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Integrating Health Considerations into Wollondilly Shire Council Planning Processes

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Photos provided by Wollondilly Shire Council.

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Executive Summary

Background

South Western Sydney Local Health District, Population Health (SWSLHD) and Wollondilly Shire Council (WSC) have been working together to identify ways of integrating health considerations into policy and planning processes. This work began with WSC's involvement in a Learning-by-Doing training on health impact assessment in 2013 and culminated in a joint Council and Health Forum to discuss ways of integrating health into WSC's business and land use planning processes. It was decided that the Centre for Health Equity Training, Research and Evaluation (CHETRE) would undertake a research project to identify appropriate tools, strategies and approaches that could be used to integrate the consideration of health into WSC land use planning.

Research Objectives and Methods

The aims of this research are:

- To develop a shared understanding of Wollondilly Shire Council land use planning processes and opportunities for the consideration of health within those processes;
- To identify and appraise various tools, processes, and assessment strategies that may be used to integrate health considerations into the land use planning process; and
- To appraise the applicability and appropriateness of various tools, approaches, or assessment strategies to both the Wollondilly Shire context and other planning contexts.

CHETRE used various research methods to develop an understanding of the context, processes and opportunities for the integration of health in WSC. This research was gathered through conducting key informant interviews with staff at WSC, participant observation of select planning meetings, and reviewing a number of state and local land use planning documents. CHETRE researchers also conducted a health tools audit and literature review to identify potential tools and strategies that could be used to integrate health into WSC planning. These methods were supported by additional stakeholder and expert consultation and through various validation workshops with a project steering committee composed of staff from WSC and SWSLHD.

Findings

There are opportunities within WSC processes to integrate health considerations into land use planning. Some of the enabling factors include the fact that many planners have an understanding of
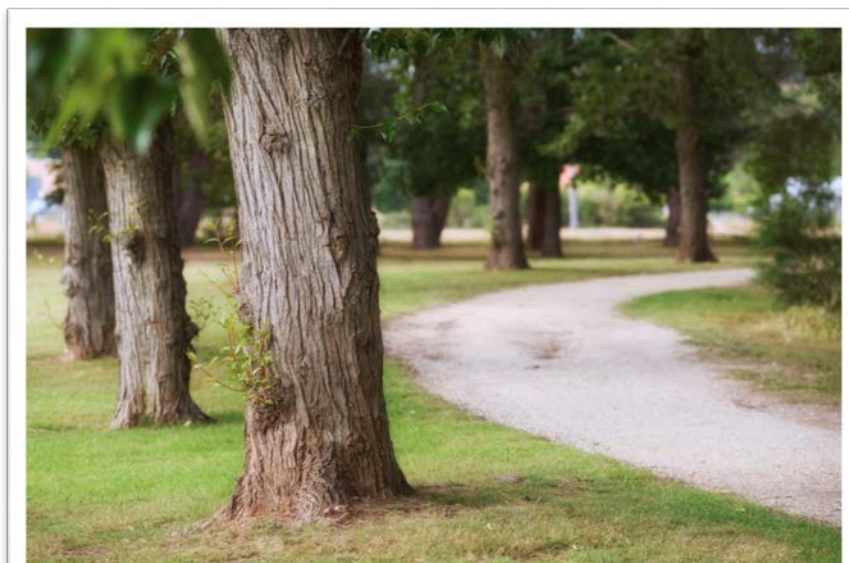
the connection between health and planning, WSC leadership is supportive of taking this integrated approach and there exists a partnership and good working relationship between WSC and SWSLHD Population Health. There are also several tools and approaches available that can help planners to consider health as part of both strategic and development assessment planning process. However, in order to successfully make this change, WSC will need to address some potential challenges.

Challenges for integrating health into planning processes include the fact that some planners view this consideration as a non-essential step for planning or as a risk to the planning process. Planners are also constrained by time and skills in their ability to conduct this level of health assessment even when they believe in its value. Lastly, integration of health needs to occur at all levels of planning in order to successfully integrate this change across all types of planning (strategic through to development assessment).

Recommendations

In order to build upon existing opportunities and to overcome potential challenges, it is recommended that WSC develop actions or approaches that can develop buy-in from staff, Council, community, and developers; increase capacity through improving understanding and skill building to assess health impacts; and develop a high-level health policy that can influence all other levels of corporate planning as well as strategic policy development.

Three potential key actions are recommended in order to achieve these goals:

1. Create a high-level health policy to guide policy development throughout the council
2. Create a health assessment policy to identify when, how and by whom health is incorporated into planning and policy making, and
3. Establish a joint staff position with SWSLHD to support the integration of health consideration into policy and practice and develop the relationship between SWSLHD and WSC.

The next steps for WSC will be to develop a work structure for accomplishing these three key goals, and to develop an overarching strategy that will guide this work moving into the future.

There are opportunities within WSC processes to integrate health considerations into planning.

Integrating Health Considerations into Wollondilly Shire Council Planning Processes

Research Report

Introduction

Background

South Western Sydney Local Health District, Population Health (SWSLHD) and Wollondilly Shire Council (WSC) have been working together to identify ways of integrating health considerations into corporate and business planning processes. This work began with WSC's involvement in the 2013/14 Health Impact Assessment (HIA) Learning by Doing Training that was conducted by the Centre for Health Equity Training, Research and Evaluation (CHETRE) with support from SWSLHD. Their involvement in the training led to the completion of an HIA of Wilton Junction, a proposed large new town development in Wollondilly Shire.

These partners have continued to work together, building on the HIA training, by looking at ways to further integrate the consideration of health into WSC business and land use planning. In November 2015, a joint Planning and Health Forum was held to identify potential ways of progressing this work. One of the outcomes of this Forum was a commitment to further investigate the potential to integrate health considerations into Wollondilly's land use planning processes by identifying appropriate tools, strategies and approaches that could be used.

Project Structure and Governance

In May 2016, WSC and SWSLHD formed a memorandum of understanding (MOU). As part of this, CHETRE was funded by SWSLHD to lead a research project to identify strategies to integrate health into planning processes within Council. Additionally, the MOU established a reference group, comprised of one key staff from each organisation, and a steering committee comprised of additional relevant staff from across the three participating organisations (see Table 1).

TABLE 1 STEERING COMMITTEE

Alison Dunshea	Population Health, South Western Sydney Local Health District	Acting Senior Project Officer
Ben Harris-Roxas	Centre for Primary Health Care and Equity	Director, SEARCH
Carolyn Whitten*	Wollondilly Shire Council	Strategic Planning Team Leader
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Tina Britton	Wollondilly Shire Council	Community Planning and Engagement Team Leader

*Member of the Reference Group

Objectives of this Research

The integration of health can occur across all levels of land use planning: high level strategic business or corporate planning (i.e., Integrated Planning and Reporting, Community Strategic Plan); lower level strategic land use development (i.e., Growth Management Strategy, policy development); development and building assessment (see Figure 1).

The steering committee recommended that a particular focus of the project should be on the lower level strategic (land use) planning. Furthermore, the steering committee recommended that the project should go beyond identifying tools (such as checklists), to take into account ways of enabling sustainable culture change (health thinking) within WSC planning.

 The aims of this research are:

- • To develop a shared understanding of Wollondilly Shire Council land useplanning processes and opportunities for the consideration of health within those processes;
- • To identify and appraise various tools, processes, and assessment strategies that may be used to integrate health considerations into the land use planning process; and
- • To appraise the applicability and appropriateness of various tools, approaches, or assessment strategies to both the Wollondilly Shire context and other planning contexts.

Furthermore, the findings of this research should guide and inform health sector engagement with WSC specifically, but may also be relevant to other local governments, NSW and across Australia.

FIGURE 1 LEVELS OF PLANNING

Methodology

In order to understand the land use planning process in WSC, and the possible opportunities and barriers to the consideration of health, the researchers decided that the project should use a variety of methods. This included:

- Semi-structured interviews with key Wollondilly Shire Council staff involved in land use planning
- Participant observation of Wollondilly Shire Council meeting relevant to land use planning
- Document review of relevant legislation, planning guidelines, and other documents identified by WSC steering committee members
- Literature review and audit of health in planning tools
- Expert stakeholder consultation
- Validation workshops with Population Health and Council to confirm analysis and findings.

Ethics

A Low and Negligible Risk (LNR) application was approved through SWSLHD Human Research Ethics Committee (HREC reference number: LNR 16/324, SSA reference number: 16/325, local project number: 16/166).

Key Informant Interviews

Semi-structured interviews were conducted with staff from WSC between September and October 2016. Participants were selected based on recommendations from the advisory group. A total of 10 staff were interviewed, and represented a cross-section of staff covering the various land use planning functions. Participants were contacted via email to request their participation for interview. Interviews were conducted in private at the work location of the participant, and in one case over the phone. Informed consent was obtained from all participants prior to the interview. All

interviews were recorded and transcribed, and thematic analysis was conducted using NVivo software. All interviews were kept confidential, de-identified, and secured according to SWSLHD Ethics guidelines. A list of interview questions can be found in Appendix A.

