this data mainly if they were directed to it via the tacit knowledge of colleagues.

The approach highlighted in the work to date, utilising meta data standards and an agreed language would clearly allow professionals or public to be “signposted” to these sources of information.

This would increase awareness and accessibility to resources but would ensure that work already carried out in developing excellent websites was not duplicated. Communities of interest could then access the relevant

information, identify and address any gaps and translate this information into effective policy and practice.

The majority of resources were funded directly or indirectly by DHSSPS.

5. What does a Public Health Knowledge Management system need to do to be effective

Utilising a ”theory of constraints approach” two key tasks were identified as essential for effective public health service. These were;

A. The ability to respond rapidly to all immediate risks and demands
B. The ability to support long term action to sustain health improvement

Consequently any knowledge management system developed for Public Health must be able to deliver on these key elements.

6. Proposed functions of a new health improvement body (in relation to Knowledge Management)

From this work a set of functions (in relation to taking forward knowledge management) for a new regional health improvement body were developed. These incorporate the principles and processes outlined above.

7. Lead and co-ordinate the development of a knowledge based approach to the delivery of Public Health practice in Northern Ireland.

8. Link to developments in Public Health knowledge management nationally and internationally and ensure consistency and links with the Republic of Ireland.

9. Build communities of practice (including academic/research and service public health) to facilitate a systematic sharing of knowledge

across public health practitioners and organisations within and outside the HPSS.

10. Identify sources of explicit knowledge and take a lead role in ascertaining how these could be developed and enhanced to underpin Public Health activity.

11. Ensure practitioners and policy makers have access to up-to-date sources of evidence and "experts" as well as guidance on the best way to translate this evidence into practice and opportunities to build capacity to enable this to be achieved.

12. Co-ordinate the surveillance of health trends and support risk assessment of threats to health and well-being and health impact assessment of new policies and developments.

7. Knowledge management in the context of the Review of Public Administration

A lead person needs to be identified at senior level to "champion" knowledge management for Public Health and ensure the development of the above functions during the proposed structural reorganisation.

This individual should harness the relevant expertise currently available across the Public Health community and lead the development of the proposed system for knowledge management for Public Health in Northern Ireland.

The new regional body on health improvement and knowledge management would be best placed within the proposed Strategic Health Authority alongside Regional Health Protection Functions. Hence the Strategic Health Authority will eventually provide the leadership role for health improvement and knowledge management.

It will however be important that the Strategic Health Authority links with the Public Health Observatory currently being developed across Ireland. This will allow strong links to be maintained and enhanced with the Observatories in the UK and ensure consistency and clear links with the Republic of Ireland. It may be appropriate for some of the functions of the new health improvement and knowledge management body relating to knowledge management to be taken forward by the Observatory.

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Appendix 3

Screening Services

Introduction

A screening sub-group, comprising Public Health physicians from the four Health and Social Services Boards and the DHSSPS and a representative from the Health Promotion Agency, has been established to develop a Project proposal for the future development of screening services in Northern Ireland. This is described below.

New HPSS Structures

In the new structures it is likely that there will be a very clear demarcation of role and function between the DHSSPS, the regional Strategic Health and Social Services Authority (SHSSA) and Trusts. These roles and functions are outlined below.

Public Health Input

Public Health Professionals have significant input to the effective development and delivery of population screening programmes. This is discussed in the final section.

DHSSPS

In relation to screening the DHSSPS should:

- Set policy on new screening programmes
- Agree policy changes to existing programmes
- Allocate funding for such programmes
- Set targets

- Hold the SHSSA accountable through a performance management framework for the effective commissioning and implementation of screening programmes.

SHSSA

Role

The SHSSA will be responsible for implementing policy and strategy, performance management and ensuring that services are accessible, responsive, high quality and efficient.

The SHSSA will carry overall responsibility for the duty of quality, governance and risk management for the HPSS.

In relation to screening programmes, the SHSSA should be responsible for:

- Commissioning screening programmes
- Implementing policy and strategy in relation to new and existing screening programmes
- Leading QA system management and quality improvement
- Performance management of screening programmes
- Regional Coordination of programmes
- Population coverage
- Standard setting
- Maintaining links with National Screening Bodies
- Supporting/leading the development of appropriate IT systems
- Developing public and professional information strategies to support the implementation of screening programmes.

