CITYFUTURES

HBEP

HEALTHY BUILT ENVIRONMENTS PROGRAM

Healthy Built Environments Program
Listening Tour
2010

Acknowledgements

This ‘Listening Tour Report’ has been prepared by the Healthy Built Environments Program’s Senior Research Officer, Ms Joanna York, supervised and edited by Healthy Built Environments Program Co-Director, Associate Professor Susan Thompson. The report presents the research findings of in-depth focus group interviews conducted in the latter part of 2010. NSW Area Health Service employees were interviewed by the Healthy Built Environments Program Senior Research Officer York and Co-Director Thompson. The HBEP acknowledges the willing, generous and honest participation of the NSW Area Health Service employees in the focus group interviews and subsequent permission for use of quotes.

List of Abbreviations

AHS: Area Health Service

AHURI: Australian Housing and Urban Research Institute

DCP: Development Control Plan

HBE: Healthy built environments

HBEP: Healthy Built Environments Program

HIA: Health impact assessment

HUDC: Healthy Urban Development Checklist

LEP: Local Environmental Plan

LGA: Local Government Area

MOU: Memorandum of Understanding

NGO: Non-government organisation

NSW: New South Wales

NSW Health: New South Wales Department of Health

PCAL: New South Wales Premier's Council for Active Living

ROC: Regional Organisation of Councils

RTA: NSW Roads and Traffic Authority

UNSW: The University of New South Wales

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EXECUTIVE SUMMARY

Health is everybody's responsibility, isn't it? Choosing good health is - we all share in it whether we work in health planning, employment, education, whatever sector.
(AHS employee, 2010)

As the body of evidence linking human health and well being to the built environment continues to grow, it becomes increasingly important to be proactive in designing built environments that support healthy living for all communities. In working towards the provision of supportive environments for health, it is essential that key stakeholder groups understand the issues and collaborate. In New South Wales (NSW) the Department of Health has a significant role, working in partnership with other government agencies that influence the way people live. NSW Health is involved in both policy development and practice initiatives.

In 2010 the Healthy Built Environments Program (HBEP) undertook a 'Listening Tour' of all the Area Health Services (AHS) in NSW to examine their current level of involvement in healthy built environments work.[1] The discussion with AHS staff during these visits focussed on three main areas:

1. Current healthy built environment initiatives (including job roles, participation in urban planning processes and use of tools and/or procedures to develop and advocate for healthy built environments).

2. Capacity building needs (specifically in relation to adding value to urban planning processes, policies and actions in healthy built environments).

3. Potential role of the HBEP in assisting with the healthy built environments work of AHSs.

Detailed analysis of the in-depth interviews conducted during the Listening Tour revealed that while there is a general awareness that NSW Health should play a significant role in integrating health considerations with planning, this has not yet been fully realised. The research shows that this situation is related to a variety of factors including lack of resources, associated diminished capacity to respond, and less-than-ideal collaboration with key stakeholders.

The research findings of the Listening Tour will directly inform the HBEP's *Workforce Development Strategy* and have input into the HBEP's *Research Strategy*.

[1] Area Health Services ceased to exist on 1st January 2011. Nevertheless, in this Report, the AHS terminology is used in relation to the data collected during 2010. Area Health Services have been replaced with 18 Local Health Districts and three Health Reform Transititonal Units. More information can be found on the NSW Health's website (www.health.nsw.gov.au).

Research Findings

The major findings of the Listening Tour can be summarised as follows.

1. Need for formalised systems and procedures

a. The AHSs receive planning proposals for development projects and strategic policies on an ad hoc basis, and sometimes, not at all.

b. There is a lack of consistent internal processes for dealing with planning proposals.

c. The AHSs are not monitoring or evaluating their recommendations on planning proposals to see if they are being implemented. Further, AHSs rarely evaluate the actual recommendation process to make improvements in the way they respond.

d. There is a poor integration of healthy built environment responsibilities into work plans and position descriptions within AHSs.

e. There is a widespread reliance on personal relationships and individual drive to stay aware of planning proposals and changing legislation.

f. Local government areas in each AHS region receive uneven attention.

2. Current lack of capacity and identification of capacity building needs

a. AHS employees have positive views of healthy built environment initiatives but not enough time and resources to implement them.

b. There is a poor external perception of some responses by AHS employees to planning proposals. This is largely due to AHS employees' lack of understanding of planning processes and language.

c. AHS employees require more regular training in healthy built environment tools, processes and partnerships. Education needs to embrace different formats including online, face-to-face and inter-agency forums.

d. AHS employees consider there would be value in training stakeholders such as local government and the NSW Department of Planning to increase their knowledge of health processes and healthy built environments generally.

e. There is insufficient AHS staff and resources committed to healthy built environments work, particularly in rural areas.

3. Integration and use of existing tools, techniques, resources and knowledge

a. There are mixed experiences with using different healthy built environment tools and techniques. There is an uneven understanding of available documents, indicating a range of capacity building needs.

b. Since there is a general reliance on locally produced checklists, AHS employees need more direction on the best/most appropriate tool/s to use in different situations.

c. There is a perception that there are too many healthy built environment resources and that the strengths of each could be better integrated and understood.

d. Healthy built environment knowledge is often not shared within an AHS, let alone between AHSs.

e. There is a growing need for more robust urban planning 'relevant' evidence to underpin AHS feedback on planning proposals

4. Area specific challenges – different rural and urban issues

a. Rural challenges:

- Current healthy built environment assessment tools available have a metropolitan focus.
- Large geographical area to cover.
- Communities frequently have their own 'personality' and powerful stakeholders. These must be understood and respected, while balancing the broader needs of the community[2].
- When compared with urban AHSs, rural AHSs have less overall capacity and resources dedicated to healthy built environment measures.
- NSW Health often mandates 'one-size-fits-all' programs which do not necessarily translate as well in rural settings when compared with urban contexts.
- The community's concept of 'health' is very much focussed on the hospital.[3]
- The presence of higher Indigenous populations with resulting special health and well-being needs.

b. Urban challenges:

- Stark differences in local government area (LGA) population size yet similar resource commitment required for healthy built environments work.

[2] While this point was only raised by rural AHSs during the Listening Tour, it is considered that this issue is relevant to both rural and urban AHSs.

[3] It is acknowledged that this understanding of health is evident beyond rural communities.

- Equity concerns as a result of cultural and socio-economic differences within communities.

5. Need for legislative support, inter-agency collaboration and focussed leadership

a. Healthy built environment requirements should be legislated.

b. Successful implementation of healthy built environments requires better alignment of key government departments such as the Departments of Planning and Transport, the Roads and Traffic Authority (RTA) and the Division of Local Government. This is required at Director General level to set a high degree of commitment throughout the entire organisation.

c. Preventative health initiatives should be prioritised and appropriate resources committed over the long term.

d. There is a perception that NSW Health's Executive Management understanding of the importance of healthy built environment initiatives, and their measurement of success, is poor and therefore not sufficiently prioritised in the work of NSW Health.

The Way Forward

The research findings of the Healthy Built Environment's Listening Tour will be presented to NSW Health to consider appropriate actions that further advance healthy built environments. Initiatives to enhance stakeholder relationships and engagement, together with ideas for innovative capacity building, particularly for those in rural and regional localities, are indicated. Further, it is critical that leadership and resourcing for healthy built environments in NSW are encouraged and supported in different ways.

INTRODUCTION

The Healthy Built Environments Program

The Healthy Built Environments Program vision is that built environments will be planned, designed, developed and managed to promote and protect health for all people.

The Healthy Built Environments Program is an innovative collaboration that brings the built environment and health together. The Program is situated in the City Futures Research Centre, Faculty of the Built Environment at the University of NSW (UNSW). The Healthy Built Environments Program receives its core funding from the NSW Department of Health.

