Planning for Travel or Travel Planning?

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Abstract
Having spent 8 months as the resident transport planner at the Waitemata District Health Board I have a unique insight into the aspects of implementing travel plans within a large institution. Travel plans are designed as a tool to providing economic efficiencies such as reducing the cost of travel for individuals and reducing the cost to organisations of providing tracks of land for parking that could otherwise be used for other purposes. However, ironically even with the medical evidence on their doorstep that measures such as using more active modes of transport to travel to work have considerable health benefits, changing the travel behaviour of such an institution was a lot harder than originally perceived. I would like to present my insights and experience to the conference inorder to help with developing travel plans for the future.

Introduction

The Waitemata District Health Board (DHB) serves the largest DHB population in the country - more than 525,000 people. It is also the second fastest growing of New Zealand's 20 DHBs. Within the Waitamata Region, the Heath Board employs around 5,500 people in more than 30 different locations and manages a budget of over a billion dollars a year, serving residents of North Shore City, Waitakere City and the Rodney district. Of the 30 different locations, the largest are North Shore Hospital, on the shores of Lake Pupuke in Takapuna, and Waitakere Hospital in West Auckland.

As the second fastest growing DHB there is a growing requirement to expand to meet the needs of its customers. In that respect the Waitemata DHB has undertaken, over the past few years, a building programme of over $60M – the majority programmed for the North Shore Hospital site. A large majority of the site is old and it has been difficult to not only keep up with demand for services but to also attract staff.

To comply with the requirements of the District Plan and due process, the Waitemata DHB has had, as with all developers, to submit resource consent applications to its local authority for approval. As a major trip generating activity this has resulted in the requirement for a traffic assessment to also be submitted.

An overall masterplan for the site has been developed for the site but it has not yet been presented to Council. The issues surrounding this are discussed further in this paper. Despite this it was clear to North Shore City Council at the time and on the advice of the DHB's traffic consultants that the traffic assessment should be based on an appropriate timeline in the future to ensure that the anticipated programme of works was sufficiently future proofed and that the roading infrastructure was appropriate for the level of traffic envisaged.

In answer to this the resulting traffic assessment showed a significant increase in traffic movements in and around the Takapuna site and on advice of the Council, it was suggested that a Travel Plan be developed and implemented inorder to provide some assurance that the development might meet this future scenario.

The Travel Plan – Facts and Figures

Over the next 2 years, transport planning consultants worked with representatives of the Waitemata DHB, ARTA and North Shore City Council to develop a 'plan'.

The principle aims of the travel plan were to:

- Help reduce single occupant car trips
- Reduce demand for parking on the hospital sites (currently demand exceeds capacity at both the North Shore and Waitakere Hospital sites)
- Reduce the impact of hospital traffic parking in adjacent residential areas
- Provide improved travel choices for staff
- Identify opportunities for improving passenger transport services to the area
- Reduce the transport-associated environmental impacts on the local areas.

As part of the travel plan process a 'baseline' survey of how staff presently travelled to work was undertaken.

From the first travel to work survey in 2008 the staff members of the DHB were made up, by mode of travel, of:

Table 1 2008 Travel to Work Survey

Travel mode		Reasons given to drive alone only (more than one reason given)		Where do they park	
Drove alone	62%	To save time	48%	North Shore on site	44%
Public transport	3%	Public transport not		North Shore on street[1]	3%
Cycle	2%	available	53%		
Drove with a passenger		Convenience	50%	Waitakere on site	20%
As a passenger	9%	No alternative	22%	Waitakere on street	2%
Other	5%				
(motorcycle/walked etc)	19%			Other sites	31%

[1] For North Shore actual counts showed 200 park off site and 1700 on site.

From this work and in consultation with the Board and Council a set of actions plans were developed. A representative sample of the short, medium and long term actions included in the Travel Plan are detailed below. Along with the principle aims, the ultimate goal for the travel plan to reduce the incidence of single occupant vehicles (SOV) commuting by 15 per cent and to increase by the same amount, staff use of non-SOV modes of transport for travelling to work.

Short term (within six months)

These actions were identified as requiring no major capital expenditure. These largely involve co-ordinating working groups, small events, and using existing staff, resources and activities that may be performed by the Travel Plan Co-ordinator working in conjunction with the Waitemata DHB Communications Department team. Some incidental costs may be incurred to cover promotional items, such as inexpensive high-visibility vests for cyclists.

Examples of short term actions where no funding is required include:

- Ensure all new staff receive transport information as part of their induction
- Utilise the intranet to advertise and promote Waitemata DHB Staff Travel Plan projects and initiatives
- Ensure public transport timetables were available at the information desk and in staff cafés, in easy access display stands
- Set up a ride sharing matching scheme
- Promote specific events such as 'Walk to Work Week'
- Run new bus user training.

Examples of short term actions where funding may be required include:

- Run a ride share breakfast/matching event to create opportunities for staff to set up ride sharing arrangements
- Increase the amount of secure and covered bicycle storage.

