

Reflecting and
Connecting for Our
Health, Our Future:

Flinders Island

FULL REPORT

ANTICIPATORY
CARE PROJECT



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Glossary

We use several acronyms in the report. They are listed here.

AC	Anticipatory care (see definition on p. 5)
OHOF	Our Health Our Future (the Flinders Island project)
FHOCCM	Flinders Island Health Organisation Coordination Meeting (community members and service providers)
PSO	Project Support Officer—employed by the local lead organisations and working with them and with the UTAS team
CCWG	The Healthy Tasmania Chronic Conditions Working Group
SDoH	Social determinants of health (see definition on p. 5)
PPH	Potentially preventable hospitalisations (see p. 13)
CLD	Causal loop diagram
PHT	Primary Health Tasmania

In brief

Anticipatory care (AC) is a systematic approach to care designed to support people's current and future health needs. An effective anticipatory care system relies on a combination of accessible, locally-appropriate services and facilities, and collaborative, trusting relationships between services and between services and citizens. It is undermined by poor access to resources due to stigma, cost and relationship disruption. The system is shaped by policy at all levels of government and within organisations but must reflect local ways of working and resources.

The Our Health Our Future (OHOF) work on Flinders Island has demonstrated the power of beneficial changes in the crucial 'soft infrastructure' to support anticipatory care. The project activities have built

- relationships with and between services and community members, on- and off-Island
- cultural safety and competency
- greater understanding of the role of history and place

and begun bridging the distinct divides that exist. This shift can be sustained only if there are mechanisms put in place to nurture the developing trust and safety for this essential component of anticipatory care.

Executive summary

This executive summary is formatted in four parts. For a high-level, short summary, read the **In brief** section. The **Key Points** section is a brief overview of what we have learned. The full summary is in the section, **Methods, Processes and Findings**. This document concludes with a series of **Recommendations**.

Key points

Chronic illness is a major cause of ill-health and avoidable hospitalisations in Tasmania, and this burden is not equitably distributed. Chronic disease is linked with the social determinants of health: risk is reduced when people have reliable access to economic resources, secure and good quality housing, good diet, hygiene, health services, social networks and education. We need to reduce the risks for chronic illness and find better ways to manage existing conditions to keep people well. The Anticipatory Care (AC) Action Learning Project explored whether building a more effective local anticipatory care system could start to address this problem, in four Tasmanian sites. AC identifies who is at risk of developing an illness and aims to keep people well. Effective AC may reduce the need for expensive health and social services (Baker, Leak, Ritchie, Lee, & Fielding, 2012; Tapsfield et al., 2016).

This report documents the project's aims, processes, activities, and findings for the Our Health Our Future (OHOF) on Flinders Island. We gathered qualitative data from 153 community members and service providers in the OHOF site.

What was already known

Some people living on Flinders Island have higher rates of chronic illness, and potentially preventable hospitalisations than Tasmanians overall. They also have higher risk factors for chronic illness, including being obese (30% of Islanders compared with 24.3% of Tasmanians), and alcohol consumption at levels causing lifetime harm (46.5% of Islanders compared with 20.8% of Tasmanians). The median age of Flinders residents is also considerably older (at 52) than that for Tasmanians overall (42), and there is a higher proportion of Aborigines in the population (nearly 16% compared with 4.6% for Tasmania). Being an Aborigine (Ahmed et al., 2017b) and being older (Niccoli & Partridge, 2012; Prasad, Sung, & Aggarwal, 2012) are both risk factors for chronic illness.

Flinders Island has a diverse population, and some people have very good access to services and supports of all sorts. Others contend with the negative effects of the social determinants of health (i.e., poverty, unemployment, lack of education, etc.), including racism, which has been increasingly recognised as affecting health (Priest, Paradies, Gunthorpe, Cairney, & Sayers, 2011; Walter, Hansen, & Banks, 2012; D. R. Williams & Mohammed, 2009).

What the AC project has added

Residents and service providers we talked to presented a sometimes contradictory picture of anticipatory care on Flinders Island. Most reported that the Island was very well resourced with high quality local or fly-in-fly-out health services. Nonetheless, there are long-standing problems including difficulty with service collaboration,¹ and coordination across the Island. These are essential for effective anticipatory care. There are attitudinal and historical reasons for some of this deficit.

