Evaluating the implementation and effectiveness of the Memoranda of Understanding between SWSLHD and Local Councils

Phase 1 Report: Realist Scoping Review & Document Review

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Executive summary

Background

Local Governments are the closest level of government to the communities they serve. Traditionally they provide roads, rates and garbage services, but they are also often responsible for policy and regulation, particularly through land use planning and social welfare services, that have direct impacts on (equitable) health and wellbeing among local populations. As a result, partnerships between health agencies and local government are an attractive proposition to progress actions that positively impact community health and wellbeing. Currently little research has systematically unpacked the core elements within partnerships between health agencies and local governments with the objective of improving population health and wellbeing.

South Western Sydney Local Health District (SWSLHD) population health has had a long-term interest in and partnerships with local councils in the district. The LHD and four councils have developed and are implementing MoUs with co-funded positions to support implementation of joint objectives that sit within each council and the LHD.

This current piece of research, a joint project between CHETRE, the Healthy Places Unit, Health Promotion Services, and the four councils, will be a world first in taking a sophisticated real time approach to action research to better position intersectoral partnerships for health within local government.

This two-part project will evaluate the implementation and effectiveness of Memoranda of Understanding (MOU) between SWSLHD and four Local Councils (Fairfield, Liverpool, Wollondilly and Campbelltown). Specifically, the project will evaluate:

- The ability of the MoUs to result in sustainable health and wellbeing outcomes
- The role of health partnership MoUs in building reciprocal capability and collaborative advantage between two different organizations
- The functioning and support for co-funded positions between SWSLHD and four local councils in South Western Sydney to maximise their effectiveness and impact on Council and Local Health District business
- In addition to the co-funded positions, identify what else is required to maximise the impact of the MOUs

The project involves stages across 2 phases.

Phase 1: Establishing theory of change

- Stage 1. Review of literature
- Stage 2. Review of documentation
- Stage 3. Program logic development
- Stage 4. Reporting and dissemination

Phase 2: Developing and conducting an action research evaluation.

- Stage 1. Evaluation design and protocol: data collection and analysis against the theory of change
- Stage 2. Conducting the evaluations
- Stage 3. Revisiting and refining theories of change
- Stage 4. Comparing findings
- Stage 5. Reporting and dissemination

For this first phase of the project reported here, the focus was on establishing a theory of change. This phase included a realist scoping review of the literature, document review and development of program logics for two of the four councils. The second phase of the project, subject to further agreement, would focus on developing and conducting an action research evaluation. This report contains the findings of the first phase of the project.

Aims and Methods

The overall aim of the project is to develop and implement an action research approach to evaluation where the stakeholders involved in implementing the MOUs can reflect on and navigate the business of councils and the LHD to achieve better health and wellbeing outcomes for local communities.

The objectives are to:

- Develop a theory of change for each MoU to inform ongoing partnerships
- Build capacity to evaluate partnership collaborations and practice in complex settings
- Conduct evaluations of each of the MoUs in real time focussed on processes, effectiveness, and impact
- Influence improved consideration of health and wellbeing issues in Council's business
- Influence improved consideration of councils' community strategic plans in the LHD's business

Phase 1 had three stages:

1. Scoping review of the literature
2. Document review
3. Program logic development

Results

Scoping Review

The scoping review of focus in this paper was undertaken to inform a theory of change underpinning an evaluation of partnerships between health and local government in Sydney, Australia. Our review aimed to understand what inhibits or enables successful partnerships between local government and health sectors (e.g., intersectoral partnerships).

Narrative results are presented according to each thematic group of factors identified. These are:

- Funding and resources;
- Partnership qualities;
- Governance and policy; and
- Evaluation and measures of success.

Factors identified in the included articles were also mapped against identified mechanisms, resulting in the framework presented in Table 1.

Document Review

A review of documents related to the MoUs was undertaken alongside the scoping review of the literature. All documents related to each position (the MoU documents, work plans, position descriptions, survey/evaluation results) were included in the document review. There were no major differences in the documents reviewed, work plans and position descriptions varied based on the roles and only one council had an evaluation report available.

The most frequently mentioned factors were in relation to collaboration including;

- Having a **joint governance structure** for example the governance of the partnership being managed through executive level steering committee with representatives from all partner organisations;

- **Integration** with a main focus on embedding health and wellbeing into council processes;
- **Joint objectives, priorities, values and vision** for example partners working together to improve the health and wellbeing of the local community;
- **Clear communication** including a commitment to effective communication and information sharing across multiple channels and;
- **Conflict resolution processes** having approaches for resolution at a local level to avoid escalation.

Program Logic

A series of program logic workshops and meetings were held with each of the MoU stakeholders. During this process it was established that two of the four MoUs were at a stage where developing a program logic would be appropriate and useful. One (Wollondilly) had just completed strategic planning and felt the program logic would not add to planning work, although could be useful for a retrospective evaluation. Fairfield was renegotiating their MoU so felt program logic to be premature. These two MoU's (Campbelltown and Liverpool) were workshopped at multiple meetings in which an eventual program logic was developed including the following information:

- Definition of the MoU objectives and its desired results
- Program boundaries
- Inputs, including any resourcing required for the project/activity
- Outputs, describing the activity and who is involved
- Outcomes, describing what will change as a result of the activity, these were organised by short (12 month), medium (3-5 years) and long (5+) term outcomes of the activity
- Assumptions about how/why the program would work. It should be noted that for both Liverpool and Campbelltown, outcomes were beyond the current term of the MoU, so were therefore aspirational pending MoU renewal
- External factors impacting the MoU that are beyond its control

The completed (but living documents) program logics for Campbelltown and Liverpool can be viewed on pages 28 and 37.

Recommendations

1. Logic models clearly articulate the core aspects of partnerships from capturing core actions, deliverables, expected outcomes to articulating assumptions. The development of logic models is best done to complement existing planned work and should be the focus of future evaluations.

2. Future evaluations should include the exploration of similarities and differences between the theory of change for each of the MoUs. This will enable important lessons in terms of what to invest in for which type of outcomes.
3. MoU's have the capacity to achieve targets to progress action towards shorter-term outcomes (often organisational impact type activities). Future evaluations should capture longer-term outcomes or burden of disease, in some cases, longer than the existing commitment to the partnership.
4. Different activities and approaches lead to different outcomes. For instance, strategic level planning as the main investment point in Council has different outcomes to when urban design or health promotion are the investment points. Future evaluation is important for each MoU to determine effectiveness of different approaches.
5. Whilst the program logics provide a good basis for evaluation of the MoUs, they only capture very specific activity-based outcomes. A full theory of change approach to evaluation should be adopted in order to capture the complexity within partnerships in terms of conditions and processes. Those additional dimensions will add important nuance to an evaluation that program logic cannot capture.
6. Any future evaluation should incorporate unintended impacts of the MoU which occur beyond the scope of the position's specific activities within their work plan. Evaluations should also consider benefits for both organisations
7. The two councils who were not at the stage ready to develop a program logic should consider a similar process to develop an eventual evaluation framework to inform both future strategies and evaluations.
8. Any future evaluation should consider the mutual benefits for both organisations.
9. Given the capacity constraints with completing evaluation work that is in addition to existing scope of work, dedicated resourcing would be required to conduct future evaluation (e.g., competitive grant funding from NHMRC).

Background

South Western Sydney Local Health District (SWSLHD) population health has had a long-term interest in and partnerships with local councils in the district. The work has focused on areas of common interest including the role that local government plays in shaping the urban and built environment, providing behaviour change programs and activities that promote the health and wellbeing of the communities. Local councils and their work are at the front line of creating the spaces and places that influence the health and wellbeing for the people in the local community. The LHD and four councils have developed and are implementing MoUs with co-funded positions that support implementation of joint objectives between each council and the LHD.

Co-funded positions between State government agencies and Local Councils have existed for some time (such as Road Safety Officers). However, the existence of LHD and Council MoUs and these positions to achieve health promotion and healthy place making objectives is unique, certainly in the Australian context. At the same time however, local government as an institution for local action has been well documented in the policy and public administration literature. This is especially true concerning the role of local government in developing and implementing urban policy and programs and their connection to economic development in local communities. Less is known about how to work collaboratively with local councils with the objective of improving population health and wellbeing (particularly council's specific role in leading land use planning and place making that prioritises health and wellbeing outcomes). Addressing equity adds another nuance to investigating working with local councils for change.