Medium term (within two years)

Many of the medium term actions have associated costs. They include, for example, increased provision of showers and drying rooms for staff; provision of increased space for two wheeled vehicles, and construction of dedicated cycle and walking paths into the hospitals.

Examples of medium term actions where no funding is required include:

- Investigate providing more lockers for staff
- Establish an 'Active Travel Club' among staff at key sites
- Advocate for more regular public transport services at peak travel times

- Establish 'bus buddies' or public transport user groups
- Investigate purchasing bicycles that can be used by staff for business or personal use during the day.

Examples of medium term actions where funding may be required include:

- Organise an annual 'Sustainable Transport Expo'
- Incentivise active travel options through a reward scheme
- Investigate providing a shuttle for lunchtime runs to local malls
- Increase storage facilities for bike gear
- Organise a 'moped day' with suppliers where staff have the opportunity to 'test ride' this form of transport.

Long term (within six years)
These mainly involve low priority actions that don't require funding and entail working with the local councils to advocate for more walk and cycle ways where appropriate, and with public transport providers for enhanced services.

Examples of long term actions where no funding is required include:

- Investigate establishing linkages with existing 'Walking School Buses'
- Investigate more fuel efficient/low emission fleet vehicles
- Advocate for more cycle lanes on key routes to Waitemata DHB sites.

It should be noted that during the development of the Travel Plan a number of initiatives had already been implemented:

- Establishing a secure cycle park at North Shore Hospital
- Establishing an inter-hospital Staff Shuttle Service
- Holding ARTA Public Transport Clinics at the North Shore and Waitakere Hospital sites
- Installing public transport 'real time displays' at North Shore Hospital
- Developing the branding for the Waitemata DHB Staff Travel Plan and its associated activities.

Travel Plan Coordinator

My role as Travel Plan coordinator began in January 2010 and was to continue the implementation of the action plan. Although I have a transport planning background and had in a former life helped design hospital buildings I had not worked for a DHB before. From my perspective and I am sure it is not atypical of a DHB I found that as well as being made up of an enormous number of teams, groups, service areas etc there is also a high turnover of staff with continual restructuring and reorganisation.

For example, even between the time of my interview and when I began work, within the main Waitemata Travel Plan working group many had left the DHB or their roles were so different they could no longer contribute. In addition, a new Head of Facilities Team had started and it was under this team that the Travel Plan Coordinator sat.

Also before I began, the action plan had been presented to 'the Board' but due to an administrative error had not been passed and unfortunately it was not given the opportunity to be presented again during my tenure.

Despite this during the 8 months at the Waitemata DHB I was able to:

- Promote and increase the profile of cycling through Bikewise month, bike breakfasts, learn to ride days and cycle maintenance sessions;

- Increase the number of cycle parks and applied for funding for a secure cycle parking area at Waitakere Hospital;
- Make changes to HR and Induction Day literature to inform staff about travel to work alternatives;
- Implement a communications strategy for the travel plan;
- Identify and develop a series of leaflets to communicate to staff the location of all the cycle/pedestrian links and public transport facilities, showers, parking and tips on how to travel smarter. These were available in hard copy and on the website. The maps were also eventually made available to the general public;
- Begin discussions with HR and IT about working from home policies and changing clinic times;
- Carry out the 2010 Travel to Work Survey;
- Investigate public transport initiatives/guaranteed ride home schemes/car pooling;
- Assist with the implementation of patient travel initiatives for the Northern Region.

Issues

I felt at the time that this was quite a short list of achievements as I spent many days waiting for replies, trying to find the right person to talk to, trawling through many, often disjointed policies etc however given the issues I am about to give details of, its not too bad.

Firstly, as mentioned above, the DHB is made up of an enormous number of departments and teams etc that merge and divide on what looks like a whim and each team has their own role which, from the outside, they seem to be doing the same thing but in fact there is little overlap.

For example, to set up a meeting to discuss working from home policies, as well as the Human Resources department we also needed the Recruitment team too – shouldn't they be the same people – no, one looks after the staff once they were employed, the other does the employing? Along with that, actually trying to find 'that' person who could answer your question or find a piece of information, took a long time and very few staff were actually willing to go out of their way to point you in the right direction.
Understandably, in this economic climate and with the number of internal restructures, most people were just trying to keep hold of their own job and neither had the time nor resources to help outside of their already busy scope of works.

Secondly, and a huge barrier to the travel plan, were the conflict in policies and from my understanding this was largely created by the funding mechanism for DHB's.

In very brief terms, the operational costs of a DHB are made up of some government funding but largely, from charging patients (either directly or via ACC) and from local rates. The cost of new buildings, however, comes from central government. Currently most DHB's are not making any money nor even meeting their budgets but as new facilities are centrally funded they can still build. This creates a huge conflict of interest. While the Conditions of Consent to build for North Shore Hospital included reducing the number of trips by single occupancy vehicles, the DHB wanted to create more car parking spaces (and essentially encourage single occupancy trips), over and above that required by the District Plan. By doing so they could make revenue from charging staff and patients for those spaces. In addition, it was the policy of HR (or was it Recruitment?) to attract new staff by advertising that they had lots of on-site parking.