Participant Observation

Steering committee members from WSC identified which meetings were relevant to attend for the purposes of this project. Prior to attending any meetings, all WSC planning staff were advised of the purpose of the research and notified that CHETRE staff would be attending certain meetings. One CHETRE researcher (KH) attended all meetings:

- Land and Property Panel Meeting
- Council Community Forum
- Voluntary Planning Agreement Meeting
- Rural Industry Liaison Committee

KH also spent time with a development assessment officer to discuss the development and building assessment process.

All of the transcribed interviews and notes from the participant observation were coded using qualitative data analysis software, Nvivo. Thematic analysis was conducted to understand the challenges and opportunities for integrating health into planning, as well as the context and factors that shape the planning environment.

Document Review

Wollondilly Shire Council Steering Group members identified and provided the research team with key documents to be included within the review. These documents were relevant legislations, planning guidelines and other documents.

A coding framework was developed using the research matrix and research questions (see Appendix A and B). The framework was focused on identifying the presence of health and/or health determinants and opportunities for the integration of health.

Documents were coded using NVivo software.

Data validation workshops

Two data validation workshops were held with the steering committee. The first was held in March 2017, the researchers presented the initial findings to the committee and allowed them to discuss the validity of the findings to identify whether the findings were accurate and reflected their views. The committee prioritised which areas of opportunity seemed most relevant for progressing this work which allowed the researchers to narrow the scope in looking for relevant tools and approaches (see Appendix C for meeting agenda). In the second meeting, held in May 2017, the researchers presented possible tools, approaches and strategies and offered recommendations for how to implement change. The committee then selected the priority actions to be implemented (see Appendix D for meeting agenda).

Stakeholder consultation

In addition to conducting the validation and prioritisation workshops with the Steering Committee, the researchers also engaged with other relevant external stakeholders. In order to identify relevant intervention strategies and possible health assessment tools, the researchers contacted various international and local experts in the fields of health impact assessment, health in all policies, and

land use planning. These experts provided recommendations on health assessment tools, guidance documents or theories that were useful for considering health in planning. The researchers incorporated these suggestions into the recommendations for the Steering Committee.

Tools audit

An audit was undertaken to examine the existing literature that described methods or tools for integrating health into planning. The audit consisted of a review of the tools and approaches, aiming to describe the processes detailed in the document and also the theoretical rationale and organisational contexts for use of the tool, where available. The sources for this review were uncovered using an iterative search strategy. CHETRE researchers identified an initial set of tools and resources that they knew of through their previous work in health impact assessment. Further sources were sought through email consultation with experts in health policy (described under 'stakeholder consultation'). Snowball sampling was undertaken for sources that referenced a larger project or relevant resources. Through informal literature searches of both peer reviewed and grey literature, expert consultation and snowball sampling, a total of 63 relevant sources were identified.

Exclusion criteria were applied to identified sources. Documents were included if they were in English and described processes that related to the inclusion of health in policy, planning, urban environments and/or infrastructure development. Sources were taken from government reports, journal articles, websites and conference presentations. The sources were summarised using a data auditing table (see http://bit.ly/2ekZt9H). The sources were summarised by who developed the intervention and where they are located, the level of the intervention, rationale for the intervention, details of how the intervention works, information on how health is being conceptualised, evidence of implementation or evaluation, and examples of application of the intervention if available. Fifty-seven sources were included in the final audit.

Literature review

In order to develop the recommendations, the researchers conducted a brief review of the literature to identify relevant strategies, theories and approaches for considering health. More specifically, the researchers consulted the evidence about how to create institutional change, how to develop capacity through increased learning, and how to create buy-in.

Findings

The robust methodology employed by the research team enabled them to develop a comprehensive understanding of the WSC environment and context, opportunities and challenges for incorporating health into planning, and available tools, interventions, and strategies that can enable that change to occur. The findings from each research method are summarised below.

Key informant interviews and participant observation

The key informant interviews and participant observation provided a comprehensive picture of how planning is conducted within WSC, and the potential challenges and opportunities for integrating the consideration of health into that process. The analysis of the key informant interviews and observation drew on concepts from policy making research (Howlett & Ramesh, 1998).

The WSC Environment

The WSC environment consists of entities such as people and buildings, and processes that occur such as planning proposals and development applications. Entities have attributes that may enable or constrain achieving the consideration of health in council policy and planning processes. For example, a planner may have knowledge about the relationship between the built environment and health that enables them to identify potential impacts on health that may arise from a proposed development.

WSC has different layers of influence that interact with each other (See Table 2). WSC is adaptive in that it changes in response to changes in the environment (e.g. new laws, community interests). Interventions (such as education strategies, new policies and tools) are introduced into the environment.

TABLE 2 LEVELS OF WSC ENVIRONMENT

Level	Description	WSC examples
Micro (individual level)	Includes individuals' knowledge, background, beliefs and material circumstances and, at the sub individual level, individuals' psychology and motivations.	• Staff (senior managers, planning staff) • Elected members • Community • Developers Levels and type of education, how planners perceive their role, ideas and beliefs about health (and planning)
Meso (setting level)	The setting is where activities take place including the organisational environment, organisational/departmental culture, teams, rules and processes, and the physical environment.	Relationships and networks: • Staff - Management • Developer - Approving Authority • Community – Council (elected members) Processes: • Policy development and implementation cycles • Development applications and planning proposals Institutions – provide the rules/structure from which entities act Culture (of institutions and individuals)
Macro (broader context)	Higher level regional, national global context, global trends, structures and culture of societies.	NSW Planning Legislation, Greater Sydney Commission, International interest in healthy urban design and Health in All Policies

Stakeholders

Stakeholders have the capacity to act but are also influenced by and influence structures such as relationships, roles and institutions. Stakeholders can have multiple roles (e.g. be both community member and developer) and stakeholder's attributes can vary according to different roles they have (e.g. a community member has the power to vote in local elections and a developer can appeal a planning decision). This also means that stakeholders may experience multiple (sometimes contradictory) pressures from multiple roles and social relationships (i.e. a planning or building assessment officer's personal beliefs in relation to importance of health versus guidelines related to planning approval).

Roles may have a set of practices associated with them (i.e. a planning or building assessment officer approves planning applications, carries out administrative duties etc.) and associated rules (e.g. timeframe for responding to application). Some rules are explicit (i.e. legal timeframes) and other rules are implicit (how to apply discretion in regards to approval). For experienced stakeholders (i.e. senior planners) these rules become habits- they apply them without needing to explicitly think about them. Institutional entrepreneurs are agents with an interest in specific structures or

outcomes and have influence and resources to influence institutional rules in order to achieve these outcomes.

Stakeholders are also influenced by roles and relationships, and the level of power they have in that relationship (i.e. voting power of citizens may put pressure on councillors to act in a certain way; staff might act according to the preferences of their managers).

Networks of stakeholders play an important role in influencing change. Policy networks relate to a specific policy area such as health, transport, education or the economy, or an issue that subsumes more than one of these areas. For example in Wollondilly the Wollondilly Health Alliance is a policy network focussed on health. Policy networks can involve relationships between stakeholders responsible for policy decisions (councillors and council staff) and the 'pressure participants' such as interest groups (community, developers) or other types or levels of government with which decision-makers consult and negotiate (state and federal government, Local Health District) (Cairney, 2016; Jordan, Halpin, & Maloney, 2004).

Institutions are systems of established rules, conventions, norms, values and customs (Fleetwood, 2008). In Wollondilly this includes:

- Land use planning policy and processes (formal and informal)
- Organisational culture
- Conventions such as 'following the rules'
- Policies and rules

However, institutions are ambiguous, and therefore require stakeholders within the institutions to act according to discretionary behaviour. Organisational culture, the attributes of the person and other contextual factors inform how a stakeholder might take a certain path (i.e. deciding whether or not an additional review is needed for a DA).

Challenges

Health is implicit in planning

It was clear, particularly in speaking with planning staff, that health is part of what is considered in the planning process. Many of the planning decisions that were made have relevance to health, such as understanding walkability, access to public transportation or social cohesion, but the connection between these health determinants

Many of the planning decisions that were made have relevance to health, such as understanding walkability, access to public transportation or social cohesion, but the connection between these health determinants to health outcomes was not always made explicit.

and health outcomes was not always made explicit. There was variation in how well staff understood the connection between social determinants and health outcomes which therefore affected how they approached or prioritised planning decisions that would affect health. As one participant said:

> *I feel that my job impacts places. It impacts what happens in places and spaces, and because of that, I impact how that space influences a person. I might impact the type of use that's happening in that place, whether it's someone living in that place or whether it's farming in that place. I can potentially influence how you move from that space to another space, if that space is a footpath or it's an*

isolated block. All those social determinants are connected to I guess what ability I have to influence a space and what happens in it and what doesn't happen in it, or what someone is more likely to do in it or not likely to do in it.

