UNSW SYDNEY | Australia's Global University

Never Stand Still | Centre for Health Equity Training, Research and Evaluation

NSW GOVERNMENT Health
South Western Sydney Local Health District

# Evaluating the Implementation and Effectiveness of the Memoranda of Understanding between SWSLHD and Local Councils

Phase 2: Summary Report Realist Evaluation

March 2024

## Project Team

**Project Oversight:** Patrick Harris, Centre for Health Equity Training Research and Evaluation (CHETRE)

**Project Lead:** Karla Jaques, CHETRE

**Project Officer:** Raquiba Khan, SWSLHD Health Promotion

## Project Reference Group

Jennie Pry, SWSLHD Population Health

Maria Beer, SWSLHD Population Health

Karen Wardle, SWSLHD Health Promotion

David Czerniakowski, Campbelltown City Council

Susan Gibbeson, Fairfield City Council

Dany Ngov, Fairfield City Council

Ariz Ashraff, Liverpool City Council

Claudia Horna, Liverpool City Council

Christopher Browne, Wollondilly Shire Council

Edith Barnes, Wollondilly Shire Council

# Table of Contents

# 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 Local Health District (LHD) and four councils in the district / region have developed and are implementing Memorandum of Understanding (MoUs) with co-funded positions employed to support implementation of joint objectives that sit within each council and the LHD.

This current piece of research, a joint project between Centre for Health Equity, Training, Research and Evaluation (CHETRE), the Healthy Places Unit, Health Promotion Services, and the four councils, took a sophisticated real time approach to action research to better position intersectoral partnerships for health within local government.

This two-part project evaluated the implementation and effectiveness of Memoranda of Understanding (MOU) between SWSLHD and four Local Councils (Fairfield, Liverpool, Wollondilly and Campbelltown). Phase 1 of the project was completed in 2021-2022 and was focused 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 report for phase 1 is available here and a manuscript outlining the process and findings of phase 1 has been published here. This work was approved as a quality improvement project by SWSLHD Research and Ethics Office before commencing Phase 1.

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, were consulted with and verified preliminary findings throughout the process.

# Aims

The overarching 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 project evaluated the implementation and effectiveness of MoUs between SWSLHD and the four local councils, with the specific aim to evaluate:

1. The ability of the MoUs to result in indicators for sustainable, equitable health and wellbeing outcomes;
2. the different roles of health partnership MoUs in building reciprocal capability and collaborative advantage between two different organizations;
3. 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; and

4. ways to maximise the impact and scalability of the MoUs to other LGAs, LHDs and state government authorities.

# Methods

Phase 2 was focused on developing and conducting an action research evaluation and took place over 4 stages:

- Stage 1: Comparative case study
- Stage 2: Conduct the evaluation
- Stage 3: Revisit and refine theory of change across context, processes, mechanisms, impact and outcomes
- Stage 4: Reporting and dissemination

The document review from Phase 1 was also revised with updated documents in Phase 2. This report focuses on the findings of stage 2; primarily the stakeholder consultations and the updated document review.

The following data was collected and analysed during Phase 2:

- Updated documents to review against framework
- Interviews with key LHD, Council and other stakeholders
- Interviews with co-funded positions

## Stakeholder Consultations

Semi-structured interviews were conducted with key stakeholders from SWSLHD, the four local councils, Western Sydney Health Alliance and Transport for NSW. Stakeholders were invited to participate via email and the interviews were held online and recorded for transcription.

## Data Extraction and Synthesis

Data was analysed thematically using NVivo software and was informed by the mechanisms developed in Phase 1 of this project (see Box 1). An NVivo coding framework was developed and tested by the 2 interviewers. This coding framework was revised and finalised after consulting with the Principal Investigator. As mentioned, coding was guided by the mechanisms developed in Phase 1 along with thematic themes developed using an indicative method. Data was analysed by the 2 interviewers with a sample of 50% double coded for data quality. Any conflicts were discussed to build a consensus.

**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.

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

# Results

## Stakeholder Consultations

The results are presented below in order of the mechanisms presented in Box 1, along with enablers and barriers of each. Other themes, including partnership outcomes, equity and spread of impact are also presented. These mechanisms act as pathways towards partnership outcomes, through identifying which factors shape partnership success (or not). Quotations from the data are presented thematically and are embedded with links in Appendix A. A total of 25 interviews were conducted, 16 were Council representatives, 6 Health and 3 externals.

### Mechanisms: Functional

Functional aspects refer to features related to the structure and functioning of the partnership itself. For example, the way it is governed (membership, formal agreements e.g. Terms of Reference [ToR], communication) and how it functions e.g. existence of the shared positions, funding and resourcing structures allocated to the partnership. Functional aspects were the most frequently discussed mechanism across the stakeholder consultations and was the most reported on factor in the literature.

#### *Governance*

Across all the partnerships, communication and cooperation was key to their success. Participants stressed the importance of having a clear, collaboratively developed partnership goal/vision, objectives and outcomes. The formalised governance, including the MoU itself, the shared positions, ToR, were all key to the success of the partnerships, adding value and making its work a priority. This included the MoU documents being agile and responsive to the environment. This was reflected in the literature that stressed the importance of collaboratively developed goals with clear, open channels of communication. This formalized governance was seen to be context specific and developed, so whilst the model is effective, it would need to be flexible in different contexts or as some participants phrased: 'it's not a cookie cutter model'.

Participants highlighted the importance of having technical and strategic support within the LHD, largely via the Healthy Places Team, as an integral part of the core functioning of the partnerships. This was identified as a challenge for the Fairfield position, working more closely with the Health Promotion team rather than a team dedicated to supporting the shared positions. The ability to access research/academic support from units such as CHETRE was also highlighted.

Participants believed that strong partnerships are grounded in common values and goals and mutual trust; to encourage partners to trust each partner by being open and transparent. Also, importance was placed on being resilient and respectful to the sensibilities and knowledge that each partner brings to the table. This was also reflected in the literature, with trust and transparency being paramount to these types of partnerships. Investment in relationships and rapport were critical to longer term functioning and success even though this may not align with formal short term 'outcomes' or performance indicators.

Some participants felt having representatives from other organisations in executive groups for example the PHN or the Western Sydney Health Alliance can be effective in terms of achieving shared outcomes as it helps widen the support channels and bring everyone on the same page.

Having the governance in place for the partnerships through the existence of the MoUs was viewed by a number of participants as important to ensure the work continues/doesn't get lost within the broader external context and work for example Western Sydney or Greater Sydney plans or Alliances.

### *Shared Position*

Participants highlighted the importance of the shared/co-funded position to the success of the partnerships. This was reflected in the literature, with multiple studies having a joint position to achieve the partnership objectives. Having a designated person, whose role was to deliver the objectives of the partnership was a key driver of success, value add and visibility within organisations.