By and large, the literature (Healey et al., 2017, Lowndes and Leach, 2004, Pierre, 1999, Pierre, 2012) suggests that the progress and successful implementation of initiatives with councils is subject to two factors: objectives that align with and progress the core business of councils, and the various formations of stakeholders that are then created to progress those objectives. The objectives that Councils achieve are often situated within wider policy drivers for example at state or even Federal levels (state level planning policies for instance either facilitate or constrain the role of local government). Councils are also uniquely engaged with local residents, communities and local issues, both influencing and being influenced by these local concerns. Various constellations of stakeholders, both internal and external to councils, then progress action to achieve these objectives. Along the way are critical factors such as leadership, power, interests, skills and relationships. However, what is not well known is how these factors play out in particular contexts

such that they can be effectively navigated to influence council business and the local communities. There is some literature on the understanding and adoption of health as a concept in councils (Browne et al., 2019, Browne et al., 2016, Lawless et al., 2017), but limited knowledge about how to progress health outcomes within the business of councils. This is a fertile area for knowledge and one that the Health/Council MoUs are pioneering both in Australia and internationally. The LHD and CHETRE have previously undertaken research with Wollondilly shire to identify opportunities within that council to influence its planning functions, with that work resulting in the current MOU and the strategic direction and support for the co-funded officer. Additionally, health promotion and population health have had a longer history of collaboration with councils that predate and influenced the content of the MoUs. The oldest collaboration, with Fairfield Council, has been the subject of several internal evaluations (Aves, 2011, SWSLHD, 2017).

Purpose of this document

The purpose of this report is to present the findings of phase 1 of this work. The report contains the findings from the realist scoping review, document review and initial stages of program logic focussed meetings pertaining to each partnership.

Aims

The overall aim of the project is to develop and implement an action research approach to evaluation where the stakeholders involved in implementing the MOUs can reflect on and navigate the business of councils and the LHD to achieve better health and wellbeing outcomes for local communities.

The objectives are to:

- Develop a theory of change for each MoU to inform ongoing partnerships
- Build capacity to evaluate partnership collaborations and practice in complex settings
- Conduct evaluations of each of the MoUs in real time focussed on processes, effectiveness, and impact
- Influence improved consideration of health and wellbeing issues in Council's business
- Influence improved consideration of councils' community strategic plans in the LHD's business

Methods

The project involves stages across 2 phases. This report is focused on the first phase of the project. Phase 2 is a subsequent project and is subject to future agreement.

Phase 1: Establishing theory of change

- Stage 1. Review of literature
- Stage 2. Review of documentation
- Stage 3. Program logic development
- Stage 4. Reporting and dissemination

Phase 2 (next stage of work): Developing and conducting an action research evaluation.

- Stage 1. Evaluation design and protocol: data collection and analysis against the theory of change
- Stage 2. Conducting the evaluations
- Stage 3. Revisiting and refining theories of change
- Stage 4. Comparing findings
- Stage 5. Reporting and dissemination

This report contains the findings of Phase 1 deliverables:

- Realist scoping review
- Document review
- Initial program logic for two MoUs

This work was led by CHETRE but the project reference group, consisting of members from, Population Health, council staff associated with each of the positions and CHETRE, were consulted with and verified preliminary findings throughout the process.

Scoping Review

A scoping review approach was taken to gain insight into the main concepts, theories, sources and knowledge gaps around partnerships between health and local governments (Tricco et al., 2018). The following databases were searched for studies published between January 2000 and July 2021: MEDLINE, Scopus, Web of Science, and ProQuest Central. A set of search terms (Table 1) used for each area of interest were compiled. The database search results were exported to EndNote,

duplications removed and screened for relevancy using Covidence systematic review software. Remaining data was analysed using qualitative analysis techniques.

Table 1: Search term groups were combined with the Boolean operator 'AND'

SEARCH #1 "local government*" OR "provincial government" or "city government*" or "local authority" or "local council*" or "city council*" OR "shire council*" OR municipal* OR "local partnership*"
SEARCH #2 policymaker OR policymakers OR initiative* OR "logic model" OR collaboration OR "memoranda of understanding" OR "memorandum of understanding" OR partnership* OR co-production OR co-design OR "capacity building" OR "theory of change" OR intersectoral OR inter-sectoral
SEARCH #3 "Health in all policies" OR "healthy public policy" OR "healthy communities" OR "health equity" OR "health inequity" OR "population health" OR "health systems" OR "social determinants of health" OR "health partnership*" OR "urban health" OR "health service*" OR "healthy municipal*" OR "healthy cities" OR "healthy city" OR "intersectoral health" OR "intersectoral model" OR "health authorit*" OR "health sector"

Inclusion and exclusion Criteria

Articles were included in the review if they were: (i) peer-reviewed, (ii) evaluated an intersectoral partnership that occurred between local government and a health partner (iii) reported an outcome related to change (iv) high-income context (v) published between (2005-2021), and (vi) in English. Articles were excluded if (i) they were reviews, study protocols, commentaries, editorials, books, or theses; (ii) did not include an evaluative component, (iii) did not report an outcome related to change; (iv) or did not contribute meaningfully to answering the research question, purpose, or objectives.

Data extraction & synthesis

Categorical data (author, year, country, methods, sample) from each article were extracted. An inductive thematic analysis was performed on each article identified for inclusion in the final synthesis, whereby any data (qualitative or quantitative) related to the facilitation of partnerships between local government and health organisations, and changes or outcomes that resulted from the partnership were coded using NVivo qualitative data analysis software.

Partnership Definition

An intersectoral relation, alliance, or coalition that includes a local government actor and one or more public health partners, which work to improve health or health services.

Outcome definition

Changes or outcomes as a result of the partnership, organisational in nature. Clinical or population health changes/outcomes were analysed as secondary to organisational changes/outcomes.

The aim was to map these facilitating factors against a 'causal pathway' to determine the underlying 'mechanisms' that drive partnership outcomes. Thematic groups were discussed among the team, and further categorised as four mechanisms that shape the success of partnerships between local government and health organisations (Box 1).

Box 1: Mechanisms that shape the success of partnerships between local government & health organisations

Functional aspects of the partnership: related to the structure and functioning of the partnership itself.

Organisational factors impacting the partnership: related to the structure and culture of the organisations in the partnership.

Individual factors impacting the partnership: related to agentic factors surrounding the individuals or actors involved in the partnership e.g personalities, skills.

External factors impacting the partnership: related to factors outside of the partnership and organization that have impact on both e.g policy, legislation, local leadership.

The scoping review resulted in the development of a framework.

Document Review

A review of documents related to the MoUs was undertaken alongside the scoping review of the literature. All documents related to each position (the MoU documents, work-plans, position descriptions, survey results) were included in the document review. These documents were used to inform the theory of change by providing information on the core tasks and responsibility related to the role but also provided wider context to each council, including connections up to state and federal influences on the work of councils, and to local external factors and stakeholders. Documents identified for inclusion were recorded in an excel spreadsheet to be used for data extraction. Similar to the scoping review, data extraction was focused on the factors that lead to effective intersectoral action.

Program Logic

Within the initial phased plan, CHETRE proposed that each council would develop a program logic model for the MoU, potentially with support from CHETRE. We conducted a series of meetings with

each council to develop their program logic. However, while each council saw the benefits of the logic model approach, two of the four councils were at a stage where developing a program logic would be useful/beneficial. One (Wollondilly) had just completed strategic planning and felt the program logic would not add to planning work, although could be useful for a retrospective evaluation. Fairfield was renegotiating their MoU so felt program logic to be premature.

Results

Scoping Review

The database search identified 3472 potential studies. After removal of duplicates 1325 titles and abstracts were screened. Of these, 187 full-text publications were retrieved for consideration. A total of 159 articles were excluded after performing the full text review, leaving 28 articles for inclusion.

The majority of articles reported on partnerships in European countries (n=8), followed by Canada (n=7) and the United Kingdom (UK) (n=7), with the remainder situated in Australia (n=3) and the United States (US) (n=3). Local government partners broadly included city councils or municipalities, counties (US), local authorities (UK), and local social services or police departments. Health partners included local health departments or districts, hospitals or other health services, public health networks, and First Nations health authorities.

Narrative results are presented according to each thematic group factors identified through the analysis. These are: Funding and resources; Partnership qualities; Governance and policy; and Evaluation and measures of success. The key factors identified in the included articles were also mapped against identified mechanisms (Box 1 above), resulting in the framework presented in Table 1 at the end of this section.