In some cases, the idea that health was implicitly considered in planning meant that some potential impacts were being overlooked. For example, one participant explained "I do think [health] is an important consideration because I think yes, because I think we already impact the way in which people live their lives and how they move about, how far they have to travel and that sort of thing. I don't think that that impact is currently acknowledged. As a result, it hasn't been explored in a way of, how do we make that impact as positive as possible?" Or as another participant explained "A planner who deals with development applications might only be interested in how that house fits on that street…the weight I guess that could be given to the broader cumulative impacts that aren't acknowledged or accepted, it's either sort of just guided off-hand because all they're looking at is a house…"

Additionally, the level to which health was considered in planning varied by the level of importance that each individual planner attributed to it. Some planners fully understood the social determinants of health and therefore were able to broadly understand the implications of their work for health outcomes, while others saw health as relating more specifically to health behaviours or health services and were therefore not making the connection (or saw it as necessary to make the connection) of their work to health outcomes. One participant stated "planners who have a very traditional planning background and have only been working in planning might not see the connection between health and what they're doing and that the decisions that they make influence someone's health."

Institutionally, health impacts received far less consideration than other issues like the environment or transportation. Many staff had received training on issues like rural fire safety, or storm water, and had tools in place to consider these issues when making planning decisions, while there were no training tools or resources to explicitly consider health impacts.

There is variation in staff understanding of health

When asked to define health as a concept, staff varied considerably in their responses. Generally, staff working at the strategic level had a better understanding of the social, environmental, and structural determinants of health than the planning and building assessment staff. Many staff were

able to identify that there was a gap in expertise on health within planning. For other issues, like environmental impacts or transportation engineering, there are experts whom the planners can consult when making decisions. In the case of rural fire safety, one participant explained "For instance, if it's a really heavily bush fire prone block, and we've received a bush fire report, and

because of the potential for fire impact, you don't feel comfortable in doing the assessment on your own, then you can refer to the local office for them to provide comments." Without any health experts on staff, and without additional resources to consult, planners often made decisions about health impacts based on their own experience. One planner commented that having years of experience and seeing the relevance of planning to health outcomes enabled him to better understand this connection, but more junior staff without that experience were often not aware of the full implication or impact of their planning decisions to health. Furthermore, staff appeared to be siloed in their thinking so that planners working together at the different levels seemed to think the same way about health, but did not share a common understanding with staff in other departments (i.e., strategic planners versus planning and building assessment staff). One participant explained how this lack of understanding, or siloed understanding of health impacts, plays out in the planning process:

> …I recently had a proposal come to, what we call the variations panel, and we've got a situation where someone's intentionally made lots bigger than the standard so that they can do dual occupancies and end up with actually more houses. In the particular case there is a reserve along the creek. Now, if a reserve is faced with a bunch of blank walls and fences, no one wants to use it because it looks ugly, it feels unsafe, so we want development to face onto that reserve, have passive surveillance of it. Now the controls we've written into the document don't enunciate that well enough. We need to work out a better way to make sure when the planner is assessing that development application. Unfortunately for that particular one we got a box ticker, and they looked at the proposal and just said, "It complies, it complies." It's got this minor variation and actually came to us for a different reason. On the variation panel that day it was [the strategic planners], so not box tickers and we're going, oh well this proposal is rubbish, look what's facing the [houses]... To the defence of the planner, it's not set in our development control plan very well at all. In fact the previous version said it better than the current version. We need to look again at how we say those rules, so that when the box ticker gets it they go, "Oh, they haven't got windows and doors facing the public park, that's not good. Cross." Then it results in change. I think for the thinking planner, what we have is enough, but what we've got doesn't do it for the box ticker.

Planning is rule based

Land use planning is embedded in a complex statutory framework and across all levels of planning, planners tend to follow the specific rules or guidelines set out for conducting their work. Even in cases where there is flexibility for interpretation, planners tended to want to stick to the minimum standards, rather than creating additional work or delaying timelines. There is good justification for this considering the potential push back from industry. As one participant explained "The Department of Planning [and] Department of Health here have guidelines on healthy living and urban development guidelines. They're all there, but they're only guidelines. So they're not enforceable. If you want to achieve best practice, this is the top thing you guys need to be doing. But at the end of the day, if they only need to achieve "x" to get an approval, then they only need to do "x". That's the hard part."

Planners also have a tendency to apply a literal interpretation of the rules, particularly with the DCPs, without consideration for the original intention behind the rule. One planner explained that some of these rules have been simplified over time, leaving out the explicit intention for the rules:

It just talks about, is it consistent with planning instruments? What is the impact of the development? Is the site suitable? What's in the public interest? It's not much more than that. That was intention[al] simplification because prior to 79C we had section 90 of the Act and that listed about 25 different things planners had to consider. The development industry said, "Oh this is rubbish. These things aren't all relevant to every application." Some of the planners, some of the box tickers, were making people consider and report on things that weren't relevant to that particular proposal. They simplified it down to 79C. That's meant to be all encompassing, so all it considers; the impact of the development, the suitability of the site and the public interest, that's meant to include health. I don't know, I think that perhaps the place where the Act came from to get to 79C has been lost in that current generation, so they don't think of it that way.

Culture of compliance

Due to the regulatory nature of planning, there is a culture of wanting to meet minimum standard approaches. This was particularly apparent at the development assessment level. Since planning decisions can be legally challenged, planners seemed to want to avoid any additional assessment that would delay the development approval process or which the developer might have grounds to appeal. In some cases, planners saw the consideration of health as unnecessary and therefore as a risk to the development process. The need to meet legal planning guidance along with time constraints meant that many planners were not willing to consider additional planning issues that could appear to be hurdles for the planning process. One participant stated:

That's the issue. You have to then be able to present a case to say why something shouldn't happen and why something should happen. You have to be able to put that information together to make sure that you've got a good case. I guess [in] terms of health, for example, would that be strong enough then if something is unhealthy, if you do the checklist and they're well, it doesn't meet any of that. Is that going to be strong enough to say, "Sorry, you can't go ahead with this?"

Opportunities

Health can be integrated into various levels of planning

The fact that land use planning happens through multiple stages, across various levels of planning (strategic all the way to development and building assessment), means that the consideration of health also needs to be integrated across these different levels. Planning decisions have a trickle-

down effect, meaning that decisions made at the legislative level feed into strategic planning and policy development, which acts as a driver for development and building assessment. Considering health impacts at each of these levels of planning therefore has a flow on effect to other levels of planning. However, given the different structure of each of these planning levels, the integration of health considerations needs to be tailored to each level. At the strategic level this may mean that consideration of health is high level and reflects the broad vision but acts as a driver to the next level of planning. At the development assessment level, consideration of health may need to be more formulaic. Similarly, in order to achieve the consideration of health at each of these levels there may need to be triggers or "hooks" in place that dictate when, why and how health is considered. These could include, for example, requirements that developments of a certain scale or type requiring HIAs.

Participants also explained that the receptivity of staff to new practices is influenced by the level of regulation. Implementing new requirements, rather than recommendations, means that staff are more likely to implement them. A participant explained, "If a new requirement comes out that they have to assess x, y, and z, so we're going to send you on a training course to learn how to assess x, y, and z. They'll go, 'Yep, fine,' because their mind-set is, 'Whether I like it or not, my job is now to assess this stuff so I need to go to a training course.'"

Planning has successfully integrated other considerations
Staff identified examples of when the consideration of other new issues had been integrated into the planning process. In response to environmental concerns and the need to improve energy efficiency, BASIX (Building Sustainability Index) assessment had been integrated into the DA level. Similarly, issues regarding crime prevention led to the development of CPTED (Crime Prevention Through Environmental Design) assessment strategies also integrated into the DA level. These two assessments were successfully integrated into planning for several reasons. First, the consideration of the issue was initiated at the state level. For example, in 2004 the NSW government rolled out new legislation that required BASIX assessment in Sydney metropolitan LGAs[1]. Implementation of the new strategy was also combined with additional training, guidance, access to experts and tools that planners could employ. For example, in 2001 NSW Department of Urban Affairs and Planning published guidance for planners on crime prevention assessment in development applications[2] and the NSW Police currently offer Safer by design courses. Lastly, integration of these new approaches was rolled out in stages, allowing for staff to be upskilled while slowly expanding the approach. For BASIX assessment, this staged approach allowed for planners to initially conduct the assessment just on limited single and dual occupancies, then later expanding it to include other buildings and setting new energy efficiency targets.