As Australia faces increasing health costs from rising rates of obesity, diabetes and other lifestyle diseases, health workers are seeking to influence the design of cities to make them more supportive of healthy ways of living. Recent research has demonstrated links between modern epidemics and the way of life in cities. Car-dominated transport, reduced opportunities for exercise, increased fast-food availability and lack of social connection are all implicated. Increasingly the health sector is focusing on prevention and to be effective, health professionals need to work in collaboration with other professional groups, especially those from the built environment.

The Healthy Built Environments Program is contributing to revitalising the relationship between the built environment and health professions so that together we can create built environments that support people being healthy in their everyday lives.

Healthy Built Environments Program Strategies

The Healthy Built Environments Program strategy aims to support the development in NSW of current and future communities in which the built environment promotes good health for all. This is being done through the Healthy Built Environments Program's three identified core strategies:

Research – the Healthy Built Environments Program is developing a research strategy to prioritise research questions and foster interdisciplinary and policy relevant research. Research funding from bodies such as the Australian Research Council (ARC), National Health and Medical Research Council (NHMRC) and the Australian Housing and Urban Research Institute (AHURI) is sought to undertake relevant projects**.** An ARC Linkage research project on healthy neighbourhoods is currently underway with partners Landcom, Heart Foundation and NSW Health.

Education and workforce development – the Healthy Built Environments Program is delivering innovative, cross disciplinary education and capacity building. Specific programs

are delivered to NSW Health staff. Formal courses in healthy built environments are taught at UNSW.

Leadership and advocacy – the Healthy Built Environments Program aspires to be a leader in NSW advocating for improved links between health and the built environment. This advocacy involves government and non-government agencies, the private sector and the community and is achieved through scholarly publications disseminating the latest research, popular media articles, talks and events.

Further information on the Healthy Built Environments Program can be obtained by visiting the Program's website: http://www.fbe.unsw.edu.au/cf/hbep/ or contacting the Healthy Built Environments Program by email: hbep@unsw.edu.au

The Listening Tour

In 2010, as part of its research activities, the Healthy Built Environments Program (HBEP) undertook a 'Listening Tour' of all Area Health Services (AHS) in New South Wales. This project was a major research undertaking in the first full year of the HBEP's operation. The overarching objective of the Listening Tour was to examine the level of involvement in healthy built environments work in each AHS.[4] In-depth focus group interviews with AHS staff during these visits focussed on three main areas:

1. Current healthy built environment initiatives.
2. Capacity building needs.
3. Potential assistance from the HBEP with healthy built environments work.

In addition to information collection, the Listening Tour was useful for the HBEP to get to know staff in each AHS. The research findings of the Listening Tour will directly inform the HBEP's *Workforce Development Strategy* and have input into the HBEP's *Research Strategy*.

This report presents the findings of the HBEP's Listening Tour. The research methodology is outlined and specific results presented. Recommendations from the research findings conclude the report.

[4] Area Health Services ceased to exist on 1 January 2011. Nevertheless, in this Report, the AHS terminology is used in relation to the data collected during 2010. Area Health Services are now grouped into three clusters titled the Local Health Networks. More information can be found on the NSW Health's website (www.health.nsw.gov.au).

METHODOLOGY

Setting up the Interviews

As part of its contract with NSW Health, a key deliverable in the first year of the HBEP's operation was conducting a Listening Tour of all AHSs in NSW. To get this underway, NSW Health provided the HBEP with a nominated Healthy Built Environment Officer for each AHSs. The Healthy Built Environment Officers are listed below.

AHS	HBE Officer	Position
Sydney West AHS	Christine Newman	Manager Health Promotion & Deputy Director Centre for Population Health
North Coast AHS	Greg Ball	Assistant Director Public Health
Hunter and New England Population Health	Milly Licata	Acting Program Manager
Greater West AHS	Gerard van Yzendoorn	Senior Environmental Health Officer
Greater South AHS	Andrew Gow	Acting Director Population Health and Planning
Sydney South West AHS	Michelle Maxwell	Service Development Officer, Population Health
North Sydney Central Coast AHS	Paul Klarenaar	Manager Health Promotion Northern Beaches
South East Sydney and Illawarra AHS	Pauline Foote	Director - Division of Population Health

The HBEP contacted each Healthy Built Environment Officer. Initially this was via an email sent by HBEP Co-Director Thompson. The email introduced the Healthy Built Environments Program, the Listening Tour and the Program's Senior Research Officer, Ms Joanna York. See Appendix 1 for email of introduction.

The HBEP's Senior Research Officer then contacted each of the designated officers and discussed the purpose of the Listening Tour, including the requirement to hold a focus group interview at each AHS. The location and date of the meeting was determined by the AHS Healthy Built Environment Officer, usually after consultation with colleagues. The HBEP always offered to visit the AHS at its preferred location, primarily to reduce barriers to staff participation in the research. The costs of the HBEP travelling to the AHSs across NSW were incorporated into the Program's budget.

Although there was enthusiasm for the HBEP's Listening Tour, some AHSs had difficulty prioritising the HBEP's visit. Consequently, in some cases, the HBEP spent considerable time negotiating appropriate meeting dates. It appeared that this situation reflected low levels of commitment by senior AHS management to healthy built environments work. This needs to be further investigated, together with ways that the HBEP can support AHS management in building the capacity of their staff to deliver healthy built environments.

The Schedule

The final timetable for the 2010 AHS Listening Tour is shown in Table One below.

TABLE ONE

Area Health Service	Location of Focus Group	Date of Focus Group
Sydney South West	Liverpool	31st August 2010
North Sydney Central Coast	St Leonards	16th September 2010
Sydney West	North Parramatta	20th September 2010
South East Sydney and Illawarra	Dolls Point	27th September 2010
Greater South	Queanbeyan	2nd November 2010
North Coast	Coffs Harbour	10th November 2010
Hunter and New England Population Health	Wallsend	19th November 2010
Greater West	Orange	3rd December 2010

In some cases, the Listening Tour was combined with a capacity building workshop for AHS staff. These workshops constituted another key deliverable for the HBEP under its 'Education and Workforce Development' strategy.

Listening Tour Interview Structure and Process

In this section we detail the interview methodology for the Listening Tour.

Interview Questions

Interview questions centred on three main areas:

1. Current healthy built environment initiatives in the AHS (including job roles, participation in urban planning processes and use of tools and/or procedures to develop and advocate for healthy built environments).

2. Capacity building needs of the AHS (specifically in relation to adding value to urban planning processes, policies and actions in healthy built environments).

3. Potential role of the HBEP in assisting with the healthy built environments work of AHSs.

We devised specific interview questions for each topic area. The final list of questions used for the focus group interviews can be found in Appendix 2.

Focus Group Interview Attendance

The Healthy Built Environments Officers in each AHS organised participants for the focus group interviews. The Officers were provided with the purpose of the interview and the list of questions prior to the meeting. One focus group interview was held in each AHS.

The break-down of each Listening Tour focus group interview is listed in Table Two below. The name of the AHS is not included to ensure that interviewees cannot be identified in this report. Anonymity was guaranteed to all interview participants. The order of the focus group interviews as listed in Table Two does not follow the actual scheduling to also protect anonymity.

TABLE TWO

Focus Group Interview ID	**Numbers interviewed**	**Sex of Interviewees**	**AHS Sections/Departments Represented**
A	2	Two females	Population Health, Health Promotion
B	5	Three males, two females	Population Health
C	3	Two males, one female	Health Promotion
D	8	Eight females	Triple P, Women's Health, Health Promotion, Multicultural Health
E	6	Three males, three females	Population Health, Environmental Health, Health Development Promotion, Nursing and Midwifery Directorate
F	4	Two males, two females	Public Health, Health Promotion
G	14	Twelve females, two males	Environmental Health, Health Promotion, Population Health, Planning and Performance
H	4	Three females, one male	Environmental Health, Health Promotion

Most participants attended the focus group interviews in person. In a few cases they joined via conference phone facilities.