The funding arrangement of this position (co-funding) was also highlighted as an enabler. The co-funding of the position meant there was equal contribution and oversight of the work as opposed to the provision of funding and not being involved in the delivery of the work. It was highlighted that having only one person in this role can be limiting (in terms of how much or what work can be done) however efforts were made to 'socialise' the position, to spread the impact beyond the bounds of the partnership. It was also acknowledged by a number of participants that the role and responsibilities of the shared position should be specific as there was a risk of the remit being too broad.

### *Knowledge/skill exchange and Collaboration*

Several participants mentioned the impact the partnership itself had on bringing strengths and skills together to achieve things that would not otherwise be achieved by each partner organisation. This is reflected in the literature with the facilitation of information creation and sharing between partners being a major facilitating factor. The literature also highlighted the importance of inter-organisational capacity building. Several participants noted capacity building as a key success of the partnership.

### *Focus: Embedding Health*

The literature highlighted that focusing measures of success on singular health or social outcomes and the delivery of resource intensive behaviour change programs are barriers to effective partnerships. This was mentioned by some of the participants as well, it was perceived that focusing on embedding health as a strategic issue into councils at a policy level was more beneficial and sustainable for health and wellbeing outcomes. It was acknowledged that whilst behaviour change is important and can be an opportunity to get some 'quick wins,' there is more opportunity to for greater impact when policies change to incorporate health.

In terms of reciprocal benefit, some participants felt that health had more influence over council business rather than the reverse. This was not perceived to be a negative, just that the scope of influence is different. It was generally perceived that the partnerships were more focused on embedding health principles into council, not the other way around.

### *Shared Language*

Many of the participants highlighted that there can initially be a challenge in that local government and health are two very different organisations with different language and cultures. Some participants mentioned the need to become 'bi-lingual' or 'bi-cultural', learning about how each organisation functions and the partnership developing their own shared language.

### *Unequal Power or Investment Between Partners (funding and resourcing)*

Differing expectations and perceptions of workload was experienced in some of the partnerships. The administrative burden, particularly around the shared position was perceived not to be equal in some of the partnerships. This was reflected in the literature, with differing expectations of workload and poor administration causing a barrier to effective partnerships. It was highlighted that administrative tasks including the constant need to renew the MoU can get in the way of time dedicated to delivering outcomes and at times, undermine these intended outcomes.

Funding and resourcing were identified as a critical factor to the partnerships success and something that was an ongoing challenge for all the partnerships. The literature highlighted that partnerships that are not adequately funded lacked sustainably and longevity. Some participants highlighted that often any funding shortfalls had to be picked up from one partner, leading to a perception of an unequal partnership.

Conversely, several participants mentioned that this lack of sustainable funding was sometimes overcome through collaborative action by the partners to secure external funds to sustain their activities. However, as established in the literature, sector-based funding also has its challenges with intersectoral partnerships, as associated activities may need to be aligned with current health or government initiatives, potentially restricting how the partnership functions.

Some participants highlighted some limitations of the current funding arrangement, that although they were supportive of the funding commitment to the shared position, it meant that there was insufficient money dedicated (in an ongoing way) to deliver the objectives of the position e.g. resourcing projects or research. Some participants also highlighted that the need to renew the MoU every 3 years, to support the co-funded positions conflicts with the concept of embedding healthy built environments into the partnership organisations. True commitment was viewed as making the positions permanent, ongoing, with a particular commitment from Health to deliver healthy built environments through their local councils, however this does not align with the current funding context. This aligns with the literature, with a lack of sustainable funding a barrier to successful partnership functioning.

There was also some discussion from some participants of whether once 'health' as a concept is embedded into council's core business, it was necessary to continue investing in such partnerships. However, it was also highlighted that particularly in the case of Fairfield, the longevity of funding over 20+ years is a major strength of the partnership and the outcomes it has delivered. A risk was also highlighted that without Health having a 'seat at the table' or having that shared, collaborative learnings from both agencies, it has the potential to reduce the quality of the work, as that collaborative effort is key to success.

The current funding model was additionally highlighted insufficient by not accounting for inflation or for the salary (and on-costs e.g. superannuation and IT costs). This relatively decreasing amount impacted the ability to recruit to the position as a highly skilled role. It was suggested that the contribution amount should be flexible and based on the qualification and skills of the candidate appointed to the role.

### *Reporting and Governance*

Some participants highlighted challenges with reporting and governance of the partnerships. Reporting to two organisations raised some issues, being time consuming, complicated, and ultimately taking away time that could be spent on conducting work. Then at times, multiple levels of governance of the partnerships was also a challenge, often impacting the ability of the partnership to achieve its objectives. The literature also highlighted that the effectiveness and specifically trust building can be hampered by unequal power and hierarchical (as opposed to horizontal) relationships.

## Mechanisms: Organisational

Organisational aspects related to the partnership refer to the structure and culture of the partner organisations and the way in which these interact. This included for example, organisational readiness to support/buy in to the partnership, similarities between organisational culture, aligning the partnership with core business and inter-organisational understanding. Many organisational factors also overlap with functional aspects of the partnership.

### *Shared Objectives and Overlap*

Participants valued the necessity of considering the sets of objectives of both partners, and working in solid collaboration to achieve the goals of partnership- it must be through looking for opportunities to align with each organisations strategic plans and implementing shared activities. This was reflected in the literature where identifying areas of overlap and aligning the partnership with the core business of partner organisations being an enabling factor.

### *Organisational Buy-In*

Organisational buy in was mentioned as a key element of success across the partnerships. In some cases, it was viewed that buy in from higher levels were beneficial as they improved visibility and value to the partnership, however this was not always essential. Political will or buy in were identified as critical to some partnerships in the literature for both facilitating partnerships but also in securing funding.

### *Existing Relationships*

A number of participants highlighted existing relationships and networks within local communities as an enabling factor of the partnerships. However it was also raised that without adequate resourcing, it was difficult to work 'with' community to delivery outcomes rather than doing things 'to' the community. True collaboration and co-design with communities is costly, requiring time and resources which is something the current model does not always allow for.

### *Transformational*

Participants described that the partnerships were transformational for their organisations, as it was a completely new way of working. This was particularly the case with councils, where in the absence of the partnership, health would not be on their agendas the way that it is as a result of the partnership. Participants indicated that the partnership approach was moving forward building on each other's knowledge and skills which indicated the influence of best practice in collaboration and reciprocity.

### *Political Issues*

The political realities of local government challenged the partnership, with elections every 4 years. This was reflected in the literature, with bipartisan politics and sector reorganisation a consistent challenge to intersectoral partnerships. Strategically councils are also organisationally bound to their Community Strategic Plans that are developed based of community priorities.

There were also political and structural differences between the partner organisations that required active navigation and bridging. One council gave a particular example of a point of difference between the partnership and council, in this case it was advocacy for a hospital within the LGA. Whilst it was not something that the partnership could support, it was something that the shared position had to navigate.