Planning happens in stages
While most of the focus of this research has been on looking at how

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[1] https://www.planningportal.nsw.gov.au/planning-tools/basix
[2] http://www.police.nsw.gov.au/__data/assets/pdf_file/0003/9390/duapguide_s79c.pdf

to integrate planning into Council's land use planning processes, interview participants and members of the steering committee were quick to point out that the drivers for planning can be separate to the land use planning process. Developers and consultants are responsible for the detailed design and preparation of development proposals, and much of what impacts on health (in terms of accessibility, recreation, access to transportation, etc.) will be decided before Council's planning and building assessment staff have a chance consider or assess the development application. Even once the application is being assessed, planning and building development assessment staff are limited in their ability to require the applicant to make changes to the plans (being able to only require changes that have regulatory bearings, or else they face legal challenge). Therefore, better integration of health should also occur by creating buy-in with developers and consultants.

This buy-in from developers is likely to occur when there is a drive from the community to consider health. For example, developers are more likely to integrate healthful design if they think it will incentivise buyers or increase profits. Therefore, buy-in for healthy planning also needs to come from the community.

One participant explained how the use of BASIX criteria for energy efficiency was developed in tandem with the creation of demand by consumers and developers:

> *The market didn't necessarily bring energy efficiency online. They did in a couple of little bits, but not really. Not in a big way. It wasn't really their thing because they would have said at the time, "Well, the market isn't asking for it," but the market doesn't know about it. The market's not educated, informed about it, so they don't know. By bringing BASIX in for the energy efficiency, that created a market response, so there's more solar providers, there's rainwater tank providers, and it also had to change council perceptions, because some councils were actively not allowing rainwater tanks because there'd been a traditional issue about water quality from water tanks. The government itself has to be brought along with that change sometimes.*

Elected members also responsive to community concerns and is responsible for approving most of the strategic guidance that will in turn influence other levels of land use planning. Therefore, having buy-in from councillors for the consideration of health can also lead to better integration of health in the planning process.

Better integration of health should also occur by creating buy-in with developers

Document review

A total of 19 documents were reviewed, including:

- Wollondilly Development Control Plans 2016 (DCP), volumes 1-8
- Environmental Planning and Assessment Act 1979, sections 5,79c, 117
- Section 117 Directions (issued by Minister for Planning section 117(2) of the EP & A Act
- Wollondilly Growth Management Strategy 2011
- Wollondilly Community Strategic Plan 2013
- Building Code of Australia, volumes 1-2
- Wollondilly Local Environmental Plan (LEP) 2011 (WLEP 2011)
- Wollondilly's internal standard conditions of development consent

- Wollondilly Social Planning Strategy (SPS) 2016
- Wollondilly Development Contributions Plan 2011.

The concept of health (including social determinates of health and equity) is mentioned in various ways throughout the 19 documents that were reviewed. There were also gaps identified, where health could be better incorporated into a number of these planning documents. Examples of these are highlighted below.

Consideration of Health

Health was explicitly mentioned in several instances throughout the documents. It was mentioned in the LEP in relation to development and population growth specifically, and the impact on relevant health services was flagged as a potential issue. Environmental health was also mentioned within a number of documents (e.g. exposure to pollution) within the DCP. Health was also mentioned in relation to health outcomes of residents. An example of this was the consideration of quality of life within the *Environmental Planning and Assessment Act 1979*. Health was also integrated as a core value and goal of WSC within the SPS. The SPS also included an entire section on 'creating healthy, safe and secure communities', which emphasised the importance of health and its integration into planning. An example of this was the SPS requirement to "undertake Health Impact Assessments (HIAs) for major planning proposals."

Examples of Social Determinants of Health

Evidence of the principles of social determinants of health were identified in a number of documents in the review. There was specific mention of the accessibility of environments in 13 of the 19 documents that were reviewed. The Community Strategic Plan highlighted the importance of employment and a need to improve access to local jobs to meet the needs of the growing community. Within the DCPs, Community Strategic Plan and Development Contribution Plan, there was strong evidence of the importance and utilisation of community consultation in local planning. WSC prioritises community input and views it as an essential asset to decision making and planning processes. Housing affordability was highlighted as an important issue within the Growth Management Strategy. Sustainability of farmlands and protection of environment for recreational purposes were also mentioned within the DCPs, LEP and Community Strategic Plan.

Examples of Equity

Equity was identified within the document review. The Community Strategic Plan and Development Contributions Plan highlighted the importance of vulnerable populations' access to resources. A number of the planning documents noted access and mobility considerations within building design, for example, disability accessible buildings and parking. Additionally, housing affordability and diversity were highlighted as an issue within the Growth Management Strategy. Equity was also identified as a specific value of Wollondilly Shire Council. The Growth Management Strategy council charter states: "…to exercise its functions in a manner that is consistent with and promotes social justice principles of equity, access, participation and rights."

Opportunities for Integration

The document review highlighted opportunities for the inclusion of health (and health related issues such as equity and social determinants of health) as well as gaps in which health considerations were missing. There were opportunities for the integration of health into council policies. This could be achieved through utilising a 'health promotion' lens. There was a lack of this within the current documents, such as the DCP, where health could be included, as for example: "limiting the overall density of development *to encourage active transport and to improve health*" (health statement added). Within the Wollondilly Growth Management Strategy, health is not included as a measure when defining 'Net Community Benefit'; this is another opportunity for the integration of health into a planning policy. In a large number of the reviewed documents, there was little mention of heath in the overarching goals of the policy or plan. The inclusion of health or positive health outcomes into the goals of any document would be an effective way in which health could be integrated into council processes.

Drivers of policy

The document review also identified various drivers of the Wollondilly Shire Council's policies. These drivers are the underlying explanation or rationale for a policy. Drivers of policy were categorised into either formal or informal. Examples of formal drivers include various high level regulations and legislation which are mandatory guidelines for planning. Informal drivers of policy were the motives behind policies which were context specific to the Wollondilly region. The most frequently mentioned informal drivers of policy were environmental protection and protection of local character. All of the informal drivers of policy identified in the document review are presented in Figure 2.

FIGURE 2 INFORMAL DRIVERS OF POLICY
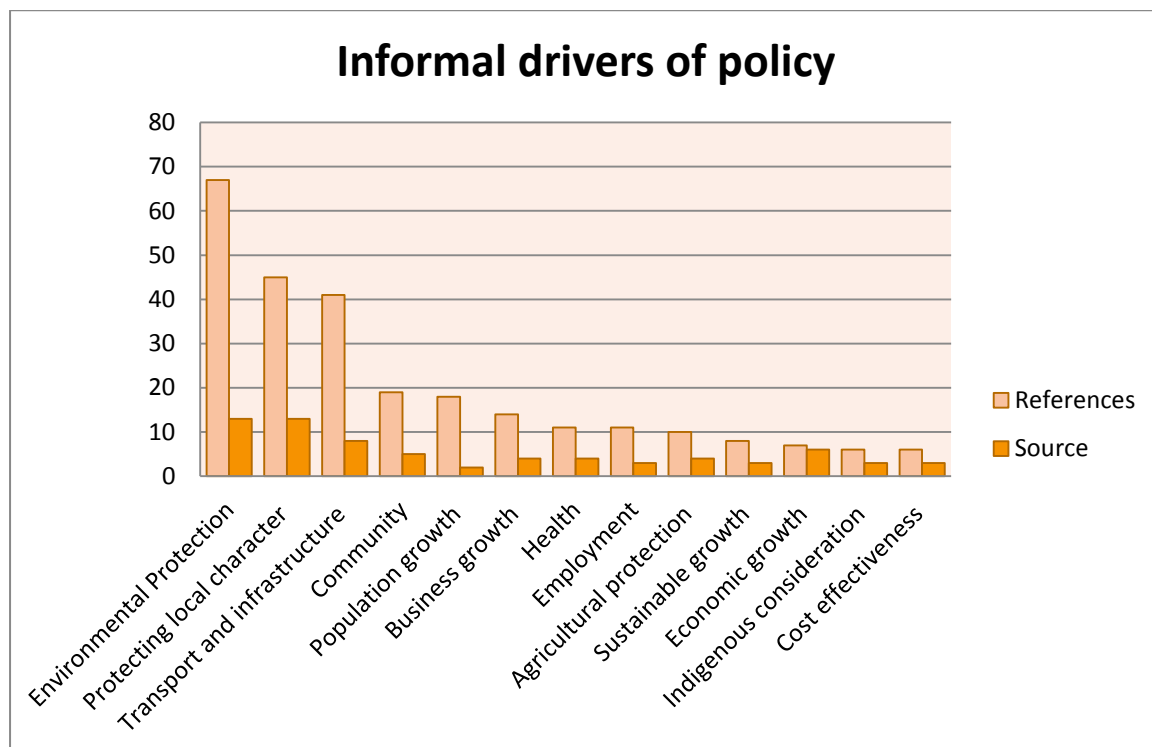
Overall, the document review highlighted various examples of where the concept of health was already present within current planning documents. The review also identified gaps in which the concept of health could be integrated more effectively into Wollondilly Shire Council's planning processes.

Health tools audit

Fifty-seven health integration documents were given full review in the data extraction table (see http://bit.ly/2ekZt9H). Broadly, processes described to integrate health into planning could be classified as:

- Health in All Policies (HiAP),
- planning guidelines,
- place-making projects,
- liveability measures,
- organisational collaboration resources, and

- resource collections.