Medical services (GPs) have historically been seen as central to AC; in this community we have found that there are many other services that can play a part; indeed, the Flinders Island Aboriginal Association Inc. (FIAAI) operates a model of anticipatory care through its holistic service, which seeks to address many of the social determinants of health. We propose that this way of working may be an ideal model for an anticipatory care system. This has been made more apparent during the project and the COVID-19 pandemic, as FIAAI, the Multi-Purpose Centre (MPC) and the Ochre Medical Centre have found and embedded new ways of collaborating.

The OHOF team worked to improve health and strengthen the local AC system through a suite of activities developed using a participatory action learning and systems thinking approach.

¹ The Flinders Health Organisation Coordination Meeting (FHOCM) had already made some headway in reducing this problem.

Actions taken in the AC Action Learning Project have increased:

- understanding that AC involves a wide range of people and services
- inter-connectedness between services and people involved in AC across the Island (extending to Cape Barren Island)
- collaborative relationships with shared goals, language, and ways of working for health advocacy, including with some fly-in-fly-out service staff
- skills for anticipatory care and strengthened relationships and collaborations among service providers such as FIAAI, MPC and Ochre; part of this is person-dependent through the PSOs and GPs, who are remaining in their substantive roles
- cultural competency among FIAAI and other services staff to work safely and effectively with community members
- engagement of some groups (including previously hard to reach people) in health-promoting activities
- awareness and support from a key funder of visiting services to the Island about the need to include collaboration in role descriptions for providers visiting the Island (and Cape Barren Island)
- service provider and community awareness of alcohol consumption as a key risk factors for chronic illness and initiated some changes in access to alternatives
- the effectiveness and authority of FIAAI in health and anticipatory care.

Over the life of the project, some inroads were made into engaging with neighbouring Cape Barren Island. Cape Barren island was not part of the initial scope of the OHOF program but was brought in through OHOF activities that focused on collaboration. The OHOF team's work to negotiate the finely balanced relationships demonstrate the importance of projects providing sufficient time for this 'soft infrastructure' work.

While these benefits from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project, they are important short to intermediate measures/markers within a system which indicate a more enabling environment. We have evidence of changed behaviours, ways of working, awareness, and relationships (human capital) which, over time, we anticipate will lead to better health and wellbeing outcomes. A longitudinal study is needed to determine the full level of benefit from the changes to the local AC system.

The project identified barriers to AC. Chief among them was the difficulties of collaborating across services, which in turn creates barriers to coordinated support for people at risk of or living with a chronic illness. A culturally competent workforce was identified as underpinning collaboration and countering racism. Further, coordination relies on collaboration, and on the policy settings of local organisations, and state and federal governments. Policy barriers include inadequate welfare supports, short-term competitive funding, business models that do not support 'soft infrastructure', and problems with the

provision of appropriate and connected services. These barriers reduce options for taking a social determinants of health—including mental health—preventive approach.

Some AC project statistics for the OHOF site

Data gathering and sharing activities	153 people
OHOF and research activities	
GAME On Flinders	143 people
Cultural competency training	48 people in 5 organisations
Alcohol Awareness	Information provided at multiple sites; District High School (Flinders and Cape Barren) staff and student participation; 4 service provider education sessions and a community awareness session scheduled
Flu vax clinic (Lady Barron)	64 immunisations completed: FIAAI and other community members, clinic staffed from three organisations
Weekly health meeting	Ochre Medical Centre Practice Manager, MPC Director of Nursing and Nurse Unit Manager, PSOs
FHOCM meetings	16 members, meeting two-monthly

This report can be read alongside the local report prepared by the OHOF team, and reports on the other three AC project sites: Clarence (Help to Health), Launceston’s northern suburbs (Our Community Our Care), and Ulverstone and the 7315 postcode area (Connecting Care). A final report, incorporating external evaluation, will be delivered in December 2020.

Methods, Processes and Findings

Why

In 2018, the Chronic Conditions Working Group (Department of Health) funded lead organisations in four Tasmanian communities and a research team from the University of Tasmania to undertake the Anticipatory Care (AC) Action Learning Project. We worked together to:

- map the local AC system
- find out how to make AC work better, and what might get in the way
- trial actions to enhance the system, and
- learn what role the local lead organisations play in AC and whether their role can be strengthened.