On top of this, obviously the promotion of clinical issues is the number one priority for the DHB but this meant that essentially there were no other resources available to promote 'non-clinical' issues such as those associated with the travel plan.

Other than myself, there was generally little support and due to our teams structure, we had no influence to change it.

Finally and an issue outside of the DHB is the resource consent process and the enforcement of consent conditions. I am not a Planner so this is just based on my experience of the Resource Management Act. Firstly, the current planning rules mean that large areas of land can basically be developed in a 'piecemeal' fashion and not as a whole. Therefore the impact of each individual part of a development is then obviously only a small percentage of a whole and is mitigated as such.

Secondly, the traffic assessment for North Shore and Waitakere Hospitals (and many similar developments) included travel demand measures to reduce the impact of the new development, so are integral to the approval to build.

In both of these cases it appears that local authorities are powerless to be able to insist on a comprehensive plan for a site as whole or to actually enforce the conditions of consent. Rules around developers contributions, zoning rules etc may put developers off revealing their overall plans but how can LA's possibly plan their infrastructure if they have no idea what is going to be built. And, once land is developed, there appears to be little comeback if sites do not mitigate their impact, other than possibly refusing future development but this may not eventuate and could have consequences on other development opportunities in the area. In addition, when developers apply for activities not zoned for, while we as transport planners produce impact assessments to mitigate, justify etc, the process of 'recalculating' this through the District Plan, for the zone changes, appears very slow whereas given the number of transport models in existence this could easily be a dynamic process.

Lessons Learnt

So what lessons were learnt from 8 months in a large institution?

Obviously, and not a new one, is the need to have management at the highest level familiar with what you are doing and to sign off the action plan. For a multi-disciplinary institution the implementation of the action plan involves many departments and all staff members are impacted so you must have the authority to communicate with these people and for them to be able to give some of their time to help too.

Unfortunately, in this case, this was out of my hands as the presentation of the Travel Plan to the Waitemata board was undertaken before I began and the new Head of Facilities either did not see the Travel Plan as a priority – they were new to the DHB, were in charge of $60M plus worth of work, and had not been involved in the process from the beginning or alternatively they may have been instructed by others above that did not appreciate the significance of the Travel Plan in the Resource Consent process.

Also the Travel Plan Coordinators role sat within the Parking Management Team in this instance. As many of the actions are around promotion and marketing, ideally this position should fit within a communications or marketing team to be most effective. This is also reflected by the fact that there is typically little capital, other than as part of wider improvements, for institutions to 'engineer' or build anything, so implementation is largely about education and marketing to change behaviour. However, some coordination with an organisations property or facilities management team is still important as you can the influence designs around access/pedestrian links etc.

Use outside resources as much as possible. I have North Shore City Council and the Auckland Regional Transport Authority to thank for a lot of the incentives and resources to run some of the promotional days.

Other regions have similar organisations than can and want to help.

Learn quickly who in your institution are the 'do-ers' and who knows everyone. Every organisation has one or two of these. Find them and use them to help you.

Money – to be really effective, all of the travel plan initiatives should relate back to a monetary background for those in management to take notice. In my view this is where there is a gap in the knowledge base for travel planning. I have seen very little research, in New Zealand, that actually quantifies some of the behaviour change initiatives but it is the monetary benefits and disbenefits that management and politicians will listen to the most. We talk too much in general terms i.e. high cost, short-term etc but cold hard cash talks much louder. It is often in the too-hard basket and most transport planners are not economists and visa versa.

Finally, just because the DHB is a 'clinical' organisation or whatever institution you are dealing with, do not assume that the lessons they teach are practised by their staff or are ingrained in their philosophy! All organisations and particularly within the service industries see their service as a priority – and would we have it any other way? What staff do outside of work hours i.e. keeping fit by cycling to work etc is not seen as a priority even if the facts show that it might increase productivity etc. Again bringing it back to monetary terms may help and really assist in changing behaviour.

I would, however, like to congratulate the Waitemata District Health Board (plus North Shore City Council and ARTA) for at least trying to be proactive, even if, cynically, it was largely forced on them by the Resource Consent process.

At the time of leaving the DHB there was no direct replacement for the travel plan coordinator role but the communication tools I left them with them will hopefully facilitate further progress. They will also continue to be in dialogue with Council regarding future plans and resource consents.

I believe travel plans will continue to have a role in managing the increasingly limited roading resources but should remain part of the package rather than stand alone but perhaps their role needs to be reviewed in line with changes to the RMA and other Council legislation.

In conclusion, following the 2010 Travel to Work Survey there had been a 1.6% shift from single occupancy vehicles to other modes (including as or with a passenger) compared to 2008. How much can be attributed to the Travel Plan – well we don't know for sure – but although small it is heading in right direction!