The sources were mainly developed for stakeholders in America, Canada, the United Kingdom, Australia and New Zealand. Sources were frequently aimed at processes in local and state government. Sources varied widely in their definitions of health, and while many explicitly or implicitly demonstrated an awareness of social determinants of health, most fell short of more conceptualising health through holistic socio-ecological models.

Health in all policies (HiAP)

The implementation of HiAP into government processes was the focus of eight documents. Most of these documents focused on describing the processes of adopting a HiAP lens or working framework within government organisations. One journal article described the successful implementation of a HiAP approach across the South Australian state government (A. Lawless et al., 2012). Another article provided the evidence basis for health and process outcomes resulting from undertaking HiAP within local councils (Shankardass et al., 2011).

Planning guidelines

There were a number of resources that were specific planning guidelines developed by governments and non-government organisations (NGOs). These resources largely focused on design guidelines for small areas such as streetscapes, buildings, roads or smaller housing developments. These documents were largely aimed at addressing influencers of sedentary behaviour and food intake by creating supportive built environments and design alternatives that encourage physical activity, access to healthy foods and social connectivity. Most of these projects appeared to be aimed at councils and development approvals to encourage healthy built design, however one project in NSW Hunter Region was created with the aims of providing guidelines to developers of new housing estates in the area (Wells et al., 2007).

Collaboration resources

A number of documents provided guidelines, resources and toolkits to encourage collaboration between public health officials and planners. While some documents discussed more traditional models of public health collaboration to address pollution, water quality and infectious disease, a number of documents demonstrated a more contemporary understanding of the potential for planning to influence public health. These showed an understanding of the potential for many different types of inter-disciplinary collaboration. Chang, Green, Steinacker, and Jonsdottir (2016) in "planning for better health in Wales" provided a structured collaboration guideline based on inter-disciplinary cooperation supported by formal policy to understand the potential triggers for collaboration and the different tools available to both assess and enhance health in council processes.

Liveability

Liveability is a planning term that is inclusive of, but broader than health specifically. However, often concepts of liveability aligned with ecological understandings of social determinants of health, particularly within the work conducted under the Place, Health and Liveability Research Program by University of Melbourne and its partners. Twelve resources included in this document review were from this body of work. The majority of these documents described the use of liveability indicators to define, monitor and evaluate health and wellbeing indicators in Victoria, Australia.

Place-making

Place making strategies appeared in a few resources and mostly utilised a community development and social justice framing for the work, as opposed to health specific lenses. These interventions aimed at increasing social capital, pride of place and more community psychology-centric views of community health.

Resource Collections

Some of the audited sources were collections of multiple tools and guidelines. Of these one that appeared especially useful was the Centre for Disease Control and Prevention website (U.S. Centers for Disease Control and Prevention, 2016), which provided a framework of practical and interactive tools for collaboration between planners and public health workers for each stage of a planning project. This framework provided multiple options for health assessment and improvement depending on the resources available for intervention. The other resource compilations such as the Built Environment Clearinghouse were less user friendly, and others such as the Premiers Council for Active Living focused specifically on physical activity interventions.

Overall, a number of resources were uncovered that provide useful ways to conceptualise health and wellbeing within government planning processes. These sources demonstrate that health has successfully been implemented into government processes in many different national and international communities, and also offer useful guidance on how to initiate these processes within councils.

Creating successful change in organisations - evidence from the literature

Planners and other stakeholders require skills and knowledge to make good decisions

In order to understand and apply 'health thinking,' stakeholders will require different types of knowledge. The levels and type of knowledge will also vary according to their roles and existing knowledge. There are a variety of ways of categorising knowledge (Anderson et al., 2001; Biggs, 1999; Biggs & Tang, 2011; Bloom, 1965). This includes declarative, functional, procedural and conditional knowledge. Procedural and conditional knowledge is a prerequisite for application of specific methods and tools (see Table 3).

TABLE 3 TYPES OF KNOWLEDGE IN THE WOLLONDILLY SHIRE CONTEXT

Types of knowledge	Wollondilly Shire context
Declarative – **knowing about things**	Knowing about key concepts of health – social determinants of health, health equity, the relationship between land use planning and health, healthy urban development and health. Knowing relevant policies, procedures, etc.
Procedural – **knowing about processes and ways of doing things**	Knowing about procedural steps of carrying out HIA. Knowing how to apply relevant tools.
Functional knowledge – **knowing how to apply knowledge**	Knowing how to use procedural and declarative knowledge and applying it to carrying out HIA, or other health-integrating tools.
Conditional – **knowing when it is appropriate to do things**	Knowing when, why and under what conditions to utilise methods and tools within HIA (and other approaches), or when to seek expert support or approval on a proposal. Knowing what conditions indicate the use of different types of approaches and knowledge. Knowing the triggers for HIA, contacting an expert, etc.

Integrating health in land use planning requires a supportive environment

In order for new approaches to be integrated into WSC, the environment of WSC first needs to be amenable to change. In a review of models and frameworks for implementing evidence-based practice a number of prerequisites for successful implementation were identified (Rycroft-Malone & Bucknall, 2010adapted from Nutely et al 2007). Meeting these prerequisites can help to ensure that the WSC environment is supportive of any health integration change.

Research needs to be translated

Research shows that evidence is socially and historically constructed. That is, a piece of research evidence is likely to mean different things to different groups and individuals. Additionally, research tends to get transformed in the process of use – research evidence is rarely used as presented, in for example, guidelines. Therefore undertaking adaptation processes are likely to make research findings more usable, including tailoring, packaging, and consensus development.

Ownership is critical

Ownership in relation to the research itself or the implementation process is likely to affect uptake. Exceptions to this would be system based, top–down approaches that "force" research use through an organisation's systems and processes.

Enthusiasts are key

People who are enthusiastic about the new issue, topic, or practice can act as champions and sell new ideas.

Conduct an analysis of context

An analysis of the context of implementation prior to designing implementation processes or strategies can facilitate more particularised approaches through the targeting of barriers and facilitators.

Ensure credibility

Research use is enhanced by credible evidence, credible champions or opinion leaders, and a commitment to process.

Provide leadership

Strong and facilitative leaders at project and organisational levels can lend strategic support and potential integration, space, resources, and authority to the process.

People who are enthusiastic about the new issues, topic, or practice can act as champions and sell new ideas.

Provide adequate support and resources

Implementation needs adequate resources and support including financial, human (e.g., dedicated project leaders), and appropriate equipment.

Develop opportunities for integration

Activities, changes, and new practices need to be integrated into an organisation's systems and processes to enhance the potential of their sustainability. Initiatives that fit with strategic priorities are more likely to be allocated adequate resources and support.

The more stable the institution, including social environment and culture, the more likely that people will feel free to challenge rules and look for alternative approaches (because they're seen as less risky). WSC appears to be a relatively stable environment, although it is subject to a slightly more unpredictable local and state political environment.

Interventions require a process of adoption

Diffusion is the process through which a new intervention (tools, approaches, ideas, etc.) is communicated over time among the members of a social system (Rogers Everett, 1995). Characteristics that determine an intervention's rate of adoption include the relative advantage of the innovation, its compatibility with existing values, its level of complexity, its level of 'trialability', and how observable the results of the innovation are to others (Rogers, 2002) (see Table 4).

Characteristics of diffusion	Wollondilly Shire context
Relative advantage – **an idea is perceived to have more value** **than the idea it replaces**	In the Wollondilly context health isn't replacing an idea but sitting alongside, and linking to, other considerations such as environmental or economic considerations.
Compatibility – **how much the idea is consistent with** **existing values**	Health sits well with existing values within Wollondilly, and is already a valuable concept as evidenced through stakeholder interviews and in some key planning documents. However, there could be conflicts between developers' economic priorities and WSC desire for healthy built environments.
Complexity – **how hard an innovation is to understand** **and use**	The ongoing work between CHETRE, SWSLHD and WSC has shown that health is a complex idea and there is a need to develop shared understandings and common language to support understanding. This also has implications for the development of interventions – complex tools and approaches will be harder to integrate.
Trialability – **how much the idea can be experimented** **with**	The long term relationship between the LHD and WSC (formalised through an MOU) provides an environment where interventions can be potentially trialled and adapted over time.
Observability – **how much the results of the innovation are** **visible to others**	Observability will to some extent depend on the interventions selected. The need for observable results should be taken into consideration in planning and implementing interventions.

Research has shown that perceived relative advantage is the most important predictor of innovation adoption (i.e. you have to show that it has a comparative advantage for people to want to adopt it). Early adopters are often the opinion leaders who are also most successful at getting others to adopt the innovation (see Figure 3). Early adopters can influence peers through role modelling, peer to peer communication, and networking. Innovations with a high level of all these characteristics, except complexity, will have greater uptake. Diffusion happens the most through word of mouth, or peer-to-peer exchange rather than scientific expertise.