We also trialled the usefulness of action learning and systems thinking for understanding and enhancing AC. The Tasmanian AC project ran from July 2018 to December 2020. The local Our Health Our Future project on Flinders Island ran from February 2019 to June 2020.

Learning about anticipatory care

Anticipatory care is a population approach to health care that identifies and engages people who are at risk of developing chronic conditions with the aim of preventing or slowing health deterioration. Through relationship building and by recognising the social context in which they live, people are supported to be 'co-producers' of their health.

The project framed AC as a system. The AC system's parts must work together effectively so we can identify and support people who are at risk of developing a chronic condition and *anticipate* their needs. An effective AC system includes ways to reduce risks and better manage existing conditions. It aims to keep more people healthy. We have defined health broadly in this project, guided by the social determinants of health (SDoH) (Marmot, 2005; Marmot & Allen, 2014). This means that our mapping of the AC system was not limited to health services, resources, or infrastructure.

What are the 'social determinants of health'?

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries. (World Health Organization (WHO), n.d.)

The four communities in the project have high rates of people being admitted to hospital for preventable conditions, including chronic illnesses. They also each have different demographical, social, cultural, and geographical characteristics, some of which may be contributing to the chronic illness load. These differences are helping us to learn what local AC systems have in common, and what different agencies (services, groups, organisations) can do in the system to support better health outcomes. The Our Health Our Future (OHOF) site is Flinders Island, in the Furneaux Group, off north east Tasmania in Bass Strait. The site's lead agency is the Flinders Island Aboriginal Association Inc. (FIAAI), which partnered with other members of the Flinders Health Organisations Coordination Meeting (FHOCM). Two people with health roles on the Island were seconded part-time to Project Support Officer roles; they are the FIAAI Health Services Manager (based at Lady Barron) and a community nurse, working out of the Multi-purpose centre (at Whitemark). The project's advisory group was FHOCM, and there was an executive comprising the CEO of FIAAI, the Director of Nursing at the MPC, a consultant to FIAAI, and a representative of Ochre Health, who provide general practice and other medical services on the Island. The executive, PSOs and FHOCM members are the OHOF team.

How

We used action learning and systems thinking. Action learning is participatory and invites people affected by a phenomenon to work together to learn about it, to make sense of what its causes might be, and to try out different ways to improve the situation. To understand the AC system, we gathered and analysed quantitative and qualitative data from, and about, people who live or provide services on Flinders Island. More than 150 people contributed to the qualitative data; this does not include observation or causal conversation data, recorded in fieldnotes. We wanted to know how they understood health, about their experience of the health system, and what supports or gets in the way of better health outcomes for the residents of the Island.

Our analysis helped us to understand what makes up the AC system in this community (our understanding of the system is being revised as we continue the analysis). Then we used a systems thinking tool, causal loop analysis, to explore with the OHOF team how the parts of the system affect one another, and to find opportunities where acting on one part of the system might have the greatest benefit for the whole system.

Several participants told us that:

the Island is really well supported. Yes, you know you can get into the GP just about same day. It's bulk-billed, you get your drugs from the same place. You've got a fantastic hospital, you've got emergency care. Yeah, you've got fly-in people consulting, ...

...this is the best serviced for a place of this degree of remoteness that I've seen anywhere.

Nonetheless, challenges to effective anticipatory care were identified, including difficulties with coordination and collaboration to support people with chronic illness, and the need for culturally safe services.

Service collaboration (quotes are from local participants):

...it's hard and we have to think creatively around how do we build that communication and that collegial aspect, because it can be very isolating over here ...