Funding and resourcing of partnerships

Funding was identified as a critical factor to partnership functioning and success, including:

- The willingness of partnership actors to secure external funding to sustain their activities (Kjelle et al., 2018, Vogel et al., 2005).

- Lack of sustainable funding as a key barrier to the functioning and continuation of the partnership (Asada et al., 2019, Chen et al., 2012, Dennis et al., 2015, Tooher et al., 2017, Vogel et al., 2005, Warwick-Giles et al., 2016).
- The costly nature of partnership oversight (Vogel et al., 2005).
- Funding existing initiatives in one partnership sector, resulted in less collective action across multiple community sectors, which was exemplified in a Canadian partnership targeting childhood obesity (Amed et al., 2015).

Resourcing was also identified as a factor critical to success, including:

- For some studies, funding was allocated to: a joint position between the two partners (Amed et al., 2015, Asada et al., 2019), or pooled budgets were created for partnership activities, (Bachmann et al., 2009, Wistow and Waddington, 2006, Kjelle et al., 2018).
- In other cases, existing human resources were allocated to partnership activities (Chen et al., 2012, Bachmann et al., 2009, Miro et al., 2014, Vogel et al., 2005).
- Overall, sharing funding and resources contributed to positive and functioning partnerships. Investing into building relationships was identified as an enabling factor in two studies (Amed et al., 2015, Bachmann et al., 2009).

Organisational factors were also enablers of partnership success including:

- One study sought to integrate local health, education and social services for children ('Children's Trusts'), whereby adequate funding of integration enabled partnership activities between the National Health System (NHS) and the local authority (Bachmann et al., 2009).
- Another study reported how poor management of integrated health and social services, created as part of a partnership between the local government and the NHS created organisational barriers to the partnership (Wistow and Waddington, 2006).

Qualities of local government & health partnerships

The qualities within the partnerships reviewed were critical to their functioning and success, this included:

- Trust and transparency were identified as key to relationship building between partners, including leaders within the partnership (Wistow and Waddington, 2006) or their representative actors (Sestoft et al., 2014, Warwick-Giles et al., 2016, Bachmann et al., 2009, Christensen et al., 2019, Tooher et al., 2017, Tugwell and Johnson, 2011, Vogel et al., 2005, Amed et al., 2015, Mantoura et al., 2007).

- Trust building was hampered by unequal power between partner representatives, and hierarchical relationships (Kirchhoff and Ljunggren, 2016, Mantoura et al., 2007, Visram et al., 2021, Wistow and Waddington, 2006).
- A UK partnership between local government and the NHS outlined that prioritising structural approaches (e.g. integrating services across sectors) at the cost of 'informal' relationship building was detrimental to the partnership (Wistow and Waddington, 2006).

Clear, open, continuous and equal channels of communication between partners was also a facilitating factor. (Tooher et al., 2017, Warwick-Giles et al., 2016, Amed et al., 2015). This included:

- Specific communication strategies included holding smaller sub-group meetings which created safer spaces to talk (Visram et al., 2021) and encouraging constructive criticism (Warwick-Giles et al., 2016) or open debate on issues (Wistow and Waddington, 2006).
- Having a shared vision or message, (Amed et al., 2015, Warwick-Giles et al., 2016) enthusiasm, (Sestoft et al., 2014) respect,(Visram et al., 2021) being flexible (Mantoura et al., 2007, Sestoft et al., 2014, Visram et al., 2021, Vogel et al., 2005) or interdisciplinary in approach, (Mantoura et al., 2007, Greaux et al., 2020) and focusing on improving vertical collaboration (Kirchhoff and Ljunggren, 2016).
- Such qualities were materialised through collaboratively developed partnership goals (Chen et al., 2012), action plans (Amed et al., 2015, Mantoura et al., 2007, Wistow and Waddington, 2006) or agendas (Warwick-Giles et al., 2016, Tooher et al., 2017, Wistow and Waddington, 2006) which assisted in negotiating, planning and executing ongoing activities and evaluation.
- Differing expectations of workload between partners, and poor management and administration of the partnership itself, was a barrier to partnership success between counties and local health districts in two US studies (Vogel et al., 2005, Chen et al., 2012). Two examples (Mantoura et al., 2007, Tooher et al., 2017) benefited from having conflict resolution mechanisms embedded in their structure.

Enabling qualities related to the broader organisational context included facilitating information creation and sharing between partners (Bachmann et al., 2009, Mantoura et al., 2007). For example:

- A partnership between a neighbourhood renewal initiative and a diabetes centre created 'knowledge banks' stored in a shared location (Christensen et al., 2019).

- Creation of a shared understanding of the social, organisational and political contexts of the sectors involved enabled an 'intersectoral point of view' between partners. (Tooher et al., 2017).
- Another study warned against applying internal organisational performance systems to external partners, which inevitably leads to disagreement and confusion (Wistow and Waddington, 2006).

Several studies noted the importance of practicing inter-organisational capacity building (Amed et al., 2015, Asada et al., 2019, Bachmann et al., 2009, Tugwell and Johnson, 2011, Vogel et al., 2005) and mutual learning between partner actors (Tugwell and Johnson, 2011). Other examples included:

- Two studies (Storm et al., 2016) stated the importance of aligning partnership with the core business of both partner organisations, including identifying areas of overlap to focus on.
- Lack of understanding and acceptance of interdependence between organisational partners (Kingsnorth, 2013) or 'siloed' ways of working (Erens et al., 2020) created barriers to partnership facilitation.
- Actions that reflected self-justification and blame between partners (Wistow and Waddington, 2006), or set agendas with the goal of conflict avoidance rather than resolution (Visram et al., 2021), were identified as organisational qualities that did not facilitate successful partnerships.

The qualities that individual people brought to the partnerships were key to the very functioning of them. Enabling qualities included:

- Individual skills aligning with the needs of the partnership (Bachmann et al., 2009) including strong leadership skills, (Leurs et al., 2008) a history or experience within the partnership, strong communication skills, and interpersonal skills such as empathy and insight (Tooher et al., 2017).

Conversely, relying on individuals as the sole drivers of a partnership (e.g. champions), or personal relationships as facilitators of the partnership created a barriers to sustainability (Tooher et al., 2017).

Governance and policy

National or local policies and legislation were identified as potential facilitating (or challenging) factors for partnerships. In particular:

- Polices which aligned with or enabled partnership goals with partnership success (Bachmann et al., 2009, Sestoft et al., 2014, Tooher et al., 2017, Visram et al., 2021, Wistow and Waddington, 2006) as well as policies that supported partnership funding (Chen et al., 2012).
- However, conflicting sectoral agendas (Tooher et al., 2017, Wistow and Waddington, 2006) and party politics or sector reorganisation (Bachmann et al., 2009, Miro et al., 2014, Warwick-Giles et al., 2016, Amed et al., 2015, Kjelle et al., 2018) were identified as barriers to effective partnerships.

Leadership and representation were also facilitating factors for partnerships. This included:

- Formal and informal leadership who advocate for the partnership (Asada et al., 2019, Leurs et al., 2008).
- The presence of local leaders, establishing community trust and equal representation on the boards of partnerships were beneficial (Bachmann et al., 2009).

The focus of the partnership can also contribute to its success. When there was a strong focus on one sector or discipline e.g. health (Christensen et al., 2019) or planning (Mantoura et al., 2007) and a segmented approach (Jabot et al., 2020), it limited the effectiveness of the partnership. One study found that the strongest motivators for intersectoral action is for public service rather than profit incentives of organisations (Bachmann et al., 2009).

Organisational level factors identified as facilitators to effective partnerships included:

- Change readiness within organisations to support the partnership as a key driver (Asada et al., 2019, Vogel et al., 2005, Wistow and Waddington, 2006, Leurs et al., 2008, Tugwell and Johnson, 2011) and willingness to take risks (Wistow and Waddington, 2006).
- One study highlighted the benefits of similarities between organisational culture, specifically the overlap between two government agencies supported the collaboration (Vogel et al., 2005). Another paper reiterated this finding, stating that mismatched organisational cultures can lead to major incompatibilities, creating inherent barriers to forming and implementing partnerships (Wistow and Waddington, 2006).
- One paper stressed the significant amount of power that the ‘champions’ or identified positions can have over the momentum of projects, both in the planning and implementation (Amed et al., 2015).

Conversely, from an organisational perspective, unwillingness to share information (Bachmann et al., 2009) and current policies and/or unwillingness to change policies (Kingsnorth, 2013, Vogel et al., 2005) prevented partnership activities thus limiting the effectiveness of the partnership.