The SHSSA should also have a role in influencing screening policy and strategy being developed by the DHSSPS.

HPSS Trusts

Role

Trusts should be responsible for the delivery, local coordination and the quality of screening services provided. The Chief Executives of Trusts should be held accountable for these functions by the SHSSA through the routine performance management arrangements.

One Trust may be tasked with taking a lead role in providing a screening programme throughout Northern Ireland.

Accountability arrangements

A clear accountability framework is essential. An outline of this in respect of screening services is attached at appendix A.

Public Health input to population screening programmes

At DHSSPS, Public Health functions are to provide leadership in relation to screening programmes through advising on:

- Policy and strategy development
- Priority setting and resource allocation
- Target setting
- Performance management

Public Health functions in relation to screening at SHSSA are:

- To provide leadership
- To influence policy and strategy
- To lead implementation of policy and strategy in relation to new and existing screening programmes
- To contribute to commissioning
- To lead QA system management and quality improvement
- To advise on performance management of screening programmes
- To establish agreed standards
- To provide regional coordination
- To support IT system development
- To promote coverage/uptake of screening programmes
- To maintain links with National Screening Bodies

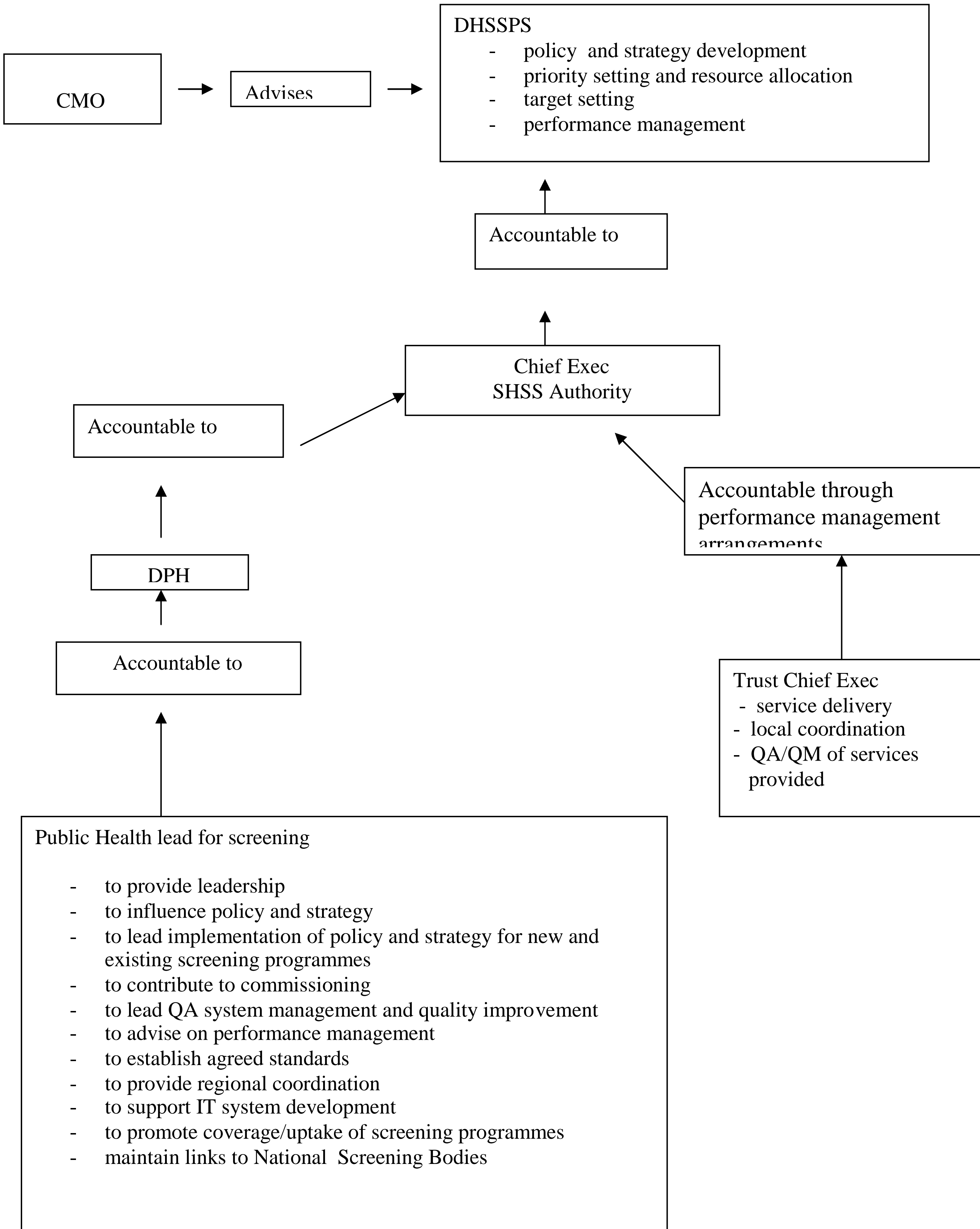
Within the SHSSA the Director of Public Health would be the lead officer responsible for population screening programmes. These responsibilities could be formally delegated to a senior public health doctor who would lead a multidisciplinary team of staff based in a regional population screening office.