Cultural competency (and historical and current racism):

Some of the Aboriginal people, some of them, they're definitely you know, head down. Yeah. Yeah, you can tell from the way they walk as they approach you, especially the women

Risky alcohol consumption was also identified as a pressing concern for anticipatory care:

I haven't been here that long, but I've never been to an event where there wasn't alcohol

The focus of project activities in OHOF was on increasing service collaboration and on alcohol awareness (in order to reduce risky levels of consumption). The causal loop analysis showed that service collaboration on Flinders Island relies on mutual trust, respect and

reliability, effective use of resources, reflexive practice, continuity of relationships and cultural competence. Service collaboration is complex in most circumstances, as it is affected by organisational culture and gatekeeping, privacy laws, and short-term competitive funding, among other things. On Flinders Island, this complexity is compounded by the fact that many services are provided by fly-in-fly-out (FIFO) practitioners, and that this results in fewer opportunities to build and sustain relationships. It is also clear that historical divisions on the Island, between the palawa and European residents, continue to affect how services operate, and whether they can meet the needs of all residents.

Why does cultural competency matter?

Attitudes about a community or a person shape how they are treated and their expectations—in life generally, and of the health system. Attitudes to Tasmania’s palawa peoples (Aborigines) are an important factor across Tasmania, including on Flinders Island. Historical and continuing discrimination shape the health and wellbeing of palawa, including through dispossession, sexual and other violence, socioeconomic disadvantage, lower life expectancy, and direct (e.g., verbal abuse) and covert racism (e.g., poorer treatment, marginalisation) (The Priority Populations Team, 2018).

Trial actions to enhance the system

Each site developed action plans based on our shared understanding of where to intervene to strengthen or improve the system. Our Health Our Future activities focused on changes to the overall AC system through improving service collaboration, and on increasing support for physical and social health:

- Direct health impact and service collaboration—
 - sub-project: Alcohol Awareness program
- Social and physical health impact—
 - sub-project: G. A. M. E. (gear access made easy) On Flinders
- Service collaboration—
 - sub-project: Increase clarity and reliability of referrals
 - sub-project: Community groups booklet/online app
 - sub-project: Cultural competency training (and development of the training)

During the project, we have continued to gather data (more than 150 people contributed to our data) and to reflect on what we are learning with the OHOF team, together and individually. New knowledge helps us to review and adjust activities. Causal loop analysis (or causal loop diagramming, CLD) has been an important tool for this. In CLD sessions, members of the team identify variables and the causal links between them to find strengths and weaknesses, and places where adjustments can be made or have been effective. CLD is part of the action learning approach.

What do we know now?

Mapping the local AC system

The project has made some changes to how AC is understood in this community, and in the lead organisation. The researchers and local team have a better understanding of what makes up the AC system, and have shown the importance of place and belonging (as a key system part) and the impact of policy and processes; these two additional parts of the system were identified during the project. Culture is important in how we understand place and belonging.

Through the project, more people (and organisations) are seeing their role in supporting people's health *as part of* the broader AC system. There is also evidence among service providers of positive attitudinal shifts and practice changes aimed at supporting safer access to health for community members. This was evident in the data and demonstrated at our final CLD session, in May 2020, where participants included people with community development, health service and healthy policy roles.

What role does the local lead organisation play in AC and can their role be strengthened?

The lead organisation in the OHOF site, the Flinders Island Aboriginal Association Inc. (FIAAI), already has a role in preventive health. FIAAI takes a holistic approach to its community, working to provide supports not just for medical health, but for country and culture, housing, education and training, and employment, somewhat mirroring the social determinants of health. This approach prepared FIAAI for thinking about a broad system that reduces risk of chronic illness:

... that sort of goes across the breadth of what [FIAAI] does, because there's so many facets of the work that's done here. So at every level—I think that you can physically see anticipatory care happening here. Because everyone draws on everyone else's strengths and experiences to facilitate the best care, whether they be in mums and bubs, or whether they be in aged care. And regardless of what your job title says that you are a part of, everyone works together to make all cogs work.

This approach was supported by FIAAI and FHOCM establishing shared goals aimed to improve the coordination of health and other services to better support people. This addressed central elements in anticipatory care: trust and established relationships, and a non-fragmented system.

What did we learn; what could be changed to make AC work better (and for more people), and what might get in the way of improvement?

We learnt that AC is best viewed through a SDoH lens, as exemplified in the ACCHO holistic model; FIAAI works in this way and has demonstrated it—and this approach—are vitally important to the AC system on Flinders Island. In working to address the SDoH,

FIAAI is acting on the 'causes of the causes' of poor health. Through the project, FHOCM has increasingly adopted this approach, strengthening the AC system overall.