Evaluation and measures of success in partnerships

Evaluation, including accountability and measures of success are important in the functioning and eventual success or failure of a partnership, these included:

- Several studies noted the need for a shared understanding and agreement of how success should be measured and reported (Amed et al., 2015, Chen et al., 2012). This included agreeance on what should and shouldn't be considered evidence (Tooher et al., 2017) whether that be service delivery measures (Kisely et al., 2010), network analysis (Chen et al., 2012), integration of health into policies (Vogel et al., 2005, Christensen et al., 2019), surveying leaders of management (Bachmann et al., 2009) or health outcomes (Bachmann et al., 2009, Tooher et al., 2017).
- Partnerships were not able to demonstrate tangible outcomes where goals had a longer-term focus with no clear or achievable outcomes (Christensen et al., 2019, Visram et al., 2021) or those focusing on single health or social outcomes (Bachmann et al., 2009) and resource intensive behaviour-change programs (Tooher et al., 2017).

Two papers identified specific tools that could be utilised in measuring the success of partnerships. One noted the Theory of Change model to demonstrate structural change (Asada et al., 2019), another utilised the Partnership Assessment Tool (PAT) (Hardy et al, 2000; Hardy et al, 2003) to analyse an integration of health and social care.

From a project management perspective, one study suggested identifying action items and plans to follow up at each meeting as an approach to both continue the momentum of the partnership and to ensure it remains accountable (Amed et al., 2015).

Framework

As a result of the scoping review, a framework was developed to describe the factors that contribute to successful and unsuccessful partnerships between local government and health organisations in high income countries. This framework provides the 'gold standard' of partnerships between local government and health organisations. The framework (Table 1) organises functional, organisational, individual and external factors that impact partnerships and provides the evidence of enablers and constraints on partnerships.

Table 2: Framework- Factors contingent to successful & unsuccessful partnerships between local government & health organisations in high-income countries

	Funding & resources	Partnership qualities	Governance & policy	Examples of evaluation measures	
Functional aspects of the partnership	Funding of joint position(Amed et al., 2015, Asada et al., 2019) or allocated human resources to partnership(Chen et al., 2012, Bachmann et al., 2009, Miro et al., 2014, Vogel et al., 2005)	Fostering trust, transparency & relationship building between partners (and partner leaders(Wistow and Waddington, 2006)) and their representative actors (Sestoft et al., 2014, Warwick-Giles et al., 2016, Bachmann et al., 2009, Christensen et al., 2019, Tooher et al., 2017, Tugwell and Johnson, 2011, Vogel et al., 2005, Amed et al., 2015, Mantoura et al., 2007)	Policies to support partnership funding (Chen et al., 2012)	A shared measurement system with agreement of how success is measured & reported (Amed et al., 2015, Chen et al., 2012)	**SUCCESSFUL PARTNERSHIP**
	Joint commission/pooled budgets(Bachmann et al., 2009, Wistow and Waddington, 2006, Kjelle et al., 2018)	Clear, open, continuous and equal channels of communication,(Tooher et al., 2017, Warwick-Giles et al., 2016, Amed et al., 2015) smaller sub-group meetings created safer spaces to talk,(Visram et al.) constructive criticism(Warwick-Giles et al., 2016) or debate(Wistow and Waddington, 2006)	Strong formal & informal leadership advocating for the partnership (Asada et al., 2019, Leurs et al., 2008)	Theory of Change as evaluation tool (Asada et al., 2019) Identifying action items and plans to follow up at each meeting (Amed et al., 2015)	
	Willingness to secure external funding to support partnership(Kjelle et al., 2018, Vogel et al., 2005)	Collaboratively developed partnership goal(Chen et al., 2012), action plan (Amed et al., 2015, Mantoura et al., 2007, Wistow and Waddington, 2006) or agenda (Warwick-Giles et al.,	Boards representing partnerships are equally representative (Bachmann et al., 2009)	Surveying leaders or managers (Bachmann et al., 2009)	

		2016, Tooher et al., 2017, Wistow and Waddington, 2006)			
	Invest funding in building relationships(Amed et al., 2015, Bachmann et al., 2009)	Shared vision, message ,(Amed et al., 2015, Warwick-Giles et al., 2016) enthusiasm, (Sestoft et al., 2014) respect (Visram et al.), and focus on vertical collaboration (Kirchhoff and Ljunggren, 2016)		Service delivery measures (if applicable) (Kisely et al., 2010)	
	Facilitating trust through resource-neutral collaborations(Sestoft et al., 2014)	Partnership based on local needs (Visram et al.) and connections in local communities (Amed et al., 2015)		Partnership Assessment Tool (Hardy, 2000)(Wistow and Waddington, 2006)	
		Conflict resolution mechanisms (Mantoura et al., 2007, Tooher et al., 2017)		Partnership effectiveness evaluated through networks built & ongoing sustainability (Chen et al., 2012)	
		Flexible approach (Sestoft et al., 2014, Visram et al., Vogel et al., 2005, Mantoura et al., 2007)			
		Interdisplinary (Mantoura et al., 2007, Greaux et al., 2020)			
	Lack of sustainable partnership funding(Asada et al., 2019, Chen et al., 2012, Tooher et al., 2017, Vogel et al., 2005, Warwick-Giles et al., 2016, Dennis et al., 2015)	Unequal power between partner representatives, hierarchical relationships (Mantoura et al., 2007, Visram et al., Kirchhoff and Ljunggren, 2016, Wistow and Waddington, 2006)	Strong focus on one aspect or discipline e.g. health (Christensen et al., 2019) or planning (Mantoura et al., 2007) and a segmented approach (Jabot et al., 2020)	Singular focus on improvement in health or social outcomes (Bachmann et al., 2009)	UNSUCCESSFUL PARTNERSHIP
	Poor management of integrated services(Wistow and Waddington, 2006)	Prioritises structural approaches at the cost of relationship building (Wistow and Waddington, 2006)		Long-term goals without achievable/clear outcomes (Visram et al., Christensen et al., 2019)	
	Funding existing initiatives in one partnership sector(Amed et al., 2015)	Differing expectations of workload (Vogel et al., 2005)		Differing understandings of how to measure effectiveness (Chen et al., 2012) or what counts as 'evidence' (Tooher et al., 2017)	

	Oversight of partnership costly(Vogel et al., 2005)	Poor management or administration of partnership (Vogel et al., 2005, Chen et al., 2012)		Resource intensive behaviour-change programs (Tooher et al., 2017)	
	Funding & resources	**Partnership qualities**	**Governance & policy**	**Evaluation & measures of success**	
Organisational factors impacting partnership	Funding of integrated services between partners(Bachmann et al., 2009)	Enabling information creation & sharing between partners (Bachmann et al., 2009, Mantoura et al., 2007) e.g knowledge banks stored in shared location(Christensen et al., 2019)	Change readiness & action within organisations to support partnership (Asada et al., 2019, Vogel et al., 2005, Wistow and Waddington, 2006, Leurs et al., 2008, Tugwell and Johnson, 2011)	Policy changes that foster uptake of health and equity (Vogel et al., 2005)	**SUCCESSFUL PARTNERSHIP**
		Identify areas of overlap between partners/sectors (Storm et al., 2016)	Organisations with clear systems of management, finance, & information (Bachmann et al., 2009)	Health equity as organisational goal e.g Health in All Policies (Christensen et al., 2019)	
		Aligning partnership with organisational core business (Tooher et al., 2017)	Organisational willingness to take risks (Wistow and Waddington, 2006)		
		Shared understanding of the social, organisational and political contexts of the sectors involved (Tooher et al., 2017)	Similarities in organisational culture between partners (Vogel et al., 2005)		
		Inter-organisational capacity building (Amed et al., 2015, Asada et al., 2019, Bachmann et al., 2009, Tugwell and Johnson, 2011, Vogel et al., 2005) & mutual learning (Tugwell and Johnson, 2011)	Internal communication about policy decisions & directions (Tooher et al., 2017)		
			Power given to joint position (Amed et al., 2015)		
			Public service rather than profit organisational incentives (Bachmann et al., 2009)		