FIGURE 3 DIFFUSION OF INNOVATION ADOPTER CATEGORIES
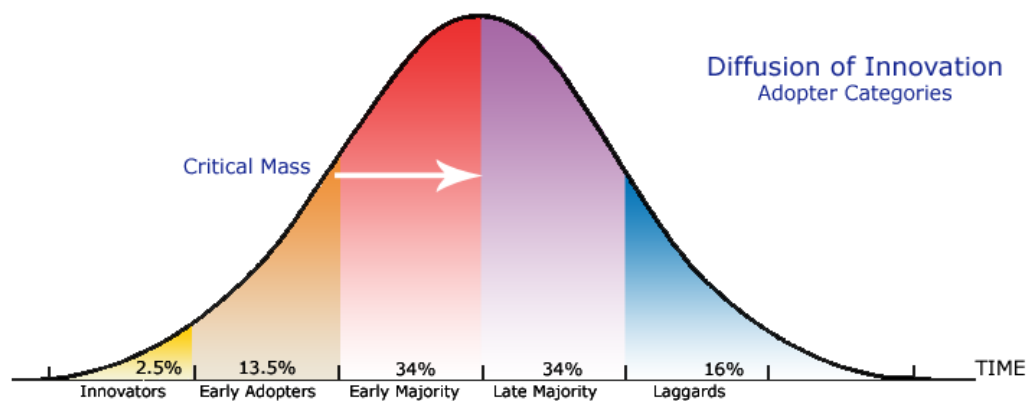
Organisations learn primarily through experiential learning (doing it yourself) or vicarious learning (learning from the mistakes and success of others). Experiential learning tends to build only on past experiences while vicarious learning can introduce organisations to new ideas and more variation in their activities. Typically, organisations will look for new ideas locally, and mimic those that are socially or geographically similar. The transfer of ideas requires some translation and therefore as these ideas are diffused they will also evolve.

Adoption can range from imitation to adaption. Adoption happens through the process of learning (or is a form of learning) (Chandler & Hwang, 2015). Mindfulness is the concept that learning can be done through intention – either purposeful and attentive, or automatic and routine. In the context of knowledge transfer, such as when adopting a diffusing innovation, mindful learning involves "attempts that adapt the knowledge to the next context," while organisations that "copy exactly" or engage in "replication understanding the underlying causal processes" are learning mindlessly (Argote: 47; see also Williams, 2007).

Development of a health integration approach may help to implement the broader goals of this work and can be worked toward achieving on an ongoing basis. For example, the health in all policies approach implemented in South Australia not only established the framework for conducting health lens analysis (similar to HIA), but also created an overarching framework that included partnerships and commitment to work collaboratively across various agencies. An evaluation of this approach found that it had led to increased understanding of policymakers of the impact of their work on health, stronger partnership between the health service and government agencies, and improvements in policy (Lawless et al., 2012).
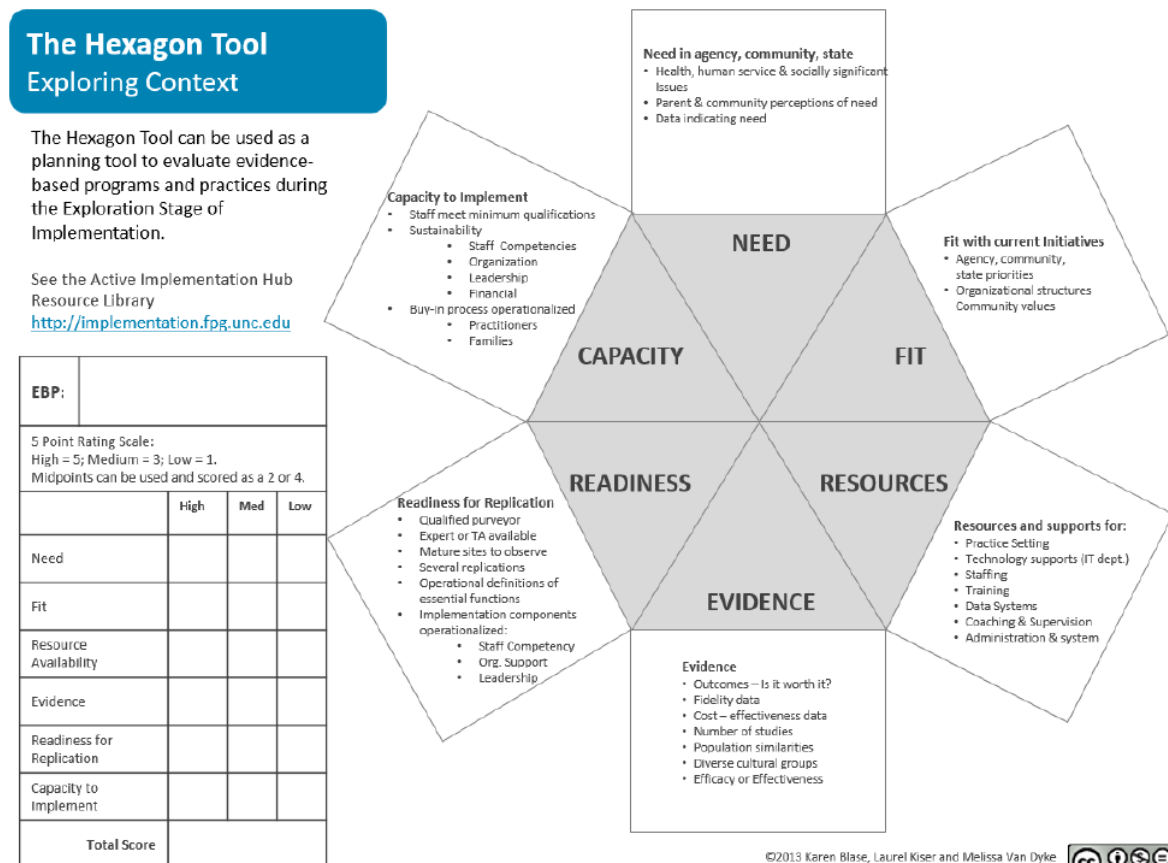
Another approach taken by Coventry City Council in the UK, was to commit to becoming a 'Marmot City.' In taking this approach, all relevant agencies across the city (policy, fire service, community sector, etc.) would work together to achieve health equity and the six policy objectives set out in the Marmot Review (Marmot et al., 2010). In 2016, Coventry City Council signed a three year MOU with Public Health England and the Institute of Health Equity at University College London in which Public Health England and the Institute of Health Equity will provide expertise and support to tackle health inequalities (Local Government Association, 2016).

There are also approaches to implementing new interventions that can provide useful guidance on the process of developing and implementing a health implementation approach. For example, planned action theories suggest a staged approach involving:

1) Identify the problem that needs addressing
2) Review the literature
3) Adapt the evidence/literature, and/or develop the innovation
4) Assess the barriers to using the knowledge
5) Select and tailor interventions to promote the use of the evidence
6) Implement the innovation
7) Develop a plan to evaluate use of the knowledge
8) Evaluate the impact or outcomes of the innovation
9) Maintain change and sustain ongoing knowledge use
10) Disseminate results of the implementation processes.

The Hexagon tool is a useful approach for selecting interventions (National Implementation Science Network, 2015). The tool is designed to help organisations systematically review new and existing innovations across six broad factors: needs, fit, resource availability, evidence, readiness for replication and capacity to implement (see Figure 4).

FIGURE 4 THE HEXAGON TOOL

The Hexagon Tool
Exploring Context

The Hexagon Tool can be used as a planning tool to evaluate evidence-based programs and practices during the Exploration Stage of Implementation.

See the Active Implementation Hub Resource Library
http://implementation.fpg.unc.edu

EBP:			
5 Point Rating Scale: High = 5; Medium = 3; Low = 1. Midpoints can be used and scored as a 2 or 4.			
	High	Med	Low
Need			
Fit			
Resource Availability			
Evidence			
Readiness for Replication			
Capacity to Implement			
Total Score			

Need in agency, community, state
- Health, human service & socially significant issues
- Parent & community perceptions of need
- Data indicating need

Capacity to Implement
- Staff meet minimum qualifications
- Sustainability
  - Staff Competencies
  - Organization
  - Leadership
  - Financial
- Buy-in process operationalized
  - Practitioners
  - Families

Fit with current initiatives
- Agency, community, state priorities
- Organizational structures Community values

Readiness for Replication
- Qualified purveyor
- Expert or TA available
- Mature sites to observe
- Several replications
- Operational definitions of essential functions
- Implementation components operationalized:
  - Staff Competency
  - Org. Support
  - Leadership

Resources and supports for:
- Practice Setting
- Technology supports (IT dept.)
- Staffing
- Training
- Data Systems
- Coaching & Supervision
- Administration & system

Evidence
- Outcomes – Is it worth it?
- Fidelity data
- Cost – effectiveness data
- Number of studies
- Population similarities
- Diverse cultural groups
- Efficacy or Effectiveness

NEED
CAPACITY
FIT
READINESS
RESOURCES
EVIDENCE

©2013 Karen Blase, Laurel Kiser and Melissa Van Dyke
Adapted from work by Laurel J. Kiser, Michelle Zabel, Albert A. Zachik, and Joan Smith (2007)

In Summary

The findings suggest that for health to be successfully considered in WSC land use planning, three main issues need to be addressed (see Figure 5). First, there is the risk that planners, developers and councillors view additional standards, such as health consideration, as irrelevant to planning and a barrier to development. In order to avoid this, it is necessary to create buy-in across the planning spectrum for the consideration of health (developers, community, councillors, planners) and to create capacity for this work through education and the provision of tools and resources.