Positive project outcomes were supported by:

- the presence of dedicated, engaged, skilled, and AC focused personnel within the OHOF team, who built on existing connections to community and services
- careful listening to community members and research findings, and acting on what has been heard
- a flexible approach that was responsive to local circumstances
- very active outreach to services and residents, through the PSOs
- early and considered adoption of systems tools and action learning for identification, planning, implementation and review of project activities.

The OHOF work also showed that changes are needed to build on these outcomes:

- it is essential that practitioners, whether on-Island, fly in fly out, or providing services to Islanders visiting mainland Tasmania, find ways to collaborate to enhance the AC system's role in preventing or managing chronic illness
- cultural competency training is important in supporting collaboration and increasing safety across the AC system. This training needs to be locally relevant and safe, and part of the induction and regular professional development for services across the anticipatory care system. FIAAI needs to be resourced to further develop the training.
- performance measures and key performance indicators (KPIs) in some services do not capture the whole picture, not accounting for things like new networks and relationships that are formed through activities, and privileging specific, countable outputs rather than community outcomes. KPIs need to take account of the externalities, and so-called 'soft' measures such as the social, environmental, emotional and community aspects of service provision
- some state and national policies and processes actively work against taking a SDoH preventive approach; this is evident in competitive and short-term funding models that reduce connection and collaboration between parts of the AC system, a lack of resources to support outreach and collaboration, and continuing problems with discharge processes from major hospitals.

Summary

The AC Action Learning Project in this site has resulted in increased:

- understanding that AC involves a wide range of people and services and their inter-connectedness
- collaborative relationships with shared goals, language, and ways of working for health advocacy, including with fly-in-fly-out staff
- skills for anticipatory care (including in sustaining collaborative relationships) among service providers, including the PSOs and GPs, who are remaining in their substantive roles

- cultural competency among FIAAI and other services staff to work safely and effectively with community members
- engagement of some groups (including previously hard to reach people) in health-promoting activities
- awareness among service provision policy makers about the need to include collaboration in role descriptions for providers visiting the Island (and Cape Barren Island)
- awareness of some risk factors for chronic illness (including alcohol consumption) and initiated some changes in access [can I say this?]
- the effectiveness and authority of FIAAI in health and anticipatory care.

Recommendations

The AC project has demonstrated that enhancing the AC system is possible at the local level through local initiatives. The project has planted the seeds of new ways of thinking and working; we make the following recommendations to support long-term benefits to AC and the health of this community. There are opportunities to maintain and build on what has been gained.

For local action

The PSOs on Flinders Island were already embedded in the community; the AC project supported them to reach beyond their usual roles, develop a strong collaborative relationship, increase coordination between FIAAI, the MPC and Ochre Health, and collaborate with off-Island service providers more effectively:

- Maintain the OHOF-instigated coordination between the FIAAI Health Service Manager and the MPC community nurse, including through shared workplaces, information sharing and work collaboration, and embed this coordination via role descriptions
- MPC and FIAAI to further explore and formalise where possible staff rotation/co-location arrangements, shared position descriptions and information sharing.

Partnerships and collaboration across the system are essential. FHOCM has a recognised role in building and sustaining collaboration across Flinders Island and with off-Island services, and in shifting attitudes to support AC. They can also—perhaps particularly through the (former) PSOs—reach out to the least connected people and services to understand local needs, people, and situations so that responses can be relevant, accessible, and meaningful:

- FIAAI and the MPC have supported the outreach, coordination and collaboration of the PSOs during the project; this needs to be sustained through their continuing substantive roles.

Collaboration and coordination are essential to the anticipatory care system, and some steps have been taken by service provision policymakers (e.g., TAZREACH) to embed these activities and ways of working:

- On- and off-Island service providers should incorporate outreach and collaboration as key tasks for all service providers working across the Furneaux Islands (including through FHOCM) and find ways to coordinate with one another to support the anticipatory care system

Performance measures or Key Performance Indicators (KPIs) have historically ignored qualitative measures of ‘soft infrastructure’ and change in favour of quantitative ‘number of services’ measures. These cannot adequately reveal how the AC (or other health and wellbeing) system is performing.