	Lack of common information systems (Kjelle et al., 2018)	Historical organisational baggage blocking change (Wistow and Waddington, 2006)	No statutory power within partnership (Visram et al.)		UNSUCCESSFUL PARTNERSHIP
		Lack of understanding and acceptance of interdependence between organisational partners (Kingsnorth, 2013) or 'siloed' ways of working (Erens et al., 2020)	Differences in organisational culture (Wistow and Waddington, 2006)		
		Self-justification & blame between partners (Wistow and Waddington, 2006)	Lengthy agendas and infrequent meetings with no minutes reported (Visram et al., 2021)		
		Agenda setting with the goal of conflict avoidance (Visram et al., 2021)	Unwillingness to share information, confidentiality concerns (Bachmann et al., 2009)		
		Applying internal organisational performance systems to external partners (Wistow and Waddington, 2006)	Current policies and/or unwillingness towards policy change preventing partnership activities (Vogel et al., 2005, Kingsnorth, 2013)		
	Funding & resources	**Partnership qualities**	**Governance & policy**	**Evaluation & measures of success**	
Individual factors impacting partnership		Individual skills aligned to the needs of partnership (Bachmann et al., 2009) e.g leadership, (Leurs et al., 2008) history & experience (Tooher et al., 2017)			SUCCESSFUL
		Interpersonal skills – empathy, insight (Tooher et al., 2017)			
		Strong interpersonal communication (Tooher et al., 2017)			

		Relying on individual 'champions' or personal relationships to facilitate partnership (Tooher et al., 2017)			UNSUCCESSFUL
	Funding & resources	**Partnership qualities**	**Governance & policy**	**Evaluation & measures of success**	
External factors impacting partnership		Builds on existing partnerships in that social/community context (Asada et al., 2019)	National or local policy/legislation aligned to or enabled partnership goals (Wistow and Waddington, 2006, Bachmann et al., 2009, Tooher et al., 2017, Visram et al., Sestoft et al., 2014)		SUCCESSFUL
			Presence of enthusiastic local leaders (Bachmann et al., 2009)		
			Community trust (Bachmann et al., 2009)		
			Conflicting sectoral agendas at higher levels of government (Tooher et al., 2017, Wistow and Waddington, 2006)		UNSUCCESSFUL
			Party politics or sector reorganisation preventing partnership engagement (Bachmann et al., 2009, Miro et al., 2014, Warwick-Giles et al., 2016, Amed et al., 2015, Kjelle et al., 2018)		
			Poor awareness/prioritisation of health equity among policymakers (Storm et al., 2016)		

Document Review

A total of 37 documents across the four council partners were included in the review. Included documents ranged from the MoU itself, work-plans, position descriptions, evaluation reports, implementation plans, guidelines and policy documents. The document review findings are in line with the literature from the scoping review and its associated framework. The most frequently mentioned factors were in relation to collaboration including;

- Having a **joint governance structure** for example the governance of the partnership being managed through executive level steering committee with representatives from all partner organisations;
- **Integration** with a main focus on embedding health and wellbeing into council processes;
- **Joint objectives, priorities, values and vision** for example partners working together to improve the health and wellbeing of the local community;
- **Clear communication** including a commitment to effective communication and information sharing across multiple channels and;
- **Conflict resolution processes** having approaches for resolution at a local level to avoid escalation.

Other frequently mentioned (but to a lesser extent) factors included:

- funding (joint resourcing);
- The importance of monitoring and evaluation, formal work plans and measurable outcomes.

There were no major differences in documentation between each of the councils' documents. Each of the MoU documents were relatively similar. Work-plans, position descriptions and implementation plans had variations based on the specific role. With regards to the documents provided, only one out of the four MoUs had evaluation plans available for review.

Program Logic

A series of meetings were held with each of the MoUs stakeholder groups to discuss program logic and its application for their work. At the first meeting, stakeholders were presented with background information around theory of change and program logic, including the presentation of multiple program logic templates. At this stage, it was decided that two of the four MoUs were at a stage where developing a program logic would be appropriate and useful. Of the two that progressed with the program logic, additional meeting/workshops were held (a total of three each). These meetings were spent working through a chosen program logic template (Studies, 2022) together to incorporate

the MoU document and associated work-plans. In between meetings, CHETRE staff would further develop the program logic to reflect the ongoing discussions, with updated program logics circulated prior to each meeting. After the third meeting, the final draft of the program logic was shared with the stakeholders to provide final edits.

The resulting program logics from Liverpool and Campbelltown (see pages 27-35 and 36-44) provide detailed descriptions of specific projects/activities of the shared MoUs including the following information:

- Definition of the MoU and its desired results
- Program boundaries
- Inputs, including any resourcing required for the project/activity
- Outputs, describing the activity and who is involved
- Outcomes, describing what will change as a result of the activity, these were organised by short (12 month), medium (3-5 years) and long (5+) term outcomes of the activity
- Assumptions about how/why the program would work. It should be noted that for both Liverpool and Campbelltown, outcomes were beyond the current term of the MoU, so were therefore aspirational pending MoU renewal
- External factors impacting the MoU that are beyond its control

These program logics are intended to be 'living documents', to be continually edited and updated. It is anticipated that a workshop will be held with all of the stakeholders across the four MoU's to present the completed program logics and receive feedback. The two councils who participated in the program logic development reflected on the process and described it as a useful capacity building activity for those involved.

Program Logic: Liverpool City Council and SWSLHD Urban Design Partnership Logic Model

1. Define situation and desired results

The purpose of the MoU is to deliver Urban Design projects and programs of work, with a focus on embedding healthy place making principles into the planning and infrastructure work that Council undertakes that will lead to long term health benefits for the communities within the Liverpool LGA. This includes the following:

- co-design healthy places and spaces that help minimise preventable disease and support physical and mental wellbeing in the Liverpool Local Government Area (LGA);
- place people and their needs at the centre of the planning and design process for the Liverpool LGA; and
- to influence and shape the development of increased and improved active and public transport, physical activity, social connectivity, reduced urban temperatures and the development of safe and people-oriented places and spaces within the Liverpool LGA.

The general scope of the position that is employed to support the MoU implementation is as follows:

1. Preparing strategic design documents (e.g., policies, plans, strategies, studies, guidelines and manuals) that integrate and promote healthy place making principles.
2. Completing referrals for Development Applications (e.g., referrals for State Significant Developments, Pre-Planning Proposals, Planning Proposals, Pre-Development Applications, Development Applications, and/or Voluntary Planning Agreements) with references to healthy place making principles.
3. Providing specialist advice and input into planning and infrastructure projects that are being completed by other teams within Council, the NSW Government, and/or other organisations.
4. Preparing Concept Plans, Project Briefs and other project management documents, to guide the execution of infrastructure projects that achieve healthy place making outcomes, by other teams in Council; and
5. Preparing grant funding applications, for infrastructure projects that will be executed by other teams in Council.

2. Establish program boundaries

- Urban Design focus
- Timeframe (3 years)
- Co-funded positions that sit with Council (4 days per week), SWSLHD (1 day per week)
- Steering group (Refer to Steering Committee Terms of Reference)
- Other stakeholders
- Work-plan, developed by both organisations (Refer to Current Work plan), with flexibility to accommodate changing priorities (e.g., grant funding opportunities that may arise)

3. Explore potential solutions

Inputs	Outputs		Outcomes		
	Activities	*Participation*	*Short (12 months)*	*Medium (2-5 years)*	*Long (5+ years)* ▪ *Public domain outcomes* • *health outcomes*
Current Projects (leading)					
Resources • Urban Designer • Time • Collaboration	Review and implementation of the Western Sydney Street Design Guidelines	Senior Healthy Places Urban Designer, HPPU, internal stakeholders	Develop and finalise draft guidelines • The document incorporates the 'Healthy Streets' Approach and other best practice healthy place making design principles.	Stakeholder engagement and adoption • The document is completed and endorsed by Council Integration into planning documents/processes • The document is used to guide the design of streets within the LGA, by Council, private developers and other agencies/ organisations.	▪ Improved street design results in increased healthy behaviours including participation in active transport, walking and cycling, perception of safety, increased foot traffic. • Reduced prevalence of non-communicable diseases • Increased mental wellbeing and social connectivity • Reduced incidence of active transport related injuries (road trauma)
Resources • Urban Designer • Time • Collaboration	Writing the Design Guidance Chapter of the Liverpool City Centre Public Domain Technical Manual	Urban designer, HPPU, internal stakeholders, Population Health	Develop draft technical manual • Technical design and standards for public domain infrastructure contributes to achieving healthier environment • Technical manual reflects best industry practice	Finalisation of technical manual (along with stakeholder engagement) Integration into planning documents/processes • Technical manual adopted and used by internal departments/teams to guide design works & assess DA's	▪ Improved design of public spaces that positively impacts the health and wellbeing of the community.
Resources • Urban Designer	Front end Planning / Design for Liverpool City Centre Priority Projects	Urban Designer, HPPU, internal and external stakeholders	Planning/design works • Front end planning and design is completed on specific projects, and	Planning/design works reflect integration of health considerations	▪ Design of places and spaces incorporate healthy streets approach and other best practice