Focus Group Process

The HBEP officers (Thompson and York) initially met with the Healthy Built Environments Officer at the AHS. The Officer then introduced focus group interviewees to the HBEP staff. Each interview was conducted by HBEP Co-Director Thompson, with the assistance of the HBEP Senior Research Officer York. Interview protocols were discussed – confidentiality, timing, recording and analysis. The purpose of the interview was reiterated immediately before commencement.

Recording of Interview

Each focus group interview was recorded electronically with the agreement of all participants. Hand written notes were also made by the HBEP representatives to augment the recordings. Following the focus group interview, the sound files were transcribed by an independent transcription service, Pacific Solutions. The transcripts are not included in this report to protect the identity of the interviewees.

Transcription Analysis

Using standard qualitative analytical techniques, the transcripts were initially reviewed and corrected for any mistakes. They were then carefully analysed for reoccurring themes. Illustrative quotes were noted for each of the identified themes. The quotes were grouped according to the relevant AHS and sent back to the Healthy Built Environment Officers. Permission to use the selected quotes anonymously was sought and granted by all AHSs.

RESULTS

In this section we provide the results of the Listening Tour. These findings were derived from the detailed analysis of focus group interview transcripts as discussed in the methodology section. It is important to reiterate that although all discussions were recorded and transcribed, in this report we do not attribute comments to any one AHS or individual. This assurance of anonymity was given at the commencement of each focus group interview to encourage honesty and openness of participants. Further, the use of the selected quotes in the report was approved by interviewees.[5]

Listening Tour: Major Themes[6]

Using standard qualitative research reporting protocols, we now discuss each theme derived from the detailed analysis of focus group interviews. Each theme has numerous sub-themes. Illustrative quotes are provided to augment understanding of the issues raised. The results of the focus group interviews underpin the recommendations made at the end of this report.

1. Need for formalised systems and procedures

a. Lack of formal notification of planning proposals and policies.

This was a widespread issue which, to varying extents, affected all AHSs interviewed. Many interviewees revealed that they actually learnt about planning proposals – be they developments or strategic policies – by chance or through personal interest. As one interviewee stated:

> *I would say the majority of the time our submissions come through reading the local paper and finding out about a development or sitting on council committees*.

There were however, some AHSs that had more formal structures that assist in the notification process.

> *We've actually got very good strong partnership agreements with some of our councils*.

Nevertheless, in general notification about proposals for developments or strategic planning policies is largely ad hoc and reliant on the cooperation of other stakeholders.

> *You might have a really progressive council or you might have a completely unstable council, it's all just so hit and miss*.

[5] Interviewees were asked to approve a list of illustrative quotes from their AHS's focus group interview. Approval was sought on the basis that the final report of the HBEP's Listening Tour might include some, but not necessarily all, of the listed quotes. Focus group interviewees were not shown any of the text used in this report in seeking approval for use of their quotes.

[6] It should also be noted that a common topic of concern was the forthcoming state-wide restructure of the NSW AHSs. Interviewees wondered how this would affect staff and their ability to continue to participate in healthy built environment initiatives.

Regardless of current procedures, all AHS interviewees spoke of the need for more formal communication channels for their local government planners. As one person put it:

> *...if they had some sort of structure to that I think we'd benefit*.

The lack of formal notification of planning proposals was a very important concern of the AHSs. The comment below summates the level of frustration identified by the NSW AHS staff regarding this issue:

> *The reality – there's no structured process for local government or Department of Planning to formally send through things for comment. Generally speaking we only comment on what's provided to us for comment. Some of my colleagues have chased the Department of Planning in the past to try and get a process where they actually forward things to us and the response you get is 'you can go to our website and look at all planning applications and work out which ones are relevant to you'. When you do that you'll spend an hour and a half at least scanning through every planning application that's been made to the Department of Planning*.

b. Lack of consistent internal processes when notification is received.

The focus group interviews revealed an absence of internal procedures to deal with planning proposals when they came into the organisation. For some, a planning document could have ended up anywhere within the office. As one interviewee put it, *originally it could have gone, who knows where in the Area*. One participant revealed that, on occasion, the documents would be discarded as rubbish. This stemmed from both poor internal procedures and a lack of capacity to deal with the proposal.

This situation is however, improving. All eight AHSs considered that staff-driven action had been taken within their organisation to improve internal notification procedures. One interviewee stated:

> *Overall, the systems are getting a little bit more consistent within our own AHS. We have a lot to do with that*.

c. Lack of monitoring and evaluation once the process is complete.

In the main, AHSs do not monitor or evaluate whether their recommendations on planning proposals are considered and/or adopted. This is problematic for both health staff and the referring organisation, usually a local council. Health staff need to know if their feedback is useful to planners and the ways in which it may need to improve to enhance its usefulness. This will ensure that the process is efficient, as well as assisting planners to contribute to the creation of a healthy built environment. Monitoring of their input will enable health staff to identify specific feedback areas that they need to improve, as well as enabling ongoing evaluation of how they have improved.

This is an area for future consideration and improvement. As one AHS employee appropriately stated:

All this good work only remains good work if the ideas that are agreed to are complied with. I'm not suggesting that we want a compliance role, but to see that there is some process in place would, I think, enhance the work that we do to ensure that things that are agreed to [by the referring authority] are complied with.

d. Poor integration of healthy built environment responsibilities into work plans and position descriptions.

Of the eight AHSs interviewed, only two have integrated healthy built environment responsibilities within their position descriptions. There was a high degree of confusion regarding how 'health' should be incorporated into internal work plans and strategies. As one interviewee stated:

...you need to know how you're going to put that across all of your strategies or otherwise this one just sits over here again on its sort of little lonesome.

Conversely, some felt that integrating 'health' into their work plans and position descriptions would be perilous.

...the danger is that if you have a unit or a person (assuming 'Healthy Built Environment' responsibilities), everyone else tends to step back, whereas I like the fact we're all involved.

Of particular concern was the admission by one AHS that their Executive Management is "re-badging" existing positions (in falls prevention and maternity) to assume healthy built environment responsibilities rather than dedicating separate resources to this area.

e. Widespread reliance on personal relationships and drive.

There is a widespread reliance on personal relationships and individual drive to stay aware of planning and development proposals, changing legislation and new strategies and policies. For some interviewees this is not difficult as their interest and hard work in healthy built environments generates benefits for their own communities. As one interviewee put it:

We live locally, so we take an interest in new development and we want to be able to influence those developments within our community.

Nevertheless, this enthusiasm results in additional work for the interviewees, which often takes place in their own time. As one AHS Manager stated:

I'd be remiss not to say that I think the achievements in part come from the blood, sweat and tears from our staff who work extremely long hours in a really, really careful way, much above and beyond what's required in order to produce this high quality work.

To ensure that they know about planning proposals, AHS employees have discovered the benefit of volunteering for local committees. One put it this way:

... so we sit on committees and find out - if you didn't sit on those council committees, you wouldn't know... you find the information out months before it hits the public exhibition.

As far as commenting on planning documents, some interviewees revealed that they respond outside of their work setting. This occurs in situations where internal procedures are lacking and staff are highly motivated in healthy built environments. As one interviewee commented:

> *Our unit does play an active role in putting in submissions because of the passion in the unit*.

Indeed, even though most AHSs lack sufficient resources to appropriately invest in healthy built environment initiatives, staff are driven by a passion for the wellbeing of their community. The following comment exemplifies this commitment:

> *We've got less capacity to do that [healthy built environments work] although we might have enormous will to do it because we, in health promotions, do understand the value of community development and building social capital.*

f. Some local government areas get more attention than others.

The AHS interviewees reported that the local government areas (LGAs) in their regions receive uneven attention. This is related to three main factors. First, the location of the AHS office. There is more knowledge about, and invariably more attention given to the LGAs where the AHS offices are located. One interviewee summarised this situation:

> *We're based in B Council. So most of our activity is with B Council and on issues affecting B Council. C Council's not too far away. So we do a reasonable amount for them as well. Plus, we're residents of C Council. Then D Council, which is further away again, we don't do that much of, because in reality they're just that much further away. And then Council E, which we [the AHS] don't have a location. So in reality, that doesn't get serviced as well, in terms of the health promotion or relation to health. There's not an office there.*

Similar situations exist in rural localities which are very geographically dispersed.