### *Scope and Approach of Planning*

The scope and approach of 'planning' within organisations was also highlighted as both a potential enabler and barrier to partnerships. How planning was conducted within local government can constrain what can be achieved. One participant described the difference in planner's views of planning, with some having an expansive, diverse view of planning whilst others had a more conservative, being more constrained to land use.

### *Commitment Beyond the Partnership*

It was acknowledged that there was huge potential for influence in this space (health and wellbeing within local government) however a number of participants mentioned a lack of wider institutionalised commitment to health and wellbeing beyond the partnership and those directly involved.

## Mechanisms: Individual

Individual aspects impacting the partnership refer to individuals or actors involved in the partnership for example, skills and personalities. Individuals, as actors within organisations are key drivers of partnerships and are their personalities and skills are as important as the partnership roles they are assigned. For example, this could be where individual skills aligned with the partnership needs, relying on individuals as drivers of the partnership or staffing issues.

### *Skills of Shared Position*

Some participants felt that whilst there are huge opportunities for health and wellbeing within Local Government, it is not resourced enough, beyond the shared positions which are only one staff member, no matter how highly skilled this individual was, it is a very large remit to cover.

### *Key Champions*

The literature found that individuals involved within intersectoral partnerships are the 'gears' that drive intersectoral action and implementation. Continuity of some actors within partner organisations was highly valued by participants. The ability of the shared positions to upskill others particularly within the council organisations was highly valued to spread and extend the impact of the role. There were examples of the positive impact of having long standing members as well as how specific members of the partnerships have driven their success. Other participants reflected on the partnerships ability to change the way people think, conceptualise and approach their work. There were also examples of networking and shared learnings occurring across LGAs.

Whilst the existence of champions was an enabler of success for some partnerships, an over-reliance on individuals rather than structures built within an organisations i.e. if an individual in a shared position role had a particular background/passion/skill, that has the potential to be lost if they were to move on. This was reflected in the literature that whilst individual actors who may champion the partnership activities or rely on personal relationships to facilitate progress can enable short term success, it is a challenge for this in the long term (i.e. beyond their involvement). It was also acknowledged in the absence of the dedicated position, the work of the partnership would essentially become impossible/lost.

### *Recruitment/Staff Turn-Over*

Across multiple partnerships, there were difficulties experiences in recruitment to the shared positions. This was attributed to multiple factors including the specific skill set that is required (covering health and planning), the high demand for planners and non-permanent contracts due to constant re-negotiation and push to provide a business case for its existence.

Staff turn-over was an issue, with the loss of capacity when staff move on and the need to retrain when new people come on board. It was also raised that in periods when the positions may be vacant, that is not accounted for in the MoUs timeframe or financial contribution.

### *Fragility*

The fragile nature of partnerships was also mentioned by some participants as a risk. This was attributed to staffing changes but also that individuals have the ability to 'unravel' partnerships.

## Mechanisms: External

External factors that impact partnerships refer to aspects outside the partnership and organisation that have an impact on both i.e. policy and legislation. This was often political and legislative environments that are beyond the control and reach of partnerships and organisations/sectors involved for example other agreements/partnerships e.g. Health Alliance, the impact of COVID-19, political issues such as broader state and federal policies.

### *Health and Wellbeing Acceptability*

Some participants expressed that generally and ideologically, health and wellbeing is not a 'controversial' or 'hard sell' across various levels of government. This meant that socio-culturally, health and wellbeing generally has good acceptability, this was viewed as an enabler for these types of partnerships as it strengthens the 'need' for them to occur.

### *COVID-19*

The COVID-19 pandemic was raised by a number of participants as both a barrier and opportunity for the partnerships. Whilst the pandemic restrictions evidently reduced the ability to deliver partnership work, existing relationships which were attributed to the partnerships assisted in the successful delivery of the emergency response to the pandemic. The reduction of activity directly with community as a result of COVID-19 restrictions also resulted in a change to refocus the work of some of the partnerships.

### *Lag between Population Growth and Infrastructure*

It was acknowledged that many LGAs in the South Western Sydney area are some of the fastest growing populations in the state however, the rapid growth in population is not in line with a growth in services and infrastructure often beyond the control or scope of local government, making it difficult to meet the needs of the community.

### *State Level Policies*

Some of the partnerships, particularly those focused on the planning level outcomes expressed that frequently there are policies that are beyond local governments control that would deem what can or cannot be achieved by the partnership. A lot of what was trying to be addressed are state controlled, well beyond the scope of what local government can influence or change. The literature also acknowledges this with political and legislative environments being integral but beyond the control of people and organisations.

It was also raised that a lot of the state controlled policies and priorities within the planning space simply do not consider health or wellbeing. However, it was also mentioned that aligning with state level priorities was an enabler, a potential avenue for funding/grants.

## Partnership Outcomes: Evaluation and Monitoring

As is established in the literature, evaluation including accountability and measures of success are important in the functioning and eventual success or failure of a partnership. Study participants highlighted the importance of incorporating measurement plan for each project in the MoU including specific outcome indicators from a health and wellbeing point of view. All the partnerships had mechanisms for monitoring and evaluating the work of the partnership, while this was usually guided by the high-level MoU, the more detailed description on objectives and outcomes of the partnership usually took the form of work plans and operational plans.

Council participants stated that they are eager to continue working with health, and they appreciated embedding health in built environment however expressed their concerns of time required to measure the set outcomes and engaging with things like organisational and partnership KPIs. Some participants also felt that, measuring outcomes in terms of health and wellbeing as challenging.

Investment of time was a major issue raised by a number of stakeholders that is, the time it takes to deliver health and wellbeing outcomes in the community. Many of the 'outcomes' of the initiates being implemented had very long-term health and wellbeing outcomes, this was particularly the case in the health in planning focused partnerships. The literature highlights that partnerships with very long-term focus with no clear or achievable outcomes were not able to demonstrate tangible outcomes.

Where the co-funded position sits within council and its primary focus was also highlighted as key to how and what outcomes could be measured. There was also some discussion about differences in language of what would be considered an outcome for each of the partner organisations. Some participants highlighted that it can be a balancing act between thinking big picture outcomes and being focused enough to provide outcomes in the shorter term. The literature also highlighted the importance of agreeance on what should and should not be considered evidence whether that be service delivery measures, network analysis, integration of health into policies or health outcomes.

Other participants highlighted the constrains of 'clinical' health measures of success, with that focus setting the partnerships up for failure as they are much too long-term outcomes (beyond any MoU agreement) which are impossible to directly correlate to the partnership's work. Studies in the literature review also highlighted this, expressing difficulty in isolating causation of outcomes to the partnerships themselves rather than being an enabler for the delivery of outcomes in a broader context.