Inputs	Outputs		Outcomes		
	Activities	***Participation***	***Short (12 months)***	***Medium (2-5 years)***	***Long (5+ years)*** ▪ ***Public domain outcomes*** • ***health outcomes***
• Time • Funding application(s) (money)	(Moore Street, Scott Street, Norfolk Serviceway, Georges River Activation Plan, Brickmakers Creek Master Plan, MUSIC Model for the Liverpool CBD)		handed over to the relevant teams for development of the Detailed Design	Funding sort to deliver projects	place making design principles ▪ Improved street design for encourages healthy behaviours including, increased participation in active transport, increased walking and cycling, improved perception of safety, increased foot traffic. • Reduced prevalence of non-communicable diseases • Increased mental wellbeing and social connectivity • Reduced incidence of active transport related injuries (road trauma)
Resources ▪ Urban Designer ▪ Time ▪ Funding application(s) (money)	Development of a Tree Management Framework for Council (Review of Tree Management Policy, Update to Tree Management Controls in DCP, and development of a Tree Management Strategy and Tree Management Plan, subject to grant funding from NSW Government)	Urban Designer, internal stakeholders	Execution of project(s)- project briefs will be developed The following projects are delivered; Review of Tree Management Policy, Update to Tree Management Controls in DCP, and development of a Tree Management Strategy and Tree Management Plan (subject to grant funding from NSW Government). If funding is not obtained, some of the work will be completed using in-house resources, and other funding will be sourced to execute these projects, as relevant opportunities arise.	Execution of project(s)- project briefs will be developed Previously mentioned documents are completed and adopted by council and are used by council, private developers and the community to guide design making related to trees within the LGA	▪ Improved and increased canopy cover across the Liverpool LGA ▪ Increased shade and shelter across the Liverpool LGA ▪ Cooler temperatures across the Liverpool LGA ▪ Increased and improved habitat for wildlife across the Liverpool LGA, through increased tree canopy cover • Reduced incidence of climate related illness

Inputs	Outputs		Outcomes		
	Activities	***Participation***	***Short (12 months)***	***Medium (2-5 years)***	***Long (5+ years)*** ▪ ***Public domain outcomes*** • ***health outcomes***
Resources • Urban Designer • Time • Collaboration	Complete referrals for proposed Private Development within the Liverpool LGA, including advice focused on addressing urban heat, active transport, pandemic proofing, and social connectivity (e.g., Providing Urban Design and Healthy Place making advice, through completing referrals for Pre-Development Applications, Planning Proposals and State Significant Developments within 14 days, using relevant best practice tools / criteria)	Urban Designer, private developers	Urban design and healthy place making advice provided at early stages of DA's and significant developments, leading to improved design outcomes from a healthy place making perspective in the subsequent applications	Healthy place making checklist developed and used in DA referrals resulting in improved design outcomes from a healthy place making perspective	▪ An inventory of practical and achievable Standard Clauses / Conditions of Consent is developed and is used in the assessment of Development Application referrals. ▪ Improved design of new developments, that deliver health and wellbeing benefits for the occupants, and other users of the developments ▪ Developments that better address the public domain, and provide increased and improved amenity and benefit to the public domain ▪ Decreased urban heat effect in new developments ▪ Increased active transport ▪ Improved responses to pandemics • Increased social connectivity and mental wellbeing • Reduced prevalence of non-communicable diseases • decreased transport related injuries i.e., road trauma)

Inputs	Outputs		Outcomes		
	Activities	*Participation*	*Short (12 months)*	*Medium (2-5 years)*	*Long (5+ years)* ▪ *Public domain outcomes* • *health outcomes*
Resources ▪ Urban Designer ▪ Time ▪ Funding application(s) (money) ▪ Collaboration	Prepare Grant Funding Applications for projects/ initiatives that will deliver on Healthy Place making & Urban Design Outcomes (e.g., DPE's 'Greening our Neighbourhoods' program)	Urban Designer, HPPU, Population Health, internal and external stakeholders	Grant funding applications for healthy place making are prepared with input from specialist healthy place making skills and expertise (including Population Health staff) and tools	▪ Successful grant funding applications ▪ Projects are delivered	▪ Increased and improved public spaces that will provide health and wellbeing benefits for the community ▪ Improved street design for encourages healthy behaviours including, increased participation in active transport, increased walking and cycling, improved perception of safety, increased foot traffic. • Reduced prevalence of non-communicable diseases • Increased mental wellbeing and social connectivity • Reduced incidence of active transport related injuries (road trauma)
Current projects (contributing)					
Resources ▪ Urban Designer ▪ Time ▪ Collaboration	Provide Urban Design/Healthy Place making comments on major Federal, NSW Government, and Council led planning and infrastructure projects, located in the Liverpool Local Government Area (LGA) advice focused on urban heat, active transport, pandemic proofing and social connectivity.	Urban Designer, internal and external stakeholders	• Urban design and health place making advice provided on major federal, state and council led planning and infrastructure projects • Advice is consistent with best industry practice and design for healthy place making	• Advice successfully informs direction of project, demonstrated in improved outcomes from healthy place making perspective of each project • An inventory of industry best-practice guidelines/tools in Urban Design and Healthy Place	▪ Improved planning instruments / tools, to facilitate healthy place making outcomes ▪ Infrastructure projects delivered that result in healthier places and spaces for the community ▪ Decreased urban heat effect in new developments

Inputs	Outputs		Outcomes		
	Activities	*Participation*	*Short (12 months)*	*Medium (2-5 years)*	*Long (5+ years)* ▪ *Public domain outcomes* • *health outcomes*
	(e.g., Edmonson Ave Upgrade, Denham Court Road Upgrade, Moore Point Place making Working Group, Sydney Metro Western Sydney Airport Line / Corridor Design, DCP Review)			making is developed. • This is shared with colleagues within and outside the team, for guiding future projects	▪ Increased active transport ▪ Improved responses to pandemics • Increased social connectivity and mental wellbeing • Improved street design for encourages healthy behaviours • Reduced incidence of active transport related injuries (road trauma)
Resources ▪ Urban Designer ▪ Time ▪ Collaboration	Collaborate with the SWSLHD Healthy Places team to organise the Western Sydney Healthy Place making Event, including presenting on healthy place making projects and opportunities	Urban Designer, HPPU, other SWSLHD / Council Partnership Officers	The annual South Western Sydney Healthy Places Forum event is successfully hosted. Knowledge exchange, collaboration and networking occurs	The knowledge shared / gained informs work undertaken by the partnership roles. New networks are utilised to troubleshoot issues, continue to share information.	The knowledge shared / gained continues to inform work undertaken by the partnership roles. The knowledge shared leads to increased promotion of the importance of healthy place making.
Resources ▪ Urban Designer ▪ Time ▪ Collaboration	Attend and actively contribute to a minimum of 4x educational sessions / workshops per calendar year, to gain and share the latest and best-practice, knowledge related to Urban Design and Healthy Place making (e.g., Healthy Streets Training, Resilience Sydney Workshops)"	Urban Designer, internal stakeholders	Knowledge, skills and expertise gained and applied to work	Knowledge skills and expertise shared with colleagues	Knowledge, skills and expertise gained informs projects being delivered
Future Potential Projects / Programs (Leading or Contributing)					

Inputs	Outputs		Outcomes		
	Activities	***Participation***	***Short (12 months)***	***Medium (2-5 years)***	***Long (5+ years)*** ▪ ***Public domain outcomes*** • ***health outcomes***
Resources ▪ Urban Designer ▪ Time ▪ Funding application(s) (money) ▪ Collaboration	Liverpool Suburbs Character Area and Public Domain Study	Urban Designer, internal stakeholders	The Study successfully establishes a baseline of Character and healthy place making information, across the LGA	Strategies to respond and deliver healthy place making across the LGA	▪ Study used in departments to inform design decisions and to support grant funding applications ▪ Improved street design for encourages healthy behaviours including, increased participation in active transport, increased walking and cycling, improved perception of safety, increased foot traffic. • Reduced prevalence of non-communicable diseases • Increased mental wellbeing and social connectivity • Reduced incidence of active transport related injuries (road trauma)
Resources ▪ Urban Designer ▪ Time ▪ Funding application(s) (money) ▪ Collaboration	Liverpool Public Domain and Urban Design Development Application Manual	Urban Designer, DA applicants	Healthy place making requirements are included in the manual	Manual adopted and used by applicants to submit DA's	▪ Improved design and healthy place making outcomes ▪ Improved street design for encourages healthy behaviours including, increased participation in active transport, increased walking and cycling, improved perception of safety, increased foot traffic. • Reduced prevalence of non-communicable diseases