> *So for me, for example, trying to do something with a community which is three or four hours away, it requires not only a time commitment but you're not there in the local community knowing who the power brokers are; what the issues are in the community.*

Second, the strength of the relationship between AHS and local government employees influences the level of attention given to different councils. A good relationship will enhance information flows and assistance.

> *...we've been asked to comment on social plans...but that, once again, hasn't been a formalised process. It's really been as a result of the relationship the local health development officer might have with their council.*

Third, the place of residence of AHS employees impacts on the extent of attention given to a council area. There is more familiarity with the LGA in which one lives, has access to local newspapers and is part of the community.

> *...we live locally, so we take an interest in new development and we want to be able to influence those developments within our community*.

2. Current lack of capacity and identification of capacity building needs

a. Positive views of healthy built environment initiatives but not enough time and resources to implement them.

It was quite clear during the Listening Tour that AHS staff support and understand the need for healthy built environment initiatives. However, this was often overshadowed by a lack of resources dedicated to this work. As one employee stated:

> *I think it is a worthwhile area to invest time in and it's as worthwhile as our other priorities. So I guess I would like to emphasise that that we advocate for some more support to do some work in this area because it is an area of need*.

Further exacerbating this issue were the recurring mentions of budget limitations in performing healthy built environments work, and an overriding directive to prioritise the preventative programs mandated by NSW Health. As one interviewee said:

> *We're fairly thin on the ground and we're tied up with a lot of imperative work that's directed from the state*.

Also evident was an understanding of the positive contribution from local government planners despite their huge workloads and lack of specific health focus. As one AHS employee put it:

> *I think the planners already do a huge amount of health. They just don't call it that. They'll call it community well-being or something but they actually do a huge amount of work [on health] anyway. I feel very positive about all our planners, they seem to be fantastically supportive around it all. It's just their capacity because of the statutory nature of that planning system is sometimes limited*.

On the whole it seems that the AHS staff are very conscious of their resource limitations but due to their high levels of professional commitment to healthy built environments, they are willing to put in additional effort. As one interviewee said:

> *If you want to influence something then you've got to put the effort in.*

b. Poor external perception of AHS response to planning proposals. AHS staff do not speak the planning 'language'.

Even when invited by local government planners to provide feedback on proposals for development or new strategic policies, several AHSs reported that they received indifferent comments about their submissions. In one instance, planners reportedly found the health comments difficult to interpret and subsequently apply. This was, the planners indicated, linked to the failure of the health submission to integrate comments into a planning perspective. This was disappointing to AHS staff and detracted from the value of their feedback. Capacity building is indicated for both planning and health staff in improving the effectiveness of submissions on planning proposals.

A further problem is that the inclusion of healthy built environments in developments and/or planning policy has no legislative mandate. Planners and health workers both find this frustrating. An interviewee described the situation thus:

> *When we meet with planners, the thing they want to know is where in their DCPs [development control plans], LEPs [local environmental plans], conditions of consent... we can fit in our healthy urban guidelines, directions, statements*.

Another difficulty relates to the endorsement of AHS submissions by NSW Health. In some AHSs any person can provide feedback on planning proposals regardless of their level of expertise. While an employee may be well meaning, this lack of process and accountability could result in inappropriate advice. Over the long term this has the potential to affect stakeholder relationships and their perceptions of the effectiveness of Health employees. There is a need to ensure the expertise underpinning feedback on planning proposals and to have the feedback endorsed by Health.

c. AHS employees require more regular training in healthy built environment tools, processes and partnerships. Education needs to embrace different formats including online, face-to-face and inter-agency forums.

The need for capacity building in healthy built environments was a reoccurring theme in the focus groups. Interviewees want regular training in healthy built environment tools, processes and partnerships. The fast moving growth in research and technical tools in healthy built environments is an additional motivating factor. As one said:

> *People can't keep abreast of all the developments and develop some expertise if they're trying to cover it all at once.*

Furthermore, AHS employees appreciate that capacity building has to be undertaken in an organised and strategic way. There are problems when this fails to occur:

> *People did the local government course and then someone did the healthy planning course and there's someone doing this and there's someone doing that, but they're not necessarily all coming together and talking about this work together across AHSs.*

Even long term employees with considerable experience reported the need for training in this rapidly developing area.

AHS employees also reflected on the lack of collaboration with other healthy built environments stakeholders.

> *I think out of all the stuff I've done in regeneration [this work] has really made that really clear to me that we sit around the table but we can't achieve the plan on our own. Just an understanding what the other services are about and what they do may make a big difference.*

AHS employees also understand the need to bring stakeholders together to facilitate a strategic approach to information sharing.

> *One community service can't do it without the other*.

It is well recognised that local government will play a significant future role in healthy built environments. As one AHS employee stated:

> *We need to be out there letting councils know that we're interested and we're going to be in it for the long haul*.

The need for formal partnerships varied from the ground level between AHSs and planners right through to the executive level in State Government.

> *One of my issues is around the relationship – or lack of – between the Department of Health and the Department of Planning and how perhaps that could be facilitated. Because it seems to me that there's not much of a relationship there. It seems to me that it would benefit AHSs a lot if there was [a relationship]*.

d. Stakeholders such as local government and the NSW Department of Planning need to increase their knowledge of processes and healthy built environments generally.

The AHS employees identified the need to train local government planners in healthy built environments so that they can integrate this knowledge into their work. There is a general feeling that over time, this will reduce, and perhaps even eliminate, the need for AHSs to provide feedback on planning proposals. An interviewee stated:

> *I think there's some benefit for further education at the councils about the process. I know that planning has probably put a certain level of information out there but I guess from a health perspective there probably hasn't been much.*

Working collaboratively with key stakeholders is also an important issue in facilitating healthy built environments. Some AHS staff expressed a preference for capacity building activities involving both health and planning professionals. As one interviewee commented:

> *Having a role to bring us together with planners and rather than separating us and trying to build capacity with health separately and I think that's another avenue we'd be interested in there.*

Specific knowledge gaps in healthy built environments for planners and local government officers were identified in the focus group interviews. The following points summarise these issues:

- They do not know who to contact in the health system: *They don't know I exist so it's really just an awareness raising thing*.

- They do not know how healthy built environments can be integrated in council plans and policies: *It was quite big and it was a bit frightening for council, I think, at the time. They couldn't see this and how it came down to management plans and the workable things.*

- Siloing of council professionals – for example, land use planners not working closely together with social planners.

- Unique council organisational structures*: ...councils also have fairly unique structures. A council might have a community planning unit that has a very broad approach to planning; where another council might have just planning associated with more the 'town planning' aspect. So they can be very, very different in how they resource their planning efforts. That may also impact on how they distribute their plans and other development applications for comment.*

Given the large number of councils that each AHS has to deal with, unique organisational structures presents a very real problem.

e. Insufficient staff and other resources committed to healthy built environments work, particularly in rural localities.

Interviewees reported that a lack of staff and other resources is a barrier to the implementation of healthy built environments work. This was the case for every AHS, regardless of location and the number of LGAs serviced. In some instances, lack of resources resulted in AHS staff rejecting opportunities to engage in healthy built environments work due to the generation of bigger workloads. As one interviewee explained:

> *There has been a discussion at the Area executive level about being more proactive and engaging particularly directly with councils and informing them more about how we do our business. That was mainly in response to the fact that every council is developing an LEP at the moment. And, of course, they're sort of coming from everywhere and expecting us to respond and look at them.*

Furthermore, since this work can be quite technical, the AHS employees felt conflicted at times. One said: *I think we can't expect to be the masters on everything*. At times, AHS employees were required to gain some expertise on unfamiliar topics thus generating additional workload and stress. This was a particular problem for rural AHSs. In some cases, engaging in healthy built environments work resulted in an additional expense for the AHS.