Participants also highlighted that process is just as important as outcomes for example the integration of health into planning and policy documents are just as important outcome as running a successful healthy eating event or increasing tree canopy in an area. One participant expressed that in integrating health into council plans, it would improve the submission process in that Health would no longer have to comment as much on submissions as it would be addressed much earlier in the planning cycle.

### Equity Considerations

When participants were asked about whether Health Equity was considered at all in terms of outcomes of the partnerships, most participants mentioned that whilst it is typically considered it is not explicitly incorporated into the partnerships or MoU agreements. Some participants indicated that local government had a tendency to consider equity in the way that they prioritise and deliver services more generally, but again it was not explicit. There were some examples of activities where equity was implicit such as the healthy streets assessment which assesses based on disadvantage or poorly prioritised areas.

### Spread of impact beyond partnership

A large number of participants highlighted the innovative model that has been developed and implemented in South Western Sydney, in particular the co-funded officer model. This model has been scaled up to different councils in the area and is being explored in an additional council (in partnership with another local health district) as well as at the state level for example, Transport NSW. Within organisations, there has been 'spread' of impact beyond the bounds of the partnership with other staff and teams to changes in career paths.

## Updated Document Review

As stated above, a document review was conducted in Phase 1 of this project. In Phase 2, any documents that had been updated since Phase 1 were requested from the partnerships. A total of 12 updated documents across 3 of the councils were reviewed against the document review findings in Phase 1. It should be noted that at time of writing, 2 out of the 4 councils were in the process of renewing their MoU agreements and therefore updated MoU documents were not available to be included in this report.

There were no major differences to what was found in Phase 1 document review in the updated documents with the exception of:

- Minor changes to streamline some of the partnerships work-plan and operational plan outcomes
- With two of the partnerships, their objectives were streamlined slightly with one placing more focus on embedding health into strategic plans

There were no major differences in documentation between each of the councils' documents. Each of the MoU documents that were provided were similar. Work-plans, operational 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.

## Recommendations

*Functional*

1. **Governance:** Future investment in partnerships ensure the following governance aspects are incorporated:
    a. Clearly communicated, collaboratively developed, vision, objectives and outcomes in place prior to the commencement of the any partnership, and any future changes developed collaboratively
    b. Formalised governance through MoU, shared position & ToR in place prior to the commencement of the any partnership
    c. Clarity that trust built through transparency of both organisations is part of the partnership process at the outset, with an acknowledgement to develop both over time and that trust can be hampered by unequal power and hierarchical relationships
    d. A mix of technical and strategic support for the partnership to be a core shared focus of both organisations, cemented in work plans and deliverables.
    e. Membership providing oversight of the partnership should be a range of broad but relevant stakeholders e.g. PHN and WSHA, supported by regular steering committee meetings and a flexible approach to strategic planning.
    f. The partnership model, including resourcing, requires being responsive and flexible to current and shifts in context
    g. Partnerships and their agreements i.e. MoU's should remain in place to ensure the work continues within the broader external context of work e.g. Western Sydney or Greater Sydney Plans or Alliances.
2. **Shared position:** The co-funded shared position is critical to the success of each partnership so should be maintained/non-negotiable mechanism for this model
    a. The shared positions funding, support and management arrangement should be shared between both organisations
3. **Knowledge/skill sharing and capacity building**: take a strategic organisational approach to develop opportunities for capacity building and information sharing beyond but supporting the shared positions.
4. **Embedding population health focussed partnerships in the strategic business of each organisation:** Take a primary focus on embedding health into councils at a strategic/population health level, given that goal encourages sustainable action rather than behavioural approaches or a disease/clinical focus. Behaviour change programs should be connected to policy/strategic level goals.
5. **Shared language**: development of shared language can take time and effort, but is core to effective working, with that effort requiring acknowledgement early and across partnership negotiations.
6. **Funding and resourcing:** Investment of funding and resources should be equal between partners to avoid unequal power balances and expectations. This extends to administrative burden and funding shortfalls.
    a. Review the current funding model (cap of $50K) and align with current funding expectations in councils.
    b. Partnerships should explore diversifying funding sources to conduct the work e.g. grants
    c. Consider longer term investment beyond a three-year cycle, supported by long term strategic alignment between councils and the LHD.

7. **Reporting and governance**: Reporting, particularly of the shared position should be streamlined between the partner organisations as to not place unnecessary administrative burden.

### *Organisational*

1. **Shared objectives & overlap:** Partnerships should actively look for opportunities to align with each organisations strategic plans and identify areas of overlap within both organisations core business.
2. **Organisational buy in:** The partnerships should continue to increase awareness within their organisations of the partnership and its outcomes, this ensures visibility and places value on the partnerships.

### *External*

1. **State Level Policies:** partnerships should explore a mechanism to advocate for the inclusion of health and wellbeing into state level planning policies / health policies that have a direct impact on what local government and the LHD can and cannot do.
    a. Partnerships should continue to advocate for better alignment of population growth and the provision of infrastructure.

### *Outcomes*

Measurement/monitoring and evaluating success should consider the following:

1. **Diverse Outcomes:** Population level health outcomes within the scope of local government require significant investment of time and resources and are too diffuse to evaluate a certain causative effect from an action to a long-term outcome Thus, an outcomes focus should guide the partnerships as long-term goals to work towards rather than as measurable achievements to judge short or medium-term success against.
    a. Unintended impacts (beyond what is included in MoUs, work plans or operational plans) for example the spread of impact beyond the partnership should be captured systematically.
    b. Logic models be developed to guide partnership activities.
2. **Equitable Outcomes**: Health equity should be explicitly incorporated into guiding documents for the partnerships including its incorporation into outcome measures

## Conclusion

This report has established the functional, organisational, individual and external level aspects that drive the effectiveness of these partnerships between Population Health and Local Government. It has also explored the key considerations for measuring outcomes in the local application of these partnerships. Generally, the information from the stakeholder interviews aligns with the literature which informed the theory of change in phase 1, with the exception of some key context specific differences. The stakeholder interviews found overwhelmingly positive responses regarding the partnerships and support for them to continue. The application of the model in each of the LGAs is innovative and has been transformational for organisations. The partnerships provide collective advantage for partner organisations, the fact that health is on the agenda of local governments is solely due to the partnerships and would not occur in their absence.