Inputs	Outputs		Outcomes		
	Activities	***Participation***	***Short (12 months)***	***Medium (2-5 years)***	***Long (5+ years)*** ▪ ***Public domain outcomes*** • ***health outcomes***
					• Increased mental wellbeing and social connectivity • Reduced incidence of active transport related injuries (road trauma)
Resources ▪ Urban Designer ▪ Time ▪ Funding application(s) (money) ▪ Collaboration	Liverpool City Centre & Liverpool LGA Signage and Wayfinding Manuals (Draft), including promoting active and public transport	Urban Designer, external consultants	Manual incorporates signage and wayfinding mechanisms to support healthy urban environments and encourage active and public modes of transport	Manual adopted and utilised	▪ Improved environment that supports health • Reduced prevalence of non-communicable diseases • Increased mental wellbeing and social connectivity • Reduced incidence of active transport related injuries (road trauma)
Resources ▪ Senior Healthy Places Urban Designer ▪ Time ▪ Funding application(s) (money) Collaboration	Various equity focussed projects and initiatives that help achieve a more equitable urban environment	Senior Healthy Places Urban Designer, internal stakeholders	Equity related projects are initiated Equity related advice and input is provided into collaboration projects	Equity related projects are delivered Equity related advice and input provided into collaboration projects has informed the development of the projects	• More equitable access to shade and shelter • More equitable access to cooler urban environments • More equitable access to water and air-conditioned facilities • More equitable access to open space • Reduced health disparities

Assumptions	• Collaborative approach with main mechanism being the Senior Healthy Places Urban Designer position, with support of Council's City Design and Public Domain team, and SWSLHD Healthy Places team • Additional projects to be added in future • Future potential projects are aspirational • Ongoing activities may not have specific timelines • 3 + years outcomes are indicative and aspirational (pending additional MoUs) • Outcomes need to be within the scope of the City Design and Public Domain team's work
External Factors	State level legislation, developer interest and resources, politics

Program: **Campbelltown City Council and SWSLHD Joint Position: Urban Strategist – Healthy Places, Logic Model April 2022**

1. Define situation and desired results

Working together to improve the health and wellbeing of the community of Campbelltown through the built environment.
The Health Partnership will provide a structure and opportunities for:

- Joint planning
- Development of collaborative initiatives
- Sharing of information, expertise and pooling of resources
- Identifying and utilizing opportunities to gather data on emerging health trends/issues
- Identifying proposals for future improvements to the built environment in the Campbelltown Local Government Area that can facilitate opportunities for better liveability and human health outcomes
- Adding value to projects and initiatives through a health-in-planning lens

2. Establish program boundaries

- Timeframe: 1 year (with possible extension subject to approval and funding from both organisations)
- Co-funded Partnership Officer (CCC provides all management, organisational and physical resources)
- Work plan- 12-month operational plan outlining objectives, strategies, budget, team members, project partners and outcomes for that financial year (or 12-month period from commencement of officer)
- Partnership steering committee

3. Explore potential solutions

Inputs (Resources)	Outputs		Outcomes		
	Activities (Work Plan)	*Participation (Project Team)*	*Short (12 months)*	*Medium (3-5 years)*	*Long (5+ years)* ▪ *organisational outcomes* • *health outcomes*
Resources • Urban Strategist - Healthy Places • Time • Money • Program costs necessary to deliver the agreed work plan • Partnership steering committee	Healthy streets assessment/design check	Urban Strategist - Healthy Places, SWSLHD Healthy Places (Population Health), Council stakeholders	One street has had a healthy streets assessment/design check conducted and concept plan completed. Any relevant grant funds acquitted.	Healthy streets principles embedded into Council's strategic planning and key design controls.	▪ Improved street design for encouraging healthy behaviours • Reduced prevalence of non-communicable diseases • Increased mental wellbeing and social connectivity • Reduce incidence of active transport related injury (road trauma) • Reduced prevalence of climate related illness

Inputs (Resources)	Outputs		Outcomes		
	Activities (Work Plan)	*Participation (Project Team)*	*Short (12 months)*	*Medium (3-5 years)*	*Long (5+ years)* ▪ *organisational outcomes* • *health outcomes*
Resources • Urban Strategist - Healthy Places • Time • Money • Program costs necessary to deliver the agreed work plan • Partnership steering committee	Review the Campbelltown LSPS 2020 from a health perspective to inform the upcoming review of this document	Urban Strategist - Healthy Places, SWSLHD Healthy Places (Population Health), Council stakeholders	Campbelltown LSPS reviewed against the Healthy Built Environment checklist and healthy place making principles	LSPS review considers findings of health perspective review of the 2020 document ▪ Clearer articulation of desired health outcomes in high-level local strategy to guide the future of Campbelltown LGA	▪ Clearer articulation of desired health outcomes in high-level local strategy to guide the future of Campbelltown LGA • Reduced prevalence of non-communicable diseases • Increased mental wellbeing and social connectivity • Reduce incidence of active transport related injury (road trauma) • Reduced prevalence of climate related illness

Inputs (Resources)	Outputs		Outcomes		
	Activities (Work Plan)	*Participation (Project Team)*	*Short (12 months)*	*Medium (3-5 years)*	*Long (5+ years)* ▪ *organisational outcomes* • *health outcomes*
Resources • Urban Strategist - Healthy Places • Time • Money • Program costs necessary to deliver the agreed work plan • Partnership steering committee	Healthy built environment checklist	Urban Strategist - Healthy Places, SWSLHD Healthy Places (Population Health), Council stakeholders	Preparation of a Healthy Built Environment checklist and consideration of healthy place making principles.	Healthy built environment checklist informs and/or incorporated into relevant Council projects and planning documents and is being used (LEPs, DCPs and guidelines, as relevant).	▪ Improved built environment to foster liveability and provide opportunities for healthy activities • Reduced prevalence of non-communicable diseases • Increased mental wellbeing and social connectivity • Reduce incidence of active transport related injury (road trauma) • Reduced prevalence of climate related illness

Inputs (Resources)	Outputs		Outcomes		
	Activities (Work Plan)	*Participation (Project Team)*	*Short (12 months)*	*Medium (3-5 years)*	*Long (5+ years)* ▪ *organisational outcomes* • *health outcomes*
Resources • Urban Strategist - Healthy Places • Time • Council funding • Partnership steering committee	No Smoking Policy with a focus on improving CBD public places, amenity and user experience	Urban Strategist - Healthy Places, Manager City Marketing and Economy, SWSLHD Healthy Places (Population Health), Council stakeholders, local businesses and Chamber of Commerce	A draft 'no smoking' policy for Campbelltown CBD (pending findings from the engagement and consultation) is adopted by CCC	No smoking policy developed and implemented.	▪ Reduced smoking in Campbelltown CBD ▪ Increased amenity within the CBD/creation of more appealing places ▪ CBD is a more inclusive place for all people • Reduced smoking related illness

Inputs (Resources)	Outputs		Outcomes		
	Activities (Work Plan)	*Participation (Project Team)*	*Short (12 months)*	*Medium (3-5 years)*	*Long (5+ years)* ▪ *organisational outcomes* • *health outcomes*
Resources • Urban Strategist - Healthy Places • Time • Money • Program costs necessary to deliver the agreed work plan • Partnership steering committee	Working collaboratively with local Aboriginal and Torres Strait Islander stakeholders to identify ways to incorporate Designing with Country principles into Council's strategic planning, city design processes, and the built environment. Incorporate Designing with Country principles into strategies for healthy place-making	Urban Strategist – Healthy Places, City Design Specialist, Aboriginal Community Development Officer, SWSLHD Healthy Places (Population Health), Council, Local Aboriginal and Torres Strait Islander stakeholders	Report capturing case studies of best practice and recommendations for practical strategies to ensure that Aboriginal design elements are included in developments being planned within Campbelltown.	Process developed and implemented to incorporate Aboriginal design elements into design and planning. Develop an integrated approach to embedding Designing with Country principles into Council's strategic planning, city design processes, and the built environment, with the aim of improving community health.	▪ Newly designed/upgraded local places reflect local cultural elements ▪ Implement place-making principles in the built, natural and social environments, based on/aligned with Designing with Country principles, that contribute to overall health outcomes, including mental health and wellbeing and liveability for the Campbelltown community, including vulnerable populations. • Increased mental wellbeing and social connectivity • Reduced prevalence of climate related illness