> *I've seen it get to the stage where it becomes that technical that we can't comment, so then we are employing consultants to assess it and tell us whether it's alright or not*.

3. Integration and exploitation of existing tools, resources and knowledge

a. Mixed experiences from utilising existing healthy built environment tools and techniques.

Many interviewees spoke highly of their past experiences with health impact assessment (HIA), particularly in regarding its ability to bring different agencies together. As one said:

I think it was a really great process. It enabled a collaboration of state agencies with Health to comment on a huge strategy document. And I think we used that framework for our next piece of work which was developing the guide – it helps us to consult with community and workshops. We sort of use the HIA framework for that process.

These relationships continued long after the HIA process had been completed.

There were however, others who did not consider the HIA process to be helpful, particularly as it is not an assessment tool used widely by local council planners. They generally use environmental impact and social impact assessments. The latter often include health issues.

I don't really understand the history [of HIAs] that well. But [I] just feel like we need to try and get the health stuff embedded within existing LEP strategic planning sort of policy level, rather than adding another whole procedure or another thing to go to. Just too many layers.

There was a mixed reaction to NSW Health's *Healthy Urban Development Checklist* (HUDC). Some found it applicable and very useful. Some were concerned by a perceived lack of evidence underpinning the document. Others used particular sections and not the entire document. A few were completely unfamiliar with the document. Several interviewees were unsure as to whether they actually had copies of the Checklist, with some responding that they did not have any. Those using AHS developed tools, such the North Sydney and Central Coast AHS's *Up for Health* and Hunter New England AHS's *Building Liveable Communities in the Lower Hunter Region* found them to be highly relevant for their healthy built environments work.

b. Need more direction on the most appropriate tool for use in different situations.

AHS employees were broadly aware of the healthy built environment tools available but reported a lack confidence in deciding which one to use in various situations. Some felt this uncertainty filtered down from NSW Health Executive Management.

NSW Health was supporting the rollout of HIA which doesn't necessarily seem to be the case anymore. It's gone out of fashion a bit, it's been replaced by checklists.

Below are some reported reasons for the confusion regarding healthy built environment tool or technique selection:

- There is no standard method for selecting the best tool or technique to use.
- Varying levels of capability and experience with different tools and techniques.
- Poor awareness of the desired outcomes of different tools and techniques.

c. Perception that there are too many healthy built environment tools and techniques and that there should be some integration of existing resources.

The focus group interviews revealed that there is a perceived need to integrate existing healthy built environment tools. While most acknowledged that there is sufficient instruction,

knowledge and evidence in existing tools, the sheer number make it difficult to select the best one to use. Accordingly, some of the AHSs believe it would be valuable to synthesise the existing documents into a single resource.

One AHS reported an attempted experience integrating social impact and health impact assessment tools. They discussed not only their difficulties, but also those experienced by an external consultant. Through this exercise they identified similarities and differences in each tool, both in terms of process and outcomes. This attempt at integration revealed wider lessons to ensure the effectiveness of healthy built environment tools. It was suggested that greater clarity is required about the purpose of each tool. In addition, a prioritisation of use would be helpful, as well as additional investment in training to use different tools and techniques.

d. Often knowledge is not shared within an AHS, let alone with other AHSs.

While knowledge sharing within AHSs is improving, the focus group interviews revealed problems. One reported example was the control of electronic access to a database of feedback on past planning applications. This was limited across health promotion staff due to information technology restrictions. In most AHSs internal politics represents a serious barrier to information sharing. As one interviewee said:

> *Internally, what we talk about is our own convoluted bureaucratic kind of system that we have to deal with.*

Our interviews did not reveal examples of information sharing between AHSs. While this may occur informally, it was interesting to note the questions we were asked during the focus groups about different procedures being used by other AHSs. This indicated a lack of knowledge dissemination between the AHSs.

e. Need for more robust urban planning 'relevant' evidence to underpin feedback on planning proposals.

The AHSs spoke of the need for urban planning 'relevant' evidence to underpin their healthy built environment recommendations. We heard of experiences where local government planners rejected health advice because it was not considered to be sufficiently substantiated for use in a planning policy or action. Given that there is no specific legislative mandate for healthy built environments, AHS employees stressed the importance of delivering robust evidence to support healthy built environment initiatives at the local government level. As one interviewee put it:

> *...the evidence produced in health [needs to be framed] around those [urban planning] issues and ... applied in the context of local government plans and policies*.

This evidence must be reviewed and revised as an ongoing matter of concern. As one interviewee declared:

Some of the advice we're giving now, we wouldn't have been giving five or ten years ago because the evidence wasn't there... So I think there is going to be ongoing work even... once we've got good systems and processes [in place]. ...you've got to maintain them, but... you've got to adjust them over time as the evidence changes or the issues change..

4. Area specific challenges – different rural and urban issues

The Listening Tour focus group interviews revealed different challenges for urban and rural AHSs in implementing healthy built environment initiatives. In this section we outline those challenges. They have implications for the nature of capacity building, suggesting that it needs to be targeted to meet the special needs presented by rural and urban situations. Further, different approaches to implementing healthy built environments may need to be considered.

a. Rural challenges.

- Current healthy built environment tools available have a metropolitan focus

A commonly identified need in rural AHSs is the perceived difficulty in finding appropriate healthy built environment checklists and related tools. As one interviewee said:

> *My biggest problem is that I can't find anywhere the criteria that are more applicable in rural environments and this makes it very difficult to respond to planning.*

There was often a high degree of anxiety and frustration expressed during the focus groups when this issue was discussed. The lack of rural-specific healthy built environment tools is a major concern. While this has resulted in some AHSs developing their own tools and approaches, others continue to struggle to find relevant guidance for rural issues.[7]

- Geographical size for which the AHS has responsibility

The rural AHSs have a much larger geographical area to cover than their urban counterparts. Coupled with comparatively limited resources, it can be difficult to engage in healthy built environment initiatives. One interviewee commented that feedback on planning proposals had to be generalised, and in some cases, could not be provided.

> *When we respond to those things, we become the point of contact. So in covering that broad spectrum of responsibilities and broad distance with a relatively small team, we have to be a bit scientific about what we buy into.*

[7] In a number of cases there was little knowledge of healthy built environment resources beyond those sponsored and specifically promoted by NSW Health. For example, *Healthy Spaces and Places*, the Planning Institute's web based resource, was not well known. Such resources could be better promoted to health staff in ways that will be of immediate benefit – for example, compiling rural case studies from various resources into a single document.

As discussed previously (see 1.f page 17), those regional and rural communities in which an AHS office is located receive more attention when compared to other locations in their region without an AHS office.

- Communities have their own 'personality' and powerful stakeholders which must be understood, respected, accommodated and balanced with broader community needs

Rural AHSs talked about varying 'personalities' characterising LGAs in their regions. These relate to geographical location – coastal or inland – as well as a broad range of environmental, social and economic factors. Interviewees explained that these 'personalities' had to be understood and respected when dealing with those communities to ensure that a good relationship was created and sustained. They also mentioned the need to establish credibility with the powerful stakeholders in a community. It takes time and effort to build up good relationships, but they are important to ensure that AHS staff and their initiatives are accepted. This can put pressure on limited resources and if an AHS employee leaves, a well established relationship with a key stakeholder can break down.

A further challenge mentioned is balancing the needs of powerful and demanding stakeholders with the rest of the community. This also requires time to build relationships and respect. This can be undermined when an employee leaves or moves into another position.