Secondly, regulations on what can be changed or challenged in a development application, and time constraints, mean that development assessors are disinclined to go beyond the minimum standards for approval. In order to consider health without it being perceived as an additional, or unnecessary barrier, there will need to be both high level policies that require the consideration of health in land use planning, and additional tools and resources available to planners to integrate health considerations into the development approval process.

Lastly, health needs to be integrated into multiple levels of planning. This will enable changes to be made at the appropriate stage while creating the drive to consider health in subsequent stages. To do this there will need to be a high-level policy that calls for this type of integration across land use planning, and the creation of buy-in from all land use planners across the planning department.

FIGURE 5 CHALLENGES AND OPPORTUNITIES FOR INTEGRATING HEALTH IN PLANNING
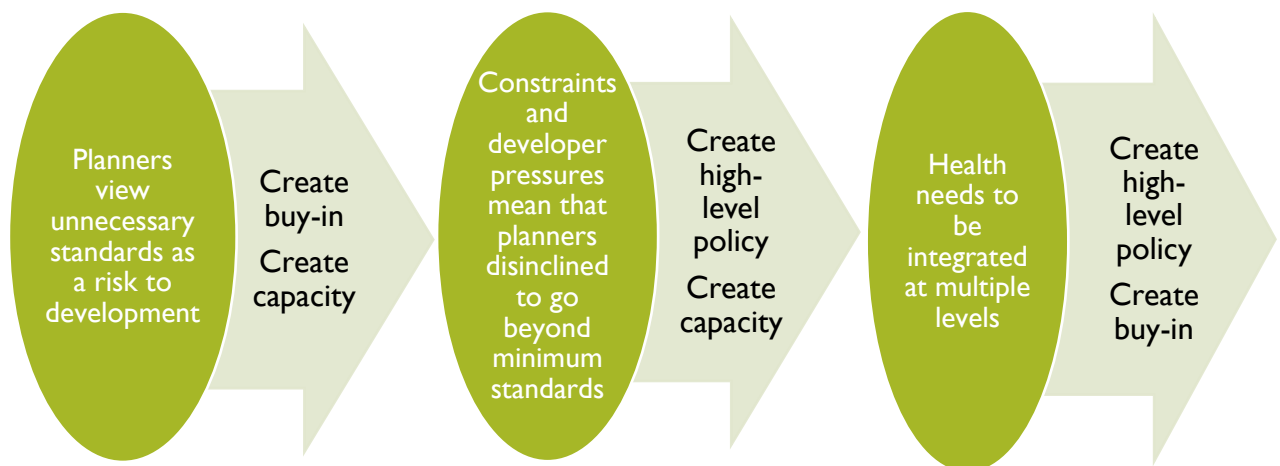
Recommendations

The findings of this research demonstrate that although there are challenges to integrating health into planning, there are useful strategies and approaches available, and there is interest within WSC to make changes. In order to do this successfully, some key considerations need to be addressed.

First, there needs to be multiple approaches. Given that land use planning occurs across multiple levels, a one-size-fits-all approach would be insufficient to adequately integrate health into all stages of planning. Similarly, each stage of planning requires a different approach. Having various approaches that address the various needs highlighted in the findings will enable a more successful integration of health into land use planning.

Secondly, integrating health into land use planning will require combining assessment tools with changing contextual factors. Creating buy-in and increasing capacity will require institutional change that will need to consider the various entities in the system (their power, how they interact, etc.) and the various stakeholders who affect planning (planners, councillors, developers, community). Changing the way that entities and stakeholders behave will require changing organisational requirements, staff competencies, beliefs and skills, and developing appropriate tools, processes, and the triggers for when they are put to use.

Based on the findings, and in consultation with the steering committee, it was decided that there are three potential main actions that should be taken to integrate health into WSC land use planning processes. These are:

1. Create a high-level health policy
2. Create a health assessment policy, and
3. Establish a joint staff position with SWSLHD.

High-level health vision

Creating a high level health and wellbeing vision, implemented at the strategic planning level, would create the impetus for health to influence and be considered at all other levels of planning. This vision could set out a WSC definition of health, healthy community goals, and strategies to achieve these goals. By integrating the vision into Council policy that requires Council approval, it also enables councillors to learn about the value of integrating health into planning and requires them to have buy-in for the policy. Once a policy is approved by Council, it would be implemented through the other levels of planning; therefore ensuring that health is considered through various planning stages. Ideally, the creation of this policy would also be carried out in consultation with the community, enabling them to also learn about the value of health in planning and creating community buy-in.

It was suggested by the Steering Committee that the Community Strategic Plan (CSP) could include a requirement for the development of a health and wellbeing policy as part of its operational plan. This document sets out the priorities for the next 4 years and once approved by Council, informs development of subsequent policies. Inclusion of this requirement in the CSP would enable further development of this work and make health a Council priority. Currently (as of June, 2017) the CSP has been adopted. The adopted CSP includes the health vision.

Creating a health and wellbeing policy, implemented at the strategic planning level, would create the impetus for health to be considered at all other levels of planning.
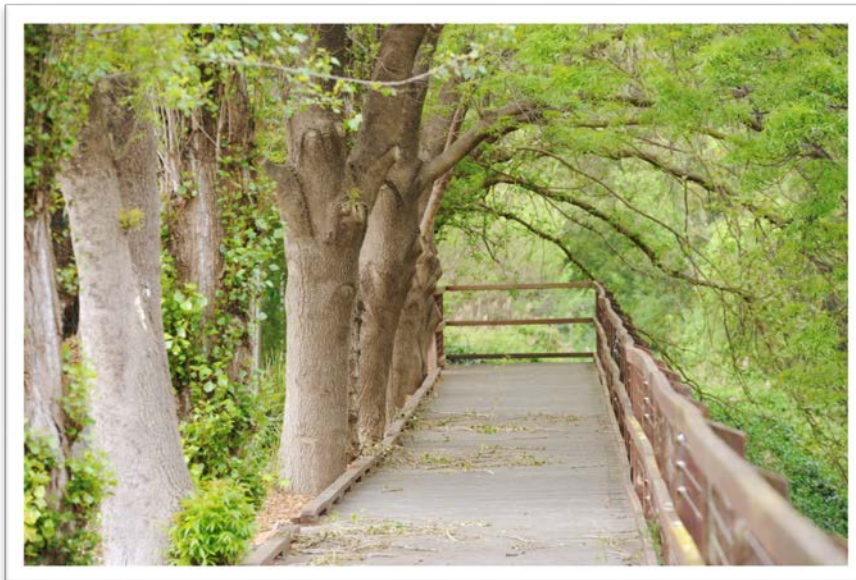
Health assessment policy

Although widely used throughout Australia, HIA is not the only tool that has been used to improve community health through informing planning processes. Innovative partnerships between health departments, planning organisations, local government, and private industry have led to the development of various approaches to integrate health into numerous types of work. Resources such as a Transport and Health Modelling Tool[3]; health checklists[4]; Active Design guidelines[5]; and health scoring criteria[6] have been used to examine how policies and plans that occur outside of the health sector have an impact on health and health equity. There have also been new policies put in place, such as the South Australian Health in All Policies approach[7], which requires active integration of health into various planning processes.

Development of a health assessment policy would establish when, how and by whom health assessment is conducted in planning. It could include the use of HIA but could also include other strategies, tools or approaches. The Steering Committee recommended that the health assessment policy apply to both development assessment and policy development across council. The development of a health assessment policy would establish:

- the tools or approaches to be used
- by the appropriate level of planning
- at a specific point in time (i.e., stage of planning or size of project)
- by the appropriate entity (WSC or external)
- with the appropriate level of involvement (with our without support from SWSLHD)
- and in what format (i.e., supplementary planning guidance).