- Revise health and social care service KPIs to reflect externalities, soft infrastructure, and experiential dimensions of performance

For local, state and national policy action

All levels of government have a role to play in efforts to alleviate chronic illness.² These recommendations to build on the gains from the AC Action Learning Project—and to spread those gains more widely—rely to a greater or lesser extent on recognising that shared role and shifting policy:

- State and federal governments need to recognise that the Aboriginal Community Controlled Health Organisation (ACCHO) model, with its holistic approach guided by the social determinants of health and cultural competency is an appropriate framework for anticipatory care, and develop policy that supports this model being applied more widely
 - The ACCHO/social determinants model demands a whole-of-government approach to preventive health
- Cultural competency training should be part of the induction and regular professional development for services across the anticipatory care system; it needs to be driven by local palawa, who are adequately resourced to develop and deliver locally relevant and safe programs
- Local, state and federal governments need to develop KPIs that reflect externalities, soft infrastructure and experiential dimensions of performance
- Factor the importance of place and belonging (including cultural concerns) into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision, town planning, and social housing and, potentially, mirroring or adopting the ACCHO model
- Flinders Council continues to be an active partner in improving health and wellbeing

Short-term project-specific funding models are damaging the AC system. To better support the health and wellbeing of the community, we need:

- To replace competitive funding models that reduce connection and collaboration between parts of the AC system with models that promote and support collaboration
- Flexible funding over longer periods

² These roles will be explored more fully in the final report.

- Funders to set broad goal/s (e.g., improve health in this community) and allow communities/leads in consultation with their community to determine what success looks like, how it will be measured, and how to allocate and manage the funding
- Funders to work as partners, providing guidance and monitoring of process (e.g., community engagement, how resources are being utilised/targeted, without being prescriptive)
- To trust local communities to identify their own priorities and develop strategies to address those priorities.

For future work on anticipatory care and preventive health

Gains from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project. An overarching aim of the AC project was to use a systems approach to identify strengths and weaknesses in AC systems and to co-design community specific responses. Assessing the longer-term health dividends is beyond the scope of the study. Therefore:

- A longitudinal study is needed to determine the level of benefit from the changes to the local AC system.
- Further flexible resourcing should be provided to build on this work.

Action learning and systems thinking have been effective here, but both rely on time and trusting relationships:

- Provide sufficient time in future anticipatory care work to develop relationships with local teams and communities, and to adapt processes and tools to maximise participation, and
- Introduce systems tools early and encourage their use—and adaptation—to suit local users. This could support the inclusion of more community members, first-hand learning about local systems (rather than through interpreters, such as researchers or members of the local site team), and thus support both genuine participation and local solutions.

There are clear mutual learning benefits for the university, the DoH and the OHOF team in the approach taken here to working to enhance anticipatory care. The contributions made by each group are particular and cannot readily be ‘swapped’. The ideal of equipping local communities to replicate the approach without these supports burdens them. Similarly, university researchers cannot ever become expert enough about a local site to work in ways that are inclusive and appropriate without partnering with locally embedded organisations:

- Future preventive health (including anticipatory care) projects should build in opportunities for mutual learning between community, university, and relevant government personnel.

Reflecting and Connecting for Our Health, Our Future: Anticipatory Care Action Learning Project Final Site Report, Flinders Island

Anticipatory Care at a whole of population level is concerned with reducing inequities through identification of geographic areas and/or specific target groups that are most at risk of preventable serious ill-health and/or deterioration of existing conditions. Key elements include screening, the provision of care pathways and appropriate interventions with monitoring and follow up.⁽³¹⁾ It could also potentially include assessment of preventative health needs across communities and at all levels of government to inform the development and implementation of plans to address identified needs.⁽³¹⁾ (Healthy Tasmania Chronic Conditions Working Group, 2018, p. 7)

Background

Chronic illnesses have replaced acute conditions as the major cause of ill-health and costs to the health system across the world. Chronic illnesses are conditions that are debilitating and long-lasting. Chronic illnesses can often be avoided, or managed so that people stay relatively well, able to participate in their community, and out of hospital. More than half of Tasmanians aged 15 years and over have three or more chronic health conditions. Only 15 per cent of Tasmanians reported having no chronic conditions (Department of Health, 2019). Rates of illness are increasing. In 2017–18, there were 15,848 potentially preventable hospitalisations (PPHs) for chronic conditions in Tasmania (49.8% of PPHs). These rates are higher than for Australia overall, where chronic conditions account for 45.4 per cent of PPHs (Australian Institute of Health and Welfare (AIHW), 2019a).