# Appendix A: Quotations

## Functional

### Governance

*Then going back to… the different expectations kind of in terms of outcomes from you know a council perspective and a health perspective managing that is pretty critical.* Health Participant

*And say yes, but there's different ways of doing it but and I think really the biggest danger for Health would be to think they can have one model and cookie cutter it* Council Participant

*So while you can pick the model up, it's the process that's important. So, that committee would need to determine its priorities, its vision, look at its stats… priorities... It's that forming stage that is really important. So I'd say yes, but don't underestimate the importance of the foundation stages of a partnership.* Council Participant

*So it's making sure that the Terms of reference, MoU's just don't sit on a shelf, that their living documents people are aware of them and that there's some sort of induction process when new people come on board.* External Participant

*I think there's different ways of doing that and I think the healthy places people obviously placed at great value on their being a team of people on a group of people. So they were creating a network… that was very that was successful.* Health Participant

*Having the healthy places team, amazing. Like there's such a good team that works really well with council and I feel like they make a huge difference in having like a manager that can… manage all the joint positions and the pieces of work and constantly be available for them if they reach out you want to be responsive.* Health Participant

*Because it's all about developing trust, leadership, shared vision, developing the relationship, the people are important… I would say absolutely, but it's the formation of the partnership that cements it into being successful.* Council Participant

*I think having the other executive there… the PHN, they bring different experiences as well and that's worked really well. But I think having that combine executive meeting and having those different perspectives and discussions at the same time really helps, it helps us drive it… If they weren't all in the in the same room at the same time. We can't have that discussion, you know yeah.* Council Participant

*They're (partnerships) all linked into the Western Sydney Health Alliance, which has some good structures, and it gets them working outside of their council thinking more broadly as well. So that works well in terms of bringing them into broader project.* Health Participant

### Shared Position

*I think the joint positions are you know a great initiative…a great way of working, a great model like I'm happy to look at other different models but I feel like having that person there to can continue it.* Health Participant

*Because without the joint funding, it wouldn't have the profile it has quite simply. Let's just call it that call it for what it is* Council Participant

*What works well is when it's a mutual… genuine partnership. As soon as people start behaving like they're my funding body, it doesn't work so well. It's a partnership… and you deal with things together.* Council Participant

*Often there isn't the funding to have a position… through Council funding alone, whereas by health Co-funding its… quite an incentive for councils to say, 'well, great, we wanna do it and if it's Co-funded, let's do it together' and I think that really helped us too with… establishing the role in and keeping it… going in, demonstrating not only the value of the outcomes, but the fact that it is Co-funded is definitely helpful*. Council Participant

*The resourcing… can be a bit of a struggle… we have one person whose role it is to do that. So I've tried to socialise it… by getting everyone trained… in healthy streets, by having them actually participate in the Social and Health Impact Assessment working group… I'm getting my team to really speak up in that space more and more.* Council Participant

## Knowledge/Skill Exchange and Collaboration

*I think what the health partnership does is give what I call collaborative advantage. Together we achieve more than if we did it a separately* Council Participant

*….all of the work that I do is about advocating for the issues that we have and how we can better improve the built environment, so it's really sort of working with them closely and using their knowledge and information to help direct our projects…* Council Participant

*And then on the flipside, the LHD capability is being built hugely by just being able to talk to planners about what it is that we expect in or can use in submissions in particular.* Council Participant

*Being able to work with our team and gain exposure and upskill in that space as well in health. So it's not just… I guess working towards common actions, but it's also a process that allows me to upskill in that space. And it allows the population health team to upskill in the work that we do… understanding that planning and urban design.* Council Participant

*So I think the partnerships have done a great job in a challenging environment of building capacity, building understanding, building relationships within the Council and the kind of representing… the opportunities and challenges for the councils across a number of forums.* External Participant

## Focus: Embedding Health

*If we focused purely on delivering, you know, sort of in a sense an individual focused or population health behaviour change… we would miss the opportunities to address all those other factors that impact on people's health… And in particular in terms of, you know kind of equity because it's those things that change that don't involve somebody having to make a choice where we stand to make the most gain.* Health Participant

*I mean if you're trying to change people's behaviour… that can be that can have problems with sustainability once you remove that, counselling or whatever… that is driving the behaviour change… But if the behaviour change is about OK well, I can't smoke in a pub anymore or I can't smoke in this park, or I then or I can't smoke within sort of certain distance of children's play equipment then that's say that's the change that you would that*

*should… have an influence on people's and smoking behaviour as you're changing sort of society's norms around smoking.* Health Participant

*I'd probably argue that you actually have more reach by embedding health into the future strategy of the city, rather than just doing, I guess opportunistic promotion events and things like that …you're talking about more long term change then rather than something that's just opportunistic.* Council Participant

## Shared Language

*Understanding how each other work… Is probably something that would have been helpful at the start of the partnership in order to be able to kind of get the most out of it… instead of instead of spending lots of time explaining to each other* Council Participant

*When people… talking about strategic planning to me… this happened with [Health]. To me, strategic planning writing the LEPs, the DCP there they are the land use documents. That's my concept. Took me a long time to work out that what they were actually talking about is about the documents that feed into that… Yes it was a straight language thing.* Council Participant

*And I used to joke that you've gotta learn to be bilingual and bicultural.* Council Participant

*I think an appreciation that sometimes in local government, it's not smart to brand everything health. But I suppose there's a better understanding of that now with health on-boarding of the wellbeing concept you know, like a few years ago… health would never talk about wellbeing. It was all health. But wellbeing is much easier for local government to talk about* Council Participant

## Unequal Power or Investment

*In terms of funding models, I've got to reapply through a competitive process to get funding each time the MoU ceases. And for me… although both our body and the LHD are really… I think the intent is there to do the right thing…Only providing a temporary role, I think, gives a perception that 'is it actually something that we all want as an outcome? Is it a long term thing'*? Council Participant

*I do get the sense that health is really trying to justify this, the value of this partnership internally…because of that there is a lot of admin and reporting associated with the partnership… that actually eats into the time available to… deliver the work that would further the outcomes that you're talking about.* Council Participant

I think that can be quite time consuming and we were just a little bit concerned about the incumbent of the role being involved in too much administrative kind of stuff. Where rather than actually spending their time getting on, we actually trying to get the work done. Council Participant

*Their [shared positions] time is valuable. We just need to think about how we get that joint position working and what they're working on to get the biggest bang for the buck.* Health Participant

*I think the key is about flexibility and then, I think there needs to be a reassessment as to the levels of commitment slash responsibility and accountability from both partners cause at the moment it's a bit of a lopsided partnership. It's probably. Maybe was a 50/50 3 years*

*ago, which led to a 60/40 and now it's probably a 70/30 and we are the 70.* Council Participant

*Partnerships really get the mutual benefit when you've got enough trust between you to be brutal…take very honest feedback... We got the grant. I wouldn't have got it without them. So it's that, yes, there's benefit.* Council Participant

*The current arrangement is structured where there's a $50,000 contribution for each partner to a role. That doesn't anywhere near fund the role and it doesn't provide any other additional funding to be able to do any work to implement what the role is seeking to do.* Council Participant

*I think we have to rather than think about this high… MOU three year Co-funding… from the district's point of view, I think we need to be looking at it like a new way of delivering joined up services rather than co-funding every three years a contract of agreement… that's our model in our LHD, we deliver healthy built environment services through council."* Health Participant