- Less overall capacity than urban counterparts and therefore fewer resources dedicated to preventative measures

Focus group interviews revealed that rural AHSs believe that they have less capacity than those in urban locations to implement and support healthy built environments. This perceived lack of capacity is further exacerbated by limited and diminishing resources of rural councils. Increasingly, they have serious problems in finding the money to fix local roads and provide basic services. As one AHS employee cogently stated:

> *A barrier that I noticed particularly related to rural councils is very many of them are cash strapped and very defensive about any suggestions of doing anything extra... we have been trying to advocate for more bicycle paths in the more outlying villages but it's all about the fact that they are not given sufficient funds from the State...*

Another AHS staff member reported experiencing "extreme hostility" from local council members when making a presentation about healthy built environments. Councillors were openly aggressive about the suggestions being made, focussing on "all of the things the health service hadn't done".

Another rural AHS spoke of the need to prioritise healthy built environments work. This AHS has formally allocated core funds to support this work:

> *In terms of the health promotion unit, we're not provided with any funds from NSW Health to do this work. So our special health promotion work is allocated to core business and healthy living environments are not one of those. So we as an Area have chosen to prioritise this work*

and invest more of our general funds to do this work. Some of the Areas don't have that capacity.

- NSW Health often mandates 'one-size-fits-all' programs which do not necessarily function well in rural settings

Interviewees expressed some concern about the way in which NSW state wide programs are mandated and rolled out. Resourcing limitations, including availability of specified experts in rural and remote regions, can limit the ability to operationalise such programs. One example was a requirement for the physical activity component of a NSW Health funded program to be delivered by a certified physiotherapist. With very few physiotherapists at the Area's disposal, the whole program was in jeopardy. The AHS managed to persuade NSW Health that the program could be delivered by 'unqualified' persons. While a positive outcome was achieved, the situation put additional strain on already limited resources.

Rural AHSs also expressed concern about their ability to innovate when all their resources are tied into state-mandated programs.

> *We've been arguing with the Centre of Health Advancement for some while that if we go down the line where we have dictated programs all the time, then we have the problem of innovation.*

> *All our money comes from head office and you don't have the flexibility to use that money to do programs that we might think are important for us.*

- The concept of 'health' is very much focussed on the hospital

This was a reoccurring theme in rural focus group interviews, although it is acknowledged that this belief is widespread and beyond rural localities. One AHS employee emphasised that:

> *People still think health is about hospitals. So just getting that frame of reference changed is a huge step.*

Another AHS employee related the community's awareness of health to the actual "bricks and mortar" of hospital buildings and medical centres. Funding for facilities which address physical inactivity, unhealthy eating options and community loneliness and isolation (all risk factors for chronic disease, which in turn is very expensive to treat) are not generally understood to be relevant to improving the community's health. With the lack of public and active transport options in rural areas this lack of awareness represents an ongoing barrier to implementing the much needed infrastructure that supports healthy lifestyles.

- Higher Indigenous population

Two of the rural AHSs spoke of their work with Indigenous communities and how this requires additional knowledge, experience and sensitivity. Despite their enhanced

understanding, there remain difficulties meeting the needs of Indigenous communities. One interviewee put it this way:

> *We have found in our work that there is a huge void in this area. There is not much knowledge at all with regard to liveability needs for our Aboriginal communities*.

Communities with a higher proportion of Indigenous people have a greater incidence of lifestyle diseases such as diabetes, which puts further strain on the health system. One AHS positively suggested that connecting authorities to better manage Indigenous issues is a valuable role that AHSs can perform. This is also within the financial capabilities of most AHSs:

> *Until we insisted that we needed to consider the needs of the Indigenous people within those communities, local government hadn't necessarily even considered that to be a priority. In some of the areas that we've worked there has been no rapport between land councils and local government. So we sort of, I think, can confidently say that we've built some of those bridges*.

b. Urban challenges.

The Listening Tour revealed specific challenges for urban AHSs. Nevertheless, the distinction of 'rural' and 'urban' issues is somewhat arbitrary. The issues raised below, while only mentioned by urban based interviewees in our research, could well challenge rural health workers.

- Stark difference in local government area population sizes yet same resource commitment required

Funding for public health initiatives is associated with population size. This does not however, recognise that the work to respond to a planning policy for a small LGA is similar to that required for a much larger council. This puts AHSs in a difficult position in applying scarce resources across their regions, as well as prioritising activities. One interviewee summarised this situation:

> *In essence, to get involved with somebody's LEP for 30,000 [population] is as time intensive as one for 200,000. So that is a problem for us, as is deciding how we prioritise, what we get involved in, and what we just have to let pass. That's something we're still grappling with*.

- Equity concerns as a result of cultural and socio-economic differences within communities

One of the metropolitan AHSs commits significant resources to equity, with two officers working in this field. This was not necessarily mirrored in other AHSs, although further research is needed to fully ascertain the situation. There is no doubt that equity considerations have to be factored into healthy built environment initiatives and that AHSs need to embrace them when responding to planning proposals. Greater attention is indicated to closely align healthy urban planning and equity. As one interviewee said:

To actually shift that to an equity focus I think there is some more work to be done there. Then that will then flow on to their impact on urban planning.

5. Need for legislative support, inter-agency collaboration and focussed leadership

a. Healthy built environment requirements should be mandated by appropriate legislation.

The necessity of mandating healthy built environment initiatives in some form of legislation was supported by every focus group. The recent inclusion of 'health' in the Sydney Metropolitan Strategy was seen as a positive step in this regard. Nevertheless, AHSs perceive that there is still a long way to go. One interviewee succinctly summarised the situation:

> *We really need a top down approach and we need legislation to do that to support us. So what we do is compulsory really, not just for good will.*

Without a change in legislation to mandate healthy built environments, AHS staff agreed that implementation will continue to be difficult. Across all focus group interviews, there was agreement that mandating healthy built environments will bring about the most immediate and effective change. Currently this happens for environmental health requirements and needs to be augmented:

> *It's easier with the things that are much more legislated, for example, some of the stuff that environmental health do.*
>
> *Whenever something is not legislated – and it's optional – you're never really going to get the uptake*.

The AHS employees spoke of the ways legislative support would affect the involvement of various stakeholders in the healthy planning process. The main issues, with quotes from the focus group interviewees, are summarised below.

<u>Local Government</u>

There was a shared belief that legislative change will result in clearer processes and roles for each stakeholder group, particularly local government.

> *I think if you had a process in LEPs that said certain things shall be done it then becomes a mandated requirement for local government to check certain things, refer certain things [to Health], get comments from certain people. That would standardise that process*.

<u>NSW Planning</u>

There was some concern over the perceived disinterest of the Department of Planning in healthy built environments and its frequent legislative changes. This perception is an important finding of the Listening Tour and needs to be addressed.

The Department of Planning has changed some of its legislation quite a few times over the last few years so that itself is a challenge. They've struggled themselves to keep up with their own legislation.

NSW Health

We also heard criticism of NSW Health and its commitment to healthy built environments. In some instances, this was linked to the failure of legislation to mandate action. The following quote refers specifically to the Planning Department of NSW Health.

They don't really want to know about workplace travel plans and things that can encourage active transport. They just want to satisfy the legislative requirements and move on.

Planning Consultants

Finally there was concern that private consultants paid by developers to provide advice will overlook healthy built environment provisions, particularly if perceived to be costly for the developer. Legislation will overcome this potential problem. As one interviewee suggested:

They [the consultants] are more or less going to tell the developer what they want to hear because they are paying the bill. So I think the legislative process needs to recognise that there needs to be an independent process that assesses probably what you call scheduled activities under the planning legislation.

b. Successful implementation of healthy built environments requires better alignment of key government departments such as Planning, Transport and Local Government. This is required at Director General level to set a high level of commitment throughout the entire organisation.

AHS employees realise that due to the lack of formalised processes, there is likely to be duplication between the various agencies involved in planning. When several agencies are working on the same project, there should be an agreed protocol for collaboration to ensure effective use of resources.

All people potentially working on exactly the same projects at the same time really need common ground.

Interviewees expressed some dissatisfaction with the lack of support for healthy built environments by several major stakeholders. In particular, the NSW Department of Planning was perceived as failing to adequately recognise 'health' in planning processes, especially at the highest level.

My worry is the higher level Department of Planning processes.