Potentially preventable hospitalisations (PPH)

“PPH are certain hospital admissions that potentially could have been prevented by timely and adequate health care in the community. There are 22 conditions for which hospitalisation is considered potentially preventable, across 3 broad categories: chronic, acute and vaccine-preventable conditions”. Our focus in the AC project is on chronic conditions.

“The term PPH does not mean that a patient admitted for that condition did not need to be hospitalised at the time of admission. Rather the hospitalisation could have potentially been prevented through the provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings (including by general practitioners, medical specialists, dentists, nurses and allied health professionals). PPH rates are indicators of the effectiveness of non-hospital care”.

Source: AIHW (2019b)

The COVID-19 pandemic adds to the risks for people with chronic illness. COVID-19 poses a particular risk to the elderly and people with chronic conditions (particularly diabetes, heart disease, kidney disease and chronic lung conditions); both groups have worse outcomes if infected (Bhatraju et al., 2020; Lippi & Henry, 2020; Yang et al., 2020). Tasmania’s chronic

illness rates and older population (Department of Treasury and Finance, 2018) make us more vulnerable to the worst outcomes from the virus.

Chronic conditions screening and management were identified as a priority in the Tasmanian Government's *Healthy Tasmania 5 Year Strategic Plan* (2016). The Healthy Tasmania Chronic Conditions Working Group responded by identifying and trialling new models of Anticipatory Care in Tasmania (Healthy Tasmania Chronic Conditions Working Group, 2018).

What is anticipatory care and how and why has this project been funded?

Anticipatory care models identify who is at risk of developing an illness and aim to keep people well. Anticipatory care is not a reactive system, but one that “anticipates health needs before they arise and that delivers continuous, integrated, preventive care with the patient as partner” (O'Donnell et al., 2012, p. e288). Effective anticipatory care reduces the use of expensive health and social services (Goodwin, Curry, Naylor, Ross, & Duldig, 2010). Historically, anticipatory care programs have been managed through general practices.

The programs combine:

a population approach with long-term productive relationships, between patients and professionals who know and trust each other, and who are guided by evidence and audit. (Watt, O'Donnell, & Sridharan, 2011, p. 2)

Anticipatory care relies on:

- trust and established relationships (between practitioners and patients)
- high quality data (about patients and their health)
- a non-fragmented system, and
- equitable access (Watt et al., 2011).

The social context

Along with the physical manifestation of disease, there is also a social context for people living with long-term poor health and their ability to engage fully in society. Many people experience:

- Disruption to daily life because of illness and or/disability
- Pressure on family and other personal relationships particularly where there is a reliance on informal care
- Regular or frequent contact with a range of health and community care providers particularly where assistance with daily living is required
- Difficulties in securing and retaining employment and maintaining an adequate level of income
- Increasing social isolation and loneliness
- Self-identity and self-worth issues potentially increasing the likelihood of mental health issues.

Source: Healthy Tasmania Chronic Conditions Working Group (2018)

Anticipatory care involves health services and individuals (Martin, Sturmberg, Stockman, Hinkley, & Campbell, 2019), but the risk of developing a chronic illness is also produced by the social determinants of health (Marmot, 2005), the “material, social, political, and cultural conditions that shape our lives and our behaviors” (Marmot & Allen, 2014, p. S517). Julian Tudor Hart, regarded as one of the two founders of anticipatory care³ (Bonn, 1999; Tudor Hart, 1971; Tudor Hart et al., 1991; Watt et al., 2011), noted the problem of treating a patient but then sending them home to the conditions that had caused their illness. This link between social (and economic) factors and health is central to anticipatory care.

The Tasmanian Anticipatory Care Project

Preliminary work by the Healthy Tasmania Chronic Conditions Working Group (CCWG) suggested that anticipatory care in Tasmania was happening in many ways, not only in GP practices. The CCWG wanted to gain a better understanding of what is already happening in Tasmania, taking a broad view that accounted for the social determinants of health.