*That's probably the key challenge is that in some ways, if they do their job really well across say… 6 year time frame, particularly for the ones that have a focus on health in planning… by that stage all of the fundamental documents that underpin the way that councils assess things should have changed and we probably shouldn't need to continue investing.* Health Participant

*What's worked really well is the jointly funded position model because they're a little bit more flexible, they can move between healthy places team and Council, lots of crossover. I often regard themselves, you know, as a team member of both organisations, and that's for me that's the best model.* Health Participant

*$100,000 doesn't cover the position at all. It certainly doesn't cover… we've got to buy [them] a new laptop… it doesn't cover any of that.* Council Participant

*What's not working is that we're only putting in 50 grand now and 50 grand Isn't worth what it was five years ago. So in terms of trying to recruit people and keep people in these positions, it's really hard to get someone of quality to do the sort of work that we want… particularly when planners and designers are in really short supply.* Health Participant

## Reporting and Governance

*Unnecessary layers of hierarchy in the it's I think some of the partnerships are over managed cause there's too many tiers... I don't think this triangular kind of hierarchical reporting system is necessary.* Health Participant

*It'll be really great going into the future to have someone that manages them all and knows what they're what they're all doing. And helping them…if it's the alliances and partnership… if that's the one rather than having all these separate things on… Our meetings are a bit ad hoc, sporadic.* Health Participant

*One if the things that is a bit tricky is the governance structures… they can be overly complicated … And particularly now that there is a Health Alliance and a Partnership that has made it incredibly difficult around governance. And one of the things that we need to do is to actually kind of bring all that together to resolve some of that* Health Participant

## Organisational

### Shared Objectives and Overlap

*And it's not just working towards the objectives that we have at Council, but it's looking at the objectives from South Western Sydney Local health district strategies like Keeping People Healthy and those are built environment strategy of framework. I think as well and looking at those actions to ensure that the projects that will be working in the future do respond to those actions in some way. Council Participant*

*I think what the health partnership does is give what I call collaborative advantage. Together we achieve more than if we did it a separately. And so, for a small contribution, equal small contribution from partnerships, I think for benefit that that actually relays to the Community, to each individual organisation, but also the cross influence of organisations is immeasurable.* Council Participant

### Organisational Buy-In

*So there's a lot of great intent on both sides, the workers and even a lot of the management are right on board trying to work collaboratively together, but then getting back up to the CEOs etcetera just to get them to meet to, you know that's the challenge.* Council Participant

*I know that's why we have been we have had such longevity is that we've always had the mayor and the General Manager engaged.* Council Participant

*The MOU really it's and the governance arrangement it's great to have… at a level where it has visibility for the most senior people in Council… chief executive and the mayor and people on the executive for council. They may not be involved … in the doing, but… having that kind of visibility I think is great.* Health Participant

### Existing Relationships

*Both from an implementation angle but also from a user angle in the past co-design, and that making sure that people who are the users of any outcomes and are involved in the process from the beginning is key… Whether we have the time and resources for that is another question, and I think that's like project sensitive as well, some projects do some projects don't.* Council Participant

*Councils run lots of events and run lots of different projects and initiatives, but the events is where people congregate, get together, celebrate and that's a great soft point for health to connect with community.* External Participant

*I think that's the value that Council has because we're so close to Community… community organisations… we have those contacts that we can implement a project like that because we've got those connections with those programmes… and we know where there are available supports within the Community* Council Participant

### Transformational

*It really allows for a collaborative process on projects and I guess a different way of working together and other organisations might not have been exposed to that way of working previously.* Council Participant

*The [co-funded positions] role and… management, play a critical role in implementing a health lens to council business where it might not naturally fit.* Council Participant

*One of the uniqueness's of partnerships… is its transformational. And it's actually mobilised the both Health and Council in putting health on the agenda, which has long term benefits and without the partnership… neither organisation would be where we are.* Council Participant

*Ensuring the cycleway infrastructure that we incorporate isn't just implemented but it does have the right elements that will allow for people to use… and promote the usage… ensuring there's enough canopy cover all those types of things…it really exposes people like myself to a new way of working.* Council Participant

*This partnership I think is very successful in getting people out of that very operational frame of mind or very tactical frame of mind in delivering a service or in providing an opportunity and start to look a little bit bigger and broader.* Council Participant

*But we upskill and we teach each other… In the beginning it was very much about providing… public health population health orientation… we've been able to lean heavily on… our joint positions to help us get the position right and the language right and the technical Information correct. So there's lots of good examples I think of reciprocal capability building.* Health Participant

## Political Issues

*I think it's really important for the officers within health who are working with Council to understand the importance of the Community Strategic Plan, which is actually not Council's vision for the future of the LGA, it's the community's vision for the LGA and it dictates everything that we do.* Council Participant

*The process… in terms of embedding it within Council processes for that long term journey, I think that's when they've been successful because I mean as we know you know a Council only be in for four years and then they're gone and the new one comes in.* Health Participant

*Because they [Health] didn't understand we have a much closer relationship with the political arm of our structure, whereas in state government the minister is a lot further away with their own advisors. In local government, we are sitting next to each other. And it's very close and sometimes things will become a political no go zone.* Council Participant

*There's things where we… don't agree but we're gonna do this outside the partnership and we need to acknowledge that we are standalone organisations and both organisations need the right to do that.* Council Participant

*And the one sort of really big piece of the puzzle that we haven't yet got in place is an amendment to the development control plan, which is actually controls. So putting the controls in that we want to see.* Council Participant

*But there is one element for Wollondilly and for the elected council, which is different to the LHD, and it's a point of difference and it's acknowledged. But that is we talk about the social and health lens and we're talking about the theory and embedding things that we do have power over the elected Council with all the growth that we've got have been advocating for a physical hospital for the LGA. So that is, I guess, so one point of difference*

*and it does come up from time to time where, and we're all very respectful of it… It places a lot of pressure on that shared position because there is a difference… We [the partnership] are all aligned in terms of what we want as outcomes, except for that, one outcome.* Council Participant

### Scope and Approach of Planning

*Other planners don't… Aren't on board with that view. And they have a more traditional and conservative view of planning, being more constrained to land use.* Council Participant

### Commitment Beyond The Partnership

*I don't feel that I've got enough resources in the right places to be able to do what we could be possibly doing around health and wellbeing… Everything else that we do around health and wellbeing is where I'm trying to influence it to be embedded within other people's positions. And I think that's a challenge.* Council Participant

## Individual

### Skills of Shared Positon

*I'm really trying to leverage that role as much as I possibly can. But it's one person with a very specific brief and it is my only health position.* Council Participant