Others referred to the lack of formal communication and cooperation between AHSs and local government as the main failure in healthy planning processes.

I think there is historic antagonism between health services and local councils. So that can be a bit of a barrier.

There was a widespread belief that there needs to be a much more systematic coordination between all stakeholder groups to ensure healthy built environments can be achieved.

c. Preventative initiatives should be prioritised and appropriate resources committed over the long term.

Further to lack of collaboration between agencies, many interviewees felt that NSW Health's organisational structure represented a significant barrier to achieving healthy built environments. Some considered that NSW Health's lack of sustained investment in this area left the AHSs to drive their own initiatives.

In terms of health promotion we're not obligated to do it. And we as an Area have made the decision to invest in that without additional support from NSW Health.

Others believed that this type of work was not prioritised highly enough. One AHS employee stated:

We're fairly thin on the ground and we're tied up with a lot of imperative work that's directed from the State.

Another reinforced this viewpoint:

I think that is another huge barrier and the fact that it's not necessarily prioritised by NSW Health as core business...

Generally AHS employees consider that NSW Health's focus on clinical services is at the detriment to preventative health initiatives. Health promotion staff believe that this is an additional obstacle to overcome.

Services are really being drawn into doing clinical work and really struggle to devote time to prevention and that stuff. So I think that's something that I constantly have to battle with.

Another AHS employee's comment provided a different perspective on the same issue:

It's interesting just to see how that trade off between what is perceived as an immediate risk versus a long term risk and we, I guess, innately prioritise the immediate risks rather than the long term ones.

While 'prevention' has been identified as a public health objective of NSW Health, many AHS employees consider that this is very much secondary to the primary care services of the Department. This results in healthy built environments work receiving low priority and insufficient resources when compared with sick care services. As one interviewee said:

We've got our own division which understands more or less what we're trying to achieve. Then you've got the other divisions [of NSW Health]: the clinical services and medical services where they really don't... understand what health promotion is because [clinical and

medical services] are very treatment centric. That's how a lot of people think about the hospital system. They call it the health system. What they think of is hospitals, treatments, emergency departments and operations. All of those things. Really... the overall health system model is a barrier, like in terms of what we do. Because it really doesn't prioritise…primary prevention highly.

d. NSW Health Executive Management do not understand healthy built environments.

There is a perception that Health's Executive Management understanding of the nature and importance of healthy built environment initiatives is poor. Accordingly, healthy built environments work is not sufficiently prioritised by NSW Health. As one interviewee said:

> *It's just so self-evident that this stuff [healthy built environment initiatives] would work and really improve the way we live. But there just hasn't been enough strong leadership to see it through.*

This comment reflects another prevalent perception uncovered during the Listening Tour that NSW Health's Executive Management has a poor understanding of how healthy built environment initiatives should be effectively developed, delivered and evaluated. This was, in part, related to the huge shifts in knowledge required in public health, especially around the concepts of research evidence. As one interviewee put it:

> *Within the health paradigm, it's a clinical model and they want randomised control trials. That's the only type of evidence [they understand].*

These perceptions have resulted in negative views of the Executive Management's leadership in healthy built environments.

6. ***Information Sharing***

At the focus group interviews many AHS employees shared different healthy built environment initiatives. These resources have been put together for other health professionals to consider. They are summarised in Appendix 3.

CONCLUSION

This report has documented the research findings of the 2010 AHS Listening Tour conducted by the HBEP. The findings reveal important information about the three key questions explored during the focus group interviews with AHS employees:

1. Current healthy built environment work
2. Healthy built environment capacity building needs
3. Potential for the HBEP to assist with healthy built environments work.

Detailed analysis of the in-depth interviews conducted during the Listening Tour revealed that while there is a general awareness that NSW Health should play a significant role in integrating health considerations with planning, this has not yet been fully realised. The research shows that this situation is related to a variety of factors including lack of resources, associated diminished capacity to respond, and less-than-ideal collaboration with key stakeholders.

The research findings of the Listening Tour will directly inform the HBEP's *Workforce Development Strategy* and input into the HBEP's *Research Strategy*. The Listening Tour has helped the HBEP develop stronger relationships with each of the AHSs. Further, there is now greater awareness by AHS staff across NSW of the HBEP's role and objectives. The HBEP's visits were well received and the Program's work enthusiastically embraced.

Keep up the good work, it's so inspiring to have someone speaking the language that you think is going to make us all live in a better environment.
(AHS employee, 2010)

THE WAY FORWARD

The research findings of the Healthy Built Environment's Listening Tour will be presented to NSW Health to consider appropriate actions that further advance healthy built environments in NSW. Initiatives to enhance stakeholder relationships and engagement, together with ideas for innovative capacity building, particularly for those in rural and regional localities, are indicated. Further, it is critical that leadership and resourcing for healthy built environments in NSW are encouraged and supported in different ways.

The following ideas to advance healthy built environments are suggested. It is recommended that these be discussed with NSW Health in determining the best way forward.

Capacity Building

- Develop adaptable internal notification procedures for planning proposals.
- Develop a database of healthy built environment case studies, including those from rural and regional localities.
- Develop training modules (face-to-face and online) for professionals involved in responding to planning proposals for development and policy initiatives. These modules need to introduce the basics of healthy built environments, provide an overview of planning processes and 'language', as well as showcase best healthy built environment practice and evidence for supportive environments. The modules would need to be reviewed and additional modules introduced for varying levels of experience.
- Recognise the special needs of rural and regional localities in capacity building and implementing healthy planning initiatives.
- Evaluate existing healthy built environment related tools to better target them for different stakeholders.

Resourcing and Capacity Building

- Interdisciplinary student placement and secondment opportunities need to be identified and widely promoted in stakeholder organisations. This can be a significant resource, as well as a capacity building opportunity for the student.

Stakeholder Engagement

- Bring the major healthy built environment stakeholder groups together in a variety of forums to advance the implementation of healthy built environments in NSW.

Major Stakeholder Groups:

- NSW Health – encompassing Population Health, Environmental Health, Planning and Performance and Health Facilities
- Local government planners – strategic, statutory, transport and social planners
- NSW Planning
- Transport departments and agencies
- Environmental sustainability departments and agencies

Advocacy and Leadership

- Work with key stakeholder groups in health and the built environment to develop greater support for healthy built environments. This support needs to emanate from the top of the organisation and filter down.

- Advocate for the inclusion of 'health' in existing NSW planning, transport, environmental and related legislation needs to continue. This advocacy can build on the work done by the HBEP in mapping relevant healthy built environments policy and stakeholder networks. The South Australia Government's model of 'health in all policy' provides an exemplar of contemporary practice and should be investigated further in relation to its applicability for NSW.

- Change the current understanding of 'health' as primarily associated with sickness, sick care services and the provision of hospitals. This is something that the HBEP, in consultation with its Advisory Board, could undertake focussing on the three domains of the HBEP Literature Review:

  - The Built Environment and Getting People Active
  - The Built Environment and Providing Healthy Food Options
  - The Built Environment and Connecting and Strengthening Communities.

APPENDICES

APPENDIX 1

Email Introducing the Listening Tour

APPENDIX 2

Questions for Focus Group Interviews

APPENDIX 3

Area Health Service Information Sharing: Ideas, Resources and Opportunities

APPENDIX 1

From: Susan Thompson

Sent: Tuesday, 27 July 2010 8:28 AM

To: 'Andrew.Gow@gsahs.health.nsw.gov.au';
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'Christine_Newman@wsahs.nsw.gov.au'

Cc: Joanna York; Tony Capon

Subject: Introducing the Healthy Built Environments Program Senior Research Officer and Notification re PIA NSW Healthy Urban Environments Award

Attachments: 2010_awardinfo.pdf

Dear Healthy Built Environments Program Contact Officers,

I am writing to introduce Ms Joanna York to you. Joanna has recently joined the Healthy Built Environments Program as its Senior Research Officer. Joanna will be in touch with each of you to discuss scheduling the Healthy Built Environments Program's inaugural visit to your Area Health Service. As part of this visit we are keen to hear about your initiatives in healthy built environments, as well as learning about your capacity building needs. We will tell you more about the activities of the Healthy Built Environments Program and offer an initial capacity building workshop for your staff while we are there. We are very excited about this phase of the Healthy Built Environments Program's activities and look forward to meeting and working with you over the next few months.