Based on experience in Northern Ireland and at National level it is recommended that commissioning of screening programmes should be

undertaken at regional level by the SHSSA and not by local commissioning groups.

Appendix A

ACCOUNTABILITY FRAMEWORK FOR SCREENINGPROGRAMMES



Appendix 4

Review of the Public Health Function Recommendation 4c: *District Councils should be given a new general power of competence to promote well being similar to that available to local authorities in England, Scotland and Wales*

District councils owe their existence to statute and all of their powers to statute. Unless they have statutory cover to do whatever they seek to do, they have no power to act. Should they act without the statutory power to do so, the act is *ultra vires* and may also attract the attention of the Local Government Auditor if resources are involved. This situation can further restrict Environmental Health departments in seeking to fully engage in broader public health initiatives.

Most, if not all, District Councils will be involved in their local Investing for Health Partnership. Many will have difficulty in allocating resources to supporting the partnerships because the work falls outside of their statutory remit. Although Environmental Health Departments are actively supporting a wide range of partnership initiatives, problems often arise because resources cannot be moved easily between the range of bodies involved and because of the lack of 'statutory comfort' to allow for participation in innovative public health initiatives.

District Councils could be given a new general power of competence to promote well being, similar to that available under the Local Government Act 2000 in England and Wales. This might help provide the statutory comfort required to address some of the difficulties described earlier.

Although commonly referred to as the 'well being powers', the Local Government Act 2000 actually refers to 'economic, social and environmental well being'. This provides a link between public health and sustainable development which is also implicit in the *Investing for Health* Strategy. The GB power is also taken a step further to place a duty on local authorities to develop and implement economic, social and environmental well being or sustainable development strategies.

The March 2005 consultation paper on the Review of Public Administration (RPA) in Northern Ireland (http://www.rpani.gov.uk/consultdocu.pdf) appears to support the introduction of a power of well being for councils and states "*Within the two-tier model envisaged for the future it would be essential for councils to have such a power to enhance their central role in the community planning process*." It is likely that the introduction of the necessary legislation would be a matter for DOE. Action in relation to recommendation 4c could include a recommendation that DHSSPS write formally to DOE and respond to the RPA consultation (ends 30 September 2005) pressing for a general power to promote well being to be introduced as a matter of urgency and certainly in advance of the general implementation of the RPA.

The relevant sections from the Local Government Act 2000 and the associated explanatory notes are attached as Annex 1 for reference.

Annex 1

Local Government Act 2000

PART I

PROMOTION OF ECONOMIC, SOCIAL OR ENVIRONMENTAL WELL-BEING ETC

Interpretation

1. In this Part "local authority" means-

(a) in relation to England-
(i) a county council,
ii) a district council,
iii) a London borough council,
iv) the Common Council of the City of London in its capacity as a local authority,
(v) the Council of the Isles of Scilly,

(b) in relation to Wales, a county council or a county borough council.