Inputs (Resources)	Outputs		Outcomes		
	Activities (Work Plan)	*Participation (Project Team)*	*Short (12 months)*	*Medium (3-5 years)*	*Long (5+ years)* ▪ *organisational outcomes* • *health outcomes*
Resources • Urban Strategist - Healthy Places Time • Partnership steering committee	Assist in implementation of key actions from Campbelltown Health and Education Precinct (CHEP) working groups (work plans are currently being developed)	Urban Strategist - Healthy Places, WSHA, WPC councils	Evidence of contribution to the work of the WSHA through the working groups	Ongoing input into WSHA activities, and initiatives to develop the CHEP	▪ Health and wellbeing incorporated into decision-making in strategic planning • Improved active transport, movement and connection for improved health & wellbeing • Improved social, cultural and economic connection and participation
Resources • Urban Strategist - Healthy Places • Time • Partnership steering committee	Contributing to review and development of revised State level strategic plans	Urban Strategist - Healthy Places, Western Parklands City, GCC	Input to review of Region and District Plans by GCC prepared and submitted as required (subject to GCC timeframes and requirements)	Healthy planning principles and actions incorporated into Region and District plans (or clear evidence of submissions/advocacy in this regard)	▪ Continued alignment within council priorities and desired outcomes for creating healthy environments • Short- and medium-term actions implemented to improve health and wellbeing through changes to the built environment

Inputs (Resources)	Outputs		Outcomes		
	Activities (Work Plan)	*Participation (Project Team)*	*Short (12 months)*	*Medium (3-5 years)*	*Long (5+ years)* ▪ *organisational outcomes* • *health outcomes*
Resources • Urban Strategist - Healthy Places • Time • Partnership steering committee	Increasing Resilience to Climate Change Program	SWSLHD Population Health and Sustainability Manager/WSHA	Support the implementation of actions and recommendations from the Climate and Health Impact IRCC guidance document for Campbelltown and Council's own Resilience Hazard Assessment (as required)	Evidence of increased climate adaptation, mitigation and resilience activity in LGA	▪ Improved responses to adverse climate events • Reduced prevalence of climate related illness
Resources • Urban Strategist - Healthy Places • Time • Partnership steering committee	Equity Making a Healthy Built Environment accessible to everyone	Urban Strategist - Healthy Places, SWSLHD Population Health, Council and community stakeholders	Assist in developing guidelines and controls to enable delivery of healthy urban spaces with a focus on locational disadvantage	Identifiable examples addressing locational disadvantage in the LGA through healthy place making.	• Reduced health disparities

Assumptions	• Building upon existing relationships between SWSLHD and CCC, working collaboratively • anything beyond the 12 months (current MoU) is aspirational (pending additional MoUs/extension of current MoU)
External Factors	Legislative requirements, external partners, potential impacts from other external factors (beyond internal control)

Discussion

This report has detailed the process and findings from Phase 1. We found that:

- The MoUs structure (including associated documents) and functionality aligns with the international literature around building effective intersectoral partnerships.
- MoUs themselves identified the importance of monitoring and evaluation but were not explicit in how this should be done. It was clear that this level of detail was provided at a work-plan level in order to produce tangible outcomes on an activity basis. Program logic provided a higher order focus for the partnerships.
- All MoUs have a unique approach to their shared positions between health and council. There is a diversity in what each MoU aims to achieve and in what space. Different activities and approaches lead to different outcomes. For instance, strategic level planning as the main investment point in Council has different outcomes to when urban design or health promotion are the investment point.
- Program logic is important in the mapping out of how a program is expected to work, however formalised evaluation of the MoUs is needed.
- There are certain aspects of health and wellbeing that may be out of scope for each of the MoUs both in terms of length of time and the scope of commitment to resourcing the partnerships.
- When presented with the findings of the scoping and document reviews, the reference group agreed that all the factors were important however, additional work was needed to apply these factors to each local context.

The purpose of Phase 1 was to inform a longer-term in-depth evaluation in phase 2. To that end, the benefit to Phase 1 was threefold. First, we systematically demonstrated the broad range of factors identified in the literature about partnerships. Those factors were supported by the reference group as relevant and important (if somewhat academic) and should be captured (at a localised level) in the Phase 2 evaluation. Second, we analysed MoU related documents (MoU's, work-plans, evaluations etc.) which mirrored the factors that were found in the literature, showing that the partnerships are conforming to best practice. Third, we introduced and discussed program logic as an approach for each partnership to identify the core aspects to their work in terms of assumptions, resources, processes and activities, and short and longer-term outcomes. Each council found program logic to be useful. Due to timing factors, two councils, with support from CHETRE, developed logic models specific

to their MoU and partnership activities. Against our goal of developing a theory of change, the models were positive in specifying activities and a range of outcomes but needed more detail. The models were effective in linking specific activities to short, medium and long-term outcomes. However, the longer the timeframe, the less tangible the link between activities and outcomes, largely due to the realities of funding and support for the work (which did not extend beyond 1-3 years). Further, the models were limited in capturing unintended impacts of the partnership e.g., new ways of working and new (strategic) relationships. Overall, the logic models, supplemented with wider factors identified in the literature review, have provided a theory of change to the basis for a more detailed evaluation.

Formalised, longer-term outcome evaluation of the partnerships is recommended. Future evaluations should not be limited to the confides of specific articulated 'activities' of the MoU. Evaluations should consider the tasks specific benefits i.e., what is explicitly outlined in work-plans/program logics as well as indirect outcomes of the MoUs such as those that occur beyond documented work-plans i.e., partnership relationships, ad-hoc contributions to policy/plans. Evaluations should also consider the mutual benefits for both organisations. This Phase highlighted the capacity constraints that would arise when future evaluation is planned, as this would be in addition to the existing scope of work of the MoUs.

The Phase 2 evaluation will compare investments options and different activities across councils. That approach will reveal what type of impact and outcomes the specific partnerships are working towards. For instance, strategic planning, urban planning, urban design or health promotion investments will tilt activities towards different types of outcomes. Whether these can be achieved including whether equity can be fully addressed, will depend on the parameters of the investment, the assumptions or parameters around each MoU, and the activities developed. The lessons from that evaluation will be able to demonstrate whether the current investments in partnerships are able to influence population health outcomes, or whether these need to be more or less comprehensive within each partnership to achieve the population level changes that councils are in a position to impact on.

Recommendations

The following recommendations are based upon Phase 1 of the project presented in this report but contribute Phase 2 of this project:

1. Logic models clearly articulate the core aspects of partnerships from capturing core actions, deliverables, expected outcomes to articulating assumptions. The development of logic

models is best done to complement existing planned work and should be the focus of future evaluations.

2. Future evaluations should include the exploration of similarities and differences between the theory of change for each of the MoUs. This will enable important lessons in terms of what to invest in for which type of outcomes.
3. MoU's have the capacity to achieve targets to progress action towards shorter-term outcomes (often organisational impact type activities). Future evaluations should capture longer-term outcomes or burden of disease, in some cases, longer than the existing commitment to the partnership.
4. Different activities and approaches lead to different outcomes. For instance, strategic level planning as the main investment point in Council has different outcomes to when urban design or health promotion are the investment points. Future evaluation is important for each MoU to determine effectiveness of different approaches.
5. Whilst the program logics provide a good basis for evaluation of the MoUs, they only capture very specific activity-based outcomes. A full theory of change approach to evaluation should be adopted in order to capture the complexity within partnerships in terms of conditions and processes. Those additional dimensions will add important nuance to an evaluation that program logic cannot capture.
6. Any future evaluation should incorporate unintended impacts of the MoU which occur beyond the scope of the position's specific activities within their work plan. Evaluations should also consider benefits for both organisations
7. The two councils who were not at the stage ready to develop a program logic should consider a similar process to develop an eventual evaluation framework to inform both future strategies and evaluations.
8. Any future evaluation should consider the mutual benefits for both organisations.
9. Given the capacity constraints with completing evaluation work that is in addition to existing scope of work, dedicated resourcing would be required to conduct future evaluation (e.g., competitive grant funding from NHMRC).

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