I'd also like to draw your attention to the Planning Institute for Australia (PIA) NSW Healthy Urban Environments Award - closing date is August 27. You may have a project which you'd like to submit for this prestigious award. I have attached the PIA Information Booklet about the awards.

We look forward to meeting with you soon. And don't forget that our web site has a lot of information for you to access: http://www.fbe.unsw.edu.au/cf/HBEP/

Best regards,

Susan Thompson for the Healthy Built Environments Program Team

CITYFUTURES

SUSAN THOMPSON
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w: http://www.fbe.unsw.edu.au/cf/hbep/ CRICOS Provider Code: 00098G

HBEP

APPENDIX 2

l <insert name of AHS> l <insert date of interview> l

AHS 'Listening Tour' Questions

Overview of the AHS's work in healthy built environments.

1. Can you please tell us about your current job descriptions and roles.

2. Does your team participate in urban planning activities/processes (with organisations such as NSW Department of Planning, local councils or developers and/or designers)? If so, can you provide details (who and how)?

3. Does your team use any standardised tools (or procedures) to respond to planning notifications and/or proposals? If so, please provide details.

4. Are you routinely notified of major development applications and/or draft planning policies? Where do they come from? How does your team respond to them?

5. Are you familiar with the Health Impact Assessment (HIA)? What do you think is the role of the HIA in the planning process? Have you used the HIA to influence planning outcomes? If so, how successful were you?

Capacity building needs in healthy built environments.

6. Do you think your team is currently adding value to urban planning processes? If so in what ways is this happening? If not, how can this be improved?

7. What do you perceive to be the barriers, if any, preventing effective engagement between urban planners and your organisation? Between you and other built environment professions?

8. How can health practitioners be most effectively involved in urban planning?

9. Is there anything else you would like to add? Particularly in regards to how your team/organisation could have more valuable involvement in urban planning activities.

Assistance with capacity building.

10. What sort of support would add value to your team's/organisation's participation in urban planning activities?

11. Is there anything else you would like to add?

APPENDIX 3

Area Health Service Information Sharing: Ideas, Resources and Opportunities

During the Listening Tour the Healthy Built Environments Program heard about a range of exciting ideas and resources from each Area Health Service. Opportunities for advancing healthy built environments work were also presented. With permission of the AHS interviewees, these ideas and resources have been summarised in this appendix.

If you would like further details about this material, contact the HBEP: hbep@unsw.edu.au and we can refer you to specific NSW Health personnel for more comprehensive information.

Strategic Healthy Built Environments Idea	**Summary Details**
Information sharing and strategic advocacy	Establishment of a strategic planning group focusing on healthy built environments Internal sharing of assessments of planning proposals
Strategic partnerships - external	Memorandum of Understanding (MoU) with local councils Public health partnerships with councils Membership of local council committees Collaboration with Regional Organisations of Councils (ROCs) Connect with special interest local groups Attend public consultation meetings
Strategic partnerships - internal	Internal interest/coordinating group - to bring staff together who have a common interest in healthy urban planning
Resourcing - staffing	Placement of planning students with AHSs Health planner placement with local councils Public Health Officer (PHO) placement with AHS to work on specific healthy built environment projects

Resourcing – assisting on projects	Health staff working with council planners on specific projects to ensure that health issues are considered Undertaking HIAs with local councils on projects and policies
Resourcing – grants	Grants for local councils for healthy built environment initiatives
Resourcing – information	Produce area specific health related information for local councils
Strategic advocacy	Promoting healthy built environment achievements internally – for example, in office memos and at meetings Promoting healthy built environment achievements externally – for example, in newsletters and at meetings
Research	Monitor and evaluate activities using health impact assessments Work with local stakeholders (for example, local councils and NGOs) on different projects
Create special interest group to promote healthy built environments and healthy lifestyles	Active Broken Hill is one such example: http://www.activebrokenhill.org.au/

RESOURCES

During the Listening Tour, interviewees spoke about helpful resources. We summarise them here. Please let the HBEP know of others.

HEALTHY BUILT ENVIRONMENT RESOURCES

Building Liveable Communities in the Lower Hunter Region

http://www.pcal.nsw.gov.au/__data/assets/file/0018/27630/building_liveable_communities.pdf

The Heart Foundation's Healthy by Design: A planner's guide to environments for active living

http://www.heartfoundation.org.au/sitecollectiondocuments/healthy%20by%20design.pdf

Up for Health

http://www.nsccahs.health.nsw.gov.au/healthpromotion/publications/documents/UP4Health_Guidelines.pdf

Senior's Living Policy – Urban Design Guidelines

http://www.planning.nsw.gov.au/settingthedirection/pdf/seniors_living_policy-urban_design_guidelines.pdf

FOOD RESOURCES

VicHealth's 'Food for All' Resources

Resources on how to collaborate with local councils in getting food security on the agenda: http://www.vichealth.vic.gov.au/en/Publications/Healthy-Eating/Food-for-All/Food-For-All---Resources-for-Local-Governments.aspx

Food Fairness Illawarra

Food policy and food security guidelines in council documents, management plans and other relevant policies:
http://www.sesiahs.health.nsw.gov.au/health_promotion_service/programs/equity/Food_Fairness_Illawarra/index.asp

Tool for Liquor Applications

The NSW Department of Health has developed a Tool to help categorise different types of liquor applications.

LOCAL GOVERNMENT RESOURCES

Below are some local council plans which embrace health in various ways. These plans were specifically mentioned during the Listening Tour. There are, no doubt, many others, so please let the HBEP know of them.

Auburn Council's Strategic Plan

Auburn Council's plan has a strong determinants of health focus.

http://www.auburn.nsw.gov.au/uploadedFiles/AuburnWeb/Council/Strategic%20Plan%20body%20endorsed%20strategy%20final%20Auburn%202030.pdf

Penrith Council's Health Strategy

http://www.penrithcity.nsw.gov.au/uploadedFiles/Website/Health/Health%20Strategy%20V4.pdf

Holroyd Council's City Health Plan

http://www.holroyd.nsw.gov.au/__data/assets/pdf_file/0012/2145/cityhealthplan06.pdf

OPPORTUNITIES

Below are some opportunities to get healthy built environments into local council plans and policies. These opportunities were specifically mentioned during the Listening Tour. There are, no doubt, others, so please let the HBEP know of them.

Community Strategic Plans

The Local Government Act 1993 - Section 402 states that "Each local government area must have a community strategic plan that has been developed and endorsed by the council. A community strategic plan is a plan that identifies the main priorities and aspirations for the future of the local government area covering a period of at least 10 years from when the plan is endorsed". More specifically it states "(a) addresses civic leadership, social, environmental and economic issues in an integrated manner".

The Community Strategic Plan provides an opportunity for local councils to input health into their strategies and policies, including planning policies and actions.

http://www.austlii.edu.au/au/legis/nsw/consol_act/lga1993182/s402.html

Aligning Health with Environmental Sustainability Initiatives

Legislation currently fails to directly support the inclusion of health in planning documents which can result in some resistance from local government planners. However, there may be an opportunity to link environmental sustainability to human health when trying to justify why planners should address particular issues in planning applications.

Introducing Built Environment Issues to Health Councils

Opportunities exist for Health Councils across NSW to take up a local issue focusing on healthy built environments.

For example: http://www.parkes.nsw.gov.au/community/1044.html

Awareness of Local Government Strategies

It is important that Health staff are aware of local government strategies, particularly population predictions. This will facilitate strong health input into those strategies.

HEALTHY BUILT ENVIRONMENTS PROGRAM

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