Promotion of well-being

2. - (1) Every local authority are to have power to do anything which they consider is likely to achieve any one or more of the following objects-

(a) the promotion or improvement of the economic well-being of their area,
(b) the promotion or improvement of the social well-being of their area, and
(c) the promotion or improvement of the environmental well-being of their area.

(2) The power under subsection (1) may be exercised in relation to or for the benefit of-

(a) the whole or any part of a local authority's area, or

(b) all or any persons resident or present in a local authority's area.

(3) In determining whether or how to exercise the power under subsection (1), a local authority must have regard to their strategy under section 4.

(4) The power under subsection (1) includes power for a local authority to-

(a) incur expenditure,

(b) give financial assistance to any person,

(c) enter into arrangements or agreements with any person,

(d) co-operate with, or facilitate or co-ordinate the activities of, any person,

(e) exercise on behalf of any person any functions of that person, and

(f) provide staff, goods, services or accommodation to any person.

5) The power under subsection (1) includes power for a local authority to do anything in relation to, or for the benefit of, any person or area situated outside their area if they consider that it is likely to achieve any one or more of the objects in that subsection.

6) Nothing in subsection (4) or (5) affects the generality of the power under subsection (1).

Limits on power to promote well-being.

3. - (1) The power under section 2(1) does not enable a local authority to do anything which they are unable to do by virtue of any prohibition, restriction or limitation on their powers which is contained in any enactment (whenever passed or made).

(2) The power under section 2(1) does not enable a local authority to raise money (whether by precepts, borrowing or otherwise).

(3) The Secretary of State may by order make provision preventing local authorities from doing, by virtue of section 2(1), anything which is specified, or is of a description specified, in the order.

(4) Before making an order under subsection (3), the Secretary of State must consult such representatives of local government and such other persons (if any) as he considers appropriate.

(5) Before exercising the power under section 2(1), a local authority must have regard to any guidance for the time being issued by the Secretary of State about the exercise of that power.

(6) Before issuing any guidance under subsection (5), the Secretary of State must consult such representatives of local government and such other persons (if any) as he considers appropriate.

(7) In its application to Wales, this section has effect as if for any reference to the Secretary of State there were substituted a reference to the National Assembly for Wales.

(8) In this section "enactment" includes an enactment comprised in subordinate legislation (within the meaning of the Interpretation Act 1978).

Strategies for promoting well-being

4. - (1) Every local authority must prepare a strategy (referred to in this section as a community strategy) for promoting or improving the economic, social and environmental well-being of their area and contributing to the achievement of sustainable development in the United Kingdom.

(2) A local authority may from time to time modify their community strategy.

(3) In preparing or modifying their community strategy, a local authority-

(a) must consult and seek the participation of such persons as they consider appropriate, and

(b) must have regard to any guidance for the time being issued by the Secretary of State.

4) Before issuing any guidance under this section, the Secretary of State must consult such representatives of local government and such other persons (if any) as he considers appropriate.

(5) In its application to Wales, this section has effect as if for any reference to the Secretary of State there were substituted a reference to the National Assembly for Wales.

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LOCAL GOVERNMENT ACT 2000

EXTRACT FROM EXPLANATORY NOTES

PART I: PROMOTION OF ECONOMIC, SOCIAL OR ENVIRONMENTAL WELL-BEING

Summary

4. Part I of the Act gives local authorities powers to take any steps which they consider are likely to promote the well-being of their area or their inhabitants. It also places authorities under a duty to develop community strategies, together with other local bodies, for this purpose. These provisions are intended to give local authorities increased opportunities to improve the quality of life of their local communities.

5. Part I also enables the Secretary of State to remove statutory constraints on authorities' ability to exercise the new well-being power and on their ability to plan co-ordinated local action.

Background

6. Local authorities are statutory corporations and operate within a framework laid down by statute. They have no powers to act other than where they are expressly authorised by law to do so. There is a wide range of statutory duties which authorities are required to fulfil, and an even wider range of permissive powers enabling them to

undertake defined activities if they so wish.