Development of this assessment policy could also help to refine the types of resources or approaches used (as listed in the health tools audit, see http://bit.ly/2ekZt9H) or could lead to the development of WSC's own assessment tool. Likewise, the policy could set out a standardisation for the minimum acceptable level of health impacts to be considered, within the bounds of what is achievable for WSC staff given their level of expertise, the stage of

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[3] http://www.cedar.iph.cam.ac.uk/research/modelling/ithim/

[4] http://advance.captus.com/planning/hia2/pdf/Module2/Ingham%20County%20Meridan%20Township%20Checklist.pdf

[5] http://www1.nyc.gov/site/ddc/about/active-design.page

[6] http://nashvillempo.org/docs/lrtp/2035rtp/Docs/MPO_Scoring_031710.pdf

[7] http://www.jstor.org/stable/41995670?seq=1#page_scan_tab_contents

planning, timeframes, etc. Developing this policy in conjunction with planning staff will also help to make the policy relevant and appropriate for planners while helping to gain their buy-in for the consideration of health.

Similarly to the health and wellbeing policy, development of the health assessment policy could also be included in the Operational Plan of the CSP, thus requiring its development while gaining council approval of the approach.

Joint staff

Establishing a new joint staff position between WSC and SWSLHD would help to achieve the other proposed actions and overcome some of the identified barriers. Based at WSC, this position could provide the necessary health expertise to work with other Council staff to support the health and wellbeing vision and the health assessment policy. Additionally, once tools or approaches are put into place, this person could help to answer additional questions, provide support to staff, and offer on-going training. For SWSLHD this person could offer assistance in understanding council land use and corporate planning processes, and guidance and support for activities such as commenting on WSC documents.

Currently there is one other joint staff position with SWSLHD based in Fairfield Council. While this position can help to serve as a model for what to establish in WSC, additional questions of the location, role and responsibilities, funding structure, governance arrangements, level of integration, etc. will need to be discussed. As with the other activities, the development of this position could be included as an action or strategy within Council's Corporate Planning documents.

Support for this joint staff position will require further governance structures to be put into place. A steering committee or advisory body could help to oversee and inform the goals of this position.

Developing a health integration approach

While all of these recommended actions will help to integrate health into WSC planning, it may also be prudent to develop an overall approach. Development of a health integration approach may help to define the broader goals of this work and can work towards achieving on an ongoing basis (rather than in stages).

While there are many different types of approaches that can be taken to integrate health into planning, an ideal approach for WSC is one that creates buy-in, learning and capacity building while also helping to improve planning.

Conclusion

Short Term Outcomes

In conducting this research, there have already been changes made to start to integrate health into planning. The Wollondilly Social Planning Strategy now includes two components that directly relate to this project: 1) a requirement to conduct HIAs on major planning proposals, and 2) an action item to undertake and implement the findings of the 'Integrating Health Considerations into Council Planning Processes' research project. These inclusions are a great outcome of this project and will help to support implementation of the recommendations.

Additionally, while this project was undergoing (April 2017), the New South Wales Govenrment Department of Planning and the Environment held a consultation around proposals to update the *Environmental Planning and Assessment Act 1979.* WSC made a submission seeking the inclusion of an explicit reference to health and wellbeing in the Objects of the Act.

Lastly, WSC staff wrote an initial draft of a health vision statement. This included underlying principles, the context and opportunities for health consideration, and operational goals and strategies. This may serve as a basis for the development of a Council-approved health and wellbeing policy.

Next Steps

In order to continue the momentum developed through this research project, several next steps need to take place in the not too distant future. Firstly, WSC and SWSLHD need to decide how they would like to continue to work together – whether through another MOU or without.

Secondly, it needs to be decided whether the original steering committee will continue to oversee this work, if the composition of the committee needs to be changed, or if any sub-committees need to be formed and/or if another MOU needs to be established between WSC and SWSLHD. Given that WSC and SWSLHD are also already actively involved in the Wollondilly Health Alliance (WHA) (aimed at health promotion in Wollondilly Shire) it will also be necessary to consider how this new role interacts with WHA.

Thirdly, it needs to be decided how and who will lead the next stage of work (i.e. implementation of the action items, development of an approach), whether that is WSC, SWSLHD or another organisation like CHETRE. Lastly, the findings of this research should be shared widely. This may take the form of presentations to WSC staff and councillors, dissemination at community forums, comments on relevant state planning such as the 'City Deal,' communication with other relevant bodies such as the Healthy Planning Expert Group, and/or peer-reviewed publication.

Through reading this report it may appear that WSC has a long way to go and many challenges ahead. In fact, the work that WSC has done so far, which includes participation in this research, proves that they are in fact ahead of the curve. For many councils, planning revolves around the three 'Rs' (rates, roads and rubbish) without any understanding or consideration of the impact on community health. Through its desire to better integrate health into land use planning, WSC has demonstrated that it has a significant understanding of the relationship between health and planning and the role land use planning has in improving community health. Through this leadership,

strategic partnership with SWSLHD, and the involvement of dedicated staff, their work in health and planning integration will keep them at the forefront of creating healthier environments.

WSC's work in health and planning integration will keep them at the forefront of creating healthier environments.

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Appendices

A. Interview Questions

1. **Can you tell me a bit about what health means to you?**
   a. *Prompts: What does it mean to you, not for planning? Does it mean health services/not being sick/or something else? (Discuss how we're thinking of health for this project).*

2. **Tell me about your role in planning.**
   a. *Prompts: Are you involved in development consent processes, or plan-making or strategic planning within Council? How?*

3. **Do you think health is an important consideration in planning?**
   a. *Prompts: Why or why not? Do you think health <u>should</u> be a consideration in planning, if it's not?*

4. **How do you think health is relevant to your work or local government planning?**
   a. Prompts: *What are some health considerations you think should be included (that aren't currently) in council planning processes? How is health relevant to what you do in Wollondilly Shire Council?*

5. **How could health be considered in Council planning activities?**
   a. *Prompts: Are there specific tools/policies/processes/strategies that you think would be useful to achieve this?*

6. **What do you think are potential barriers to health being considered in Council planning activities?**
   a. *Prompts: Are there specific barriers (a policy), or are they more general (like attitudes or the culture of planning)? Can you give me an example? Do you think this is an insurmountable barrier or are there ways to work around that?*

7. **What is needed to support opportunities to consider health in planning within Council, or to mitigate the barriers?**
   a. *Prompts: Does it require specific tools, information, leadership, knowledge, culture, processes, policies? Are there any organisational capabilities that are required? What would help <u>you</u> to better consider health in your work?*

8. **Can you think of a new issue or practice that has been introduced within local government planning that has worked well? What was it? Why did it work well?**
   a. *Prompts: For example, why has CPTED (crime prevention through environmental design) been so successful in local government and what can we learn from that? Would a tool like this work well in Wollondilly Shire Council? What were the barriers? What would support you to use a tool like that?*

B. Research matrix

What health and planning activities could be used in Wollondilly (Council/community/health service/etc.), in what circumstances, and why or why not?

Research Focus	Potential Methods	Implications/Follow-on	Rationale

Formal Processes	• Document Review/Discussion	• Wollondilly to identify key documents
		• Mapping of planning process:
		  o Number & types of proposals they review
		  o Process & timeframes for plan making
		• Read the judgements from the Land Use Tribunal
		• Consider looking at regulations (codes) for building to see what codes do look at health determinants and what's missing. Could also look at how the codes were selected to begin with
			• Explains uniformity in planning
			• Provides feasibility

Informal Processes	• Participant observation/Shadowing	• Attending strategic meetings	• Explains variation in consideration of health • Provides feasibility
Attitudes/beliefs	• Key informant interviews • Survey	• Pre/post survey (can be used for evaluation also) (exp. Questions: Do you have any influence on health and wellbeing? What is health and wellbeing? Are there any tools you currently use?) • Can compare survey to existing data (on local government attitudes)	• Explains variation • Explains mechanism • Provides feasibility
Health-related interventions	• Literature Review		• Explains range of potential activities
Community and Social Context		• Politicians can advocate for certain things to change while council workers have to follow certain regulations	

C. Meeting Agenda – Findings Validation

"The Integrating Health and Planning Working Group"

Validation of Findings meeting

Agenda

Date: 2 March 2017

Time: 9.30-11.30am

Venue: Wollondilly Shire Council

9.30-9.35	Welcome, introductions and Overview of the meeting	Maria & Carolyn
9.35-9.45	Summary of the Research Project	Katie
9.45-10.05	Research Project Findings	Katie & Fiona
10.05-10.40	Discussion and Validation of findings	Group Discussion
10.40-11.15	Prioritisation of Areas of Opportunity Exercise	Group Discussion
11.15-11.30	Next steps and close	Katie & Fiona

D. Meeting Agenda – Recommendations

"The Integrating Health and Planning Working Group"

Recommendations and next steps

Agenda

Date: 8 May 2017

Time: 10.30-12.30pm

Venue: Wollondilly Shire Council

10.30-10.35	Welcome, introductions and overview of the meeting	Maria & Carolyn
10.35-10.45	Summary of the Research Project – up til now	Katie
10.45-11.15	New findings and recommendations	Katie & Fiona
11.15-12.00	Discussion of findings and prioritisation of implementation	Group Discussion
12.00-12.30	Next steps and close	Katie & Fiona