*It's almost like we've got a part time person doing some of the stuff, not all of it because some of it's in the MoU…It spreads [the co-funded position] thin… because [they'll] have things that [the co-funded position] has to deliver on for health and commitments that [the co-funded position] has through Health… like the workload is huge for a person.* Council Participant

*We could be involved in so many things. But the problem, the danger there is that if you spread yourself too thin like its only one person in this role, they can't solve every problem that's out there.* Council Participant

### Key Champions

*The success of this one is… [Health staff member] real dedication… and [they're] really quite… provides us a lot of guidance in the development of our operational plan and even some of things that [they] goes 'ohh you know these you know, I wanna see this because this is worked really well here'… So you know [they] actually… quite influential in the way that we the work that we deliver and the way that the partnership is driven. And I think it's because… [they've] been around for a long time… If you have people who are now at executive level but have come from the bottom… They have that experience… They know what they're talking about.* Council Participant

*It's been the intent of the people involved that have really driven it, I wouldn't have said that this driver's come from the tops of the organisations… It's really been the people involved in it and I think that has led to the really successful input and collaboration… We've actually had a genuine desire to try and keep this going and to push and to get some genuine outcomes. And so there's this element of having the right people involved to get where we are and where we want to be. You can create a position and you can write MoU. But at the end of the day, it really comes down to having the right people with the right genuine desire to make it work and that's really been the case here, I think on health side and also on our [council] side, so.* Council Participant

*It's just opened up a whole new world… for me I've learnt a lot more about health that I never knew before. I didn't know how it operated… who we need to speak to, where we needed to go, etcetera. So it's all those little things that are of a huge benefit as well.* Council Participant

*Well, I certainly think that that's, healthy streets is a good example of trying to influence planners, engineers and the other people in Council to think about health explicitly. And I think it's been well received and I think it is an extension of their language in a way.* Health Participant

*I think that the partnership…the partnerships being [the co-funded positions] what worked well with it is that where you… In different LGA and we're obviously working on different issues and different project. But we were still able to come together and collaborate to really understand and to learn off each other about what we were doing and how that could be effective and how that could be applied to our own particular LGAs* Council Participant

*You've got it influence and change the system… there's no point in just putting somebody in the planning department and go 'ohh Look, it's all fixed' because once that person goes… You've got to change the systems. You've got to change your processes. You've got to change the attitudes. You have to influence it.* Council Participant

## Recruitment/Staff Turn-Over

*It's time limited… It doesn't allow us to have to give the office a certainty around the longevity as well. So [the co-funded position is] great, like [they're] not running off anywhere, but that's always the risk when you co-fund a project for a short period of time.* Council Participant

*Um so it's a struggle to keep people in positions and I say that because, you know we've kept… The [co-funded position] there purely because I guess that they are really into the work that they're doing... But if something else came up similar somewhere else with a better pay… how can you compete with that?* Health Participant

*So effectively the MOU lapsed… As a result I've had to increase [the co-funded positions] tenure as a temp employee at Council, on the notion that we will get the [next] MOU… that date's [the MoU end date] been in place for three years… Surely you know that would have been the highest priority, but… that didn't happen… Council Participant*

*We certainly would not have a position that was dedicated to health otherwise. In any shape or form.* Council Participant

*I think [health would be] less commonly… considered and probably less consistently. And then that person leaves and goes and does something else and the Council stops thinking about it. It's not as sort of consistently and it's not someone's job to make sure it's considered.* External Participant

## Fragility

*They're also super fragile. When the staff changes that they will often change as well…some of the fragility and those changes so that one of the key people who was such, and it's not just about the person, it's about the cultural change they impart on their organisation* External Participant

*An individual could quite quickly unravel a really good partnership if they came in with the wrong attitude.* Council Participant

## External

### Health and Wellbeing Acceptability

*What's nice about the talking about health is it's something that almost everyone in the community can agree on. That would be great if we had a community where people were healthier, where they live longer, where they were less impeded by health issues* External Participant

### COVID-19

*I believe it was good for the partnership because we had those relationships in place to be able to get information out to the Community about covered and the pandemic and I believed it really worked well.* External Participant

*I will add during COVID the health partnership lost, it didn't lose momentum, I would say it refocused its attention*. Council Participant

### Governance

*We tried to look at how to ensure that it could operate beyond any other partnerships or agreements going on like… the broader [council area] or the broader Western Sydney. We wanted to make sure that withstand that so that 'we've got this agreement, we're gonna do the work no matter what'. In terms of governance, we did instate that a lot more strongly in the MoU, and I think that's been of a benefit so we don't have to worry about some of the other things going on in Western Sydney, what the Wollondilly Health Alliance does, the South West etc*. Council Participant

### Lag Between Population Growth and Infrastructure

*One of the key challenges that we have at the moment is that, I guess that the quality and amount of infrastructure that's available to support the population… That's a really key issue for us at the moment, particularly as we're growing quite substantially. And of course… the MacArthur area which Campbelltown is a part of with Camden and Wollondilly is one of the fastest growing areas in Australia. So having that lag between population growth and the services and the infrastructure to support that population, particularly when we've got quite disadvantaged populations is it is an issue for sure.* Council Participant

*The growth out here is all complying development and it's all terrible. No trees and there's no space for trees that. You know, there's so many things that you could do to improve that.* Health Participant

### State Level Policies

*And they have a more traditional and conservative view of planning, being more constrained to land use. You'll find the Department of Planning have a more conservative view and they keep trying to push back and argue against the use of the EPNA (Environmental Planning and Assessment Act) and the planning instruments as a vehicle to achieve anything other than buildings* Council Participant

*It [SEPP: State Environment Planning Policies] really covers 10% of that new development. The other 90% is being covered by state controlled stuff. And so if we could get someone to actually put a health lens over the complying development code…The impacts of that would be just great for SW Sydney because we got so much of that sort of stuff happening.* Health Participant

*The technical side the problem is basically that the planning at NSW is really poorly set up for dealing with and intangibles and most of what we're dealing with is hard to quantify and it tends to be… There are some tangible things, but… Not having a health objective in the Act itself is a real problem.* Council Participant

*We've got Premier's priorities focused on urban greening and open space. So because that's happening, that's opening up more pathways and funding for local government to do this kind of stuff.* Council Participant

## Partnership Outcomes: Evaluation and Monitoring

*We have every year we have the three year… work plan are we do the MoU then we agree what we're gonna do for three years and… every six months, there is a report done to check how things are going. Then every year there's a major report done on where we were and then we do the next operational plan and pick up the things we didn't achieve.* Council Participant

*They're in our work plan. So we have an annual work plan that we report on quarterly and we and we will operate off A 3 year MOU.* Council Participant

*In the work plans, there's key deliverables. Obviously, we do a programme logic… we look at inputs…outputs, and we look at what the change is. We report on those the environmental things, some of them are policy, some of them are… on the ground.* Council Participant