7. In addition, local authorities have a small number of 'general' powers. The most significant of these is section 137 of the Local Government Act 1972, which permits authorities to incur expenditure that is in the interests of their area, subject to certain conditions. One of those conditions is that section 137 cannot be used for any purpose for which there is authority in other legislation, or to overcome any limitations, prohibitions or conditions in other legislation.

8. This formulation has, on occasion, led the courts to take a restrictive view of the activities that can be pursued using section 137. In some cases, the courts have inferred from the absence of specific powers in other legislation that certain activities are prohibited and that an authority cannot, therefore, rely on its section 137 powers to overcome that prohibition. This has created uncertainty amongst local authorities and their potential partners about the extent to which authorities can rely on their general powers to undertake certain activities.

9. The scope of section 137 is further restricted by the limit on how much authorities can spend (currently between £1.90 and £3.80 per head of population depending on the class of authority); and by the additional restrictions placed on section 137 by the Local Government and Housing Act 1989. As a result of the 1989 Act, authorities must now be able to establish that any expenditure under section 137 is of "direct" benefit to their area which is "commensurate with the expenditure to be incurred".

10. Local authorities also have general economic development powers under sections 33 to 35 of the Local Government and Housing Act 1989. Again, these powers are heavily constrained by the restrictions placed on their use.

11. In the White Paper, *Modern Local Government: In Touch with the People*1, the Government set out its view that community leadership should be at the heart of the role of modern local authorities. To enable local authorities to develop that role and to respond to the needs of local communities, the White Paper argued that authorities would need the freedom to work with other local public, private and voluntary organisations to develop solutions to local problems.

12. To provide authorities with the necessary freedoms, the White Paper proposed that local authorities' general powers should be extended; specifically, that they should be given a new discretionary power to take steps which in their view promote the economic, social and environmental well-being of those who live in, work in or visit the local area.

13. To facilitate a more co-ordinated and coherent response to local service delivery, the White Paper also proposed that authorities should be required to develop community strategies. These strategies, developed with local people, business, public and voluntary organisations would set out how the authority and its partners would work together to promote the well-being of their local community.

Commentary on sections

Sections 2 and 3: Promotion of well-being

14. *Section 2* provides local authorities with a power to take any steps which they consider are likely to promote or improve the economic, social or environmental well-being of their local community, subject to the restrictions contained in *section 3*.

15. Together, these sections allow local authorities to undertake a wide range of activities for the benefit of their local area and to improve the quality of life of local residents, businesses and those who commute to or visit the area. This is intended to clear up much of the uncertainty which currently exists about what authorities can do. Sections 2 and 3 allow authorities to take any action, unless it is subject to statutory prohibitions, restrictions or limitations specifically set out in legislation. The intention is to broaden the scope for local authority action while reducing the scope for challenge on the grounds that local authorities lack specific powers.

16. Amongst other things, *section 2(3)* means local authorities must consider the objectives and priorities contained in their community strategy before they take action under the power in *section 2(1)*. This is in no way meant to limit the scope of the power in section 2(1). Rather it is designed to encourage authorities to think about the broad goals and objectives contained in the community strategy, before deciding how best to use their well-being power.

17. Additionally, *section 2(4)* makes clear that the power in section 2(1) enables authorities to work in partnership with other bodies. For example, it allows authorities to assist other statutory bodies to discharge their functions, or to exercise those functions on their behalf. This is intended to help local authorities and other statutory service providers to work together to provide services in ways which meet the needs of communities.

18. Section 3 prevents local authorities from using the power in section 2 to raise money. It also allows the Secretary of State, in relation to England, and the National Assembly for Wales (NAW), in relation to Wales, to prevent authorities from using the power to do anything which they specify by order that authorities should not do. This section also permits the Secretary of State and the NAW to issue guidance to authorities on the exercise of the power. Before issuing any guidance, the Secretary of State and the NAW would have to consult local government and others.

Section 4: Strategies for promoting well-being

19. *Section 4* requires authorities to work together with other bodies to establish a strategy for promoting the well-being of their local communities. Such strategies are intended to allow authorities, and other bodies who provide local services, to establish common priorities and determine the steps which they would take to address them.

20. This section also allows the Secretary of State and the NAW, following consultation with local government and others, to issue guidance on the exercise of the power.