*But we certainly have deliverables that we're trying to achieve against in the MoU and then that's broken down into the to the work plan that we go through with the incumbent.* Council Participant

*The short answer is yes, but it is hard to quantify. I think we are playing for a long game, we are chipping away, at being an advocate…on incremental behaviour change. These are that are gonna happen immediately, or overnight, as the level of time and consistency to deliver you know step change that that eventually we see in terms of community outcomes.* Council Participant

*There's a risk you not being able to link the intent of this partnership and the importance of keeping these concepts on everyone's prioritised agenda on a regular basis, which is what the partnership does very well, so maybe that's an indicator of success, is it does keep these concepts on the table, it keeps the conversation alive and it means in the back of our minds, as EMs (executive managers) at Council, there's always this piece of how is that being addressed.* Council Participant

*And we're very much keen to work with health and embed health into the built environment and the future of the city. But in order to do that… we need to be able to have the space to be able to spend time on that rather than spending time on things like reporting against KPIs… which is actually quite difficult to do in the strategy space, particularly when you're talking about things that probably aren't going to be delivered for another 10 or 20 years... Perhaps moving forward, what would be helpful is to actually talk*

*less about KPIs and more about the governance structure of the partnership.* Council Participant

*At a population health level, increased measures of wellbeing and health outcomes… But, it's beyond specific health… Part of that is how people live their lives, navigate their worlds, have the opportunity to have healthy lifestyles and participate in their community. I think it's really hard to measure that success... I don't know how you'd measure. I genuinely think it's a very tough call and I take my hat off to you, if you find a way of doing that, I think it's for a very bright mind… If I was to offer suggestion for how it could do better, I'd say articulate what you want to measure… How you want to measure that value, because for me it's not clear and I don't know if I'm not close in it enough to understand how that is measured.* Council Participant

*There's significant differences of what a role would achieve based on the different deliverables of each Council… [another council] I would say is more of that Community service driven type role where there might be those programme or service delivery outcomes that are achieved quicker, whereas ours is… that more strategic focus and long term benefit.* Council Participant

*If there was a bit more flexibility with time error and failure and learning from mistakes, there would be… much better outcomes… I've been on the receiving end of programmes and projects in the past and it doesn't always have to succeed.* Council Participant

*Yeah. It's a bit of a challenge and again, it's limited capacity… Cause we don't do the recreation and open space planning. It does make it a little bit difficult for us to sort of have any sort of influence in that space.* Council Participant

*So we are always kind of walking that fine line between what we see as an outcome and what a Council sees as an outcome and councils see process as outcomes.* Health Participant

*[Focusing the work of the position] So that we do get outcomes and by doing so that helps demonstrate the value of the partnership too by seeing tangible results. I think the challenge is… just keeping the remit quite focused on what's most valuable.* Council Participant

*How could you possibly make a causal link between something I do and diabetes going down? It's a multipronged multifaceted number of programmes that have got to do that.* Council Participant

*It's been a while since I've read the MoU, but my take on the work we do and the work we report against is better integrating health and wellbeing outcomes into the planning system. And generally… elevating the topic as a discussion within a broader policy setting. So actually reporting on these things, acknowledging what we do or what we can do to improve outcomes on the ground through our planning processes and our reporting processes, so that's how I see it.* Council Participant

*If that position is doing what it can possibly do, we won't need to comment on those proposals because they're being dealt with much earlier on in the planning cycle. That's a measure of outcome. We're saying, one day we're gonna get a proposal, it'll be on exhibition, and we'll look at it and we'll go, 'There's nothing to comment on' because it's all addressed.* Health Participant

*The cross influence of organisations is immeasurable. I don't think it can measure that, so it's probably more of a story to tell. Because it has been a long journey, but that collaborative advantage is invaluable.* Council Participant

## Equity Considerations

*I don't recall it being part of MoUs, it might be referred to in a general way… I would think that some of the MoU would pick up equity in… One of the projects or something that might be worked on but I don't have any specific recollection of… where that was explicitly stated.* Health Participant

*I would say it's not explicit because there is a tendency always to look at… Where disadvantage experienced and what can we do to… create more access or equity or level playing field somewhat. I think that's the tendency of all people, either in health, local government setting or community services… that's always the fall back. But whether it provides outcomes for people who aren't experiencing that disadvantage… Because it's looking at creating you know change as to how people experience and function in their city* Council Participant

*I don't think it's considered as strongly as it could be, particularly if I think about the health in planning type approaches… I think in Fairfield the rhetoric is there. Is it as embedded in the work as it could be? A lot of the time, yes, because… they're very cognisant of… socio economic disadvantage and access and equity issues around CALD populations given… that's their everyday bread and butter. Is it a as it explicit as it could be? No. So I do think there's probably opportunities to strengthen that.* Health Participant

*For example, a healthy Street assessment. The time they might look at an area that is disadvantaged, no public transport, there's been no upgrading… in that area… hasn't been given budget priority. So a healthy streets assessment will come back to council with a bunch of low scorers and you can make a case for rectifying it… So I think it's a tool, these sort of tools show up the discrepancy between and there's also funding. Council has funding for particular places, which have been a bit underserviced... So maybe they're not using the language of 'Health Equity', but it's definitely considered in the way that some of the funding is allocated.* Health Participant

## Spread of Impact Beyond Partnership

*I think just to say that I think it's been a really innovative model. It's quite… forward leaning of the health districts to have undertaken this and quite thoughtful, a… it's a good recognition of the critical role that Councils play on the ground… It's certainly something that I would hope personally, continues, it's strengthened and rolled out further. It's… of great value to Western Sydney but also, what we're learning from it is of valuable broadly across the state and the country too.* External Participant

*But one of the… big benefits that we saw early on was that the likelihood… you will reach out to the other organisation to understand things or discuss things to improve the quality of those submissions and things and even in terms of us advocating for health to be at the table for, you know, regional planning and those sorts of things.* Council Participant

*That's an ongoing conversation that I'm now having with the local health districts about could you replicate something similar to the roles that you have within the councils… within government agencies such as Transport for NSW* External Participant

*And they [Transport for NSW] said what they why they wanted to do this Co funded partnership with us at the end of the day, was cause they were really impressed of the reach that we have with councils and the planning and transport part of councils.* Health Participant

*It's almost been a bit of an awareness pace for other staff within the Council and I hope the Community too. I have actually lined up[staff member external to the partnership] to get some mentoring and exposure to some of the work that the positon does, so we are now doing shared learnings within, but also encouraging others to maybe go down different career pathways too. So that's been a benefit* Council Participant

*Using those as mechanisms to drive healthier priorities at the policy level, then actually developing strategies, which sort of translate those policies into deliverables and actions that we or other departments in Council can execute so things like developing a tree strategy which we don't currently have and the position is working on and then advising into projects that are being done by other areas to achieve healthier place making outcomes.* Council Participant