Aims

The Tasmanian Department of Health (DoH) received funding from the Australian Government to conduct research to better understand and learn from communities about different ways anticipatory care happens and what works well and why. Between late 2018 and June 2020, the Department and the University of Tasmania worked with four Tasmanian communities to apply an action learning approach to anticipatory care to:

- Increase our knowledge and understanding of how anticipatory care occurs in different communities
- Better understand the enablers and barriers to anticipatory care experienced by communities
- Increase our knowledge and understanding about how communities and health services can work together to engage ‘at risk’ Tasmanians in primary and preventative health care, including assessment and management of their health needs.

(Anticipatory Care, Project Guidelines, 2018)

The research questions

The CCWG engaged the University of Tasmania to work with the project site teams to learn how anticipatory care is operating in Tasmania, and what difference local factors, actions, and particular agencies make. The learnings and findings from the anticipatory care project will be used to develop best practice approaches, as information to support other communities to provide anticipatory care, and to inform future policies and funding models (Department of Health, 2018). There are overall research aims (see Box, above) as well as specific research questions.

³ The other is C. Van den Dool, a Dutch GP.

The research questions (RQs) for the whole AC project are:

Mapping anticipatory care:	What does anticipatory care look like in each community? What are the shared elements and what are not? What is working, and who is it working for? What is not working, or who is not benefiting? And how does anticipatory care look and function in an isolated and under-resourced community?
Opportunities for enhancing AC:	What elements in the existing system can be influenced (and are they within the capacities of local actors)? What gets in the way?
Actions and outcomes:	What actions are the sites implementing? What changes have the actions resulted in—what differences can be seen at individual, organisation, service and community levels?

In keeping with the broad scope of the project, the CCWG also wanted to get a better understanding of the roles of different sorts of agencies in anticipatory care. For this reason, there is an additional research question in each site. On Flinders Island, the lead organisation is the Flinders Island Aboriginal Association Inc., and the local research question is:

Our Health Our Future RQ	What is the role of FIAAI in anticipatory care, and can it be strengthened?
---------------------------------	---

Choosing the locations and lead agencies

The Department selected four communities for the project on the basis of:

- Potentially Preventable Hospitalisations data over 3 years from 2012/13 to 2015/16 (inclusive of both the separation and actual rates)
- Australian Bureau of Statistics data including socio-economic indexes for areas (SEIFA)
- Qualitative criteria including for community development and readiness, local leadership and collaboration potential and ability to improve and innovate (see Farmer & Nimegeer, 2014; O'Donnell et al., 2012)
- Equity criteria, including ensuring a spread of sites across the three regions of Tasmania (north, north west and south) and a balance of urban and rural/remote sites

The selected lead organisations are a local government, a GP clinic, two neighbourhood houses, and an Aboriginal Community Controlled Organisation. This span of partners enables us to learn how an array of organisations support anticipatory care. This fits into a social determinants of health approach.

Ethics

Ethical approval for the project was gained from the Tasmanian Social Sciences Human Research Ethics Committee, with amendments approved as needed. The HREC project approval number is H0017669.

The characteristics of the Our Health Our Future site



The Our Health Our Future area is Flinders Island (see Appendix 1). The project’s lead organisation is the Flinders Island Aboriginal Association Inc. (FIAAI). Flinders Island is classified as remote—it lies between Tasmania’s north east coast, and the south east coast of Victoria. Access is by plane (daily services), or boat (weekly), and is dependent on the weather. There are two main population centres, Whitemark on the west coast, and Lady Barron on the southern coast. Each has around 150 residents. The remainder of the Island’s approximately 900 residents lives in smaller settlements or on properties across the Island. The Islands have a tragic history, having been the site for the incarceration of Tasmanian Aborigines in the 19th century. This history still shapes Island life.

The Islands’ small population has a median age of 52 (57 on neighbouring Cape Barren, which was only peripherally involved in the AC project), ten years (and 15 years on Cape Barren) older than the Tasmanian median, and much older than the Australian median of 37. The main population age differences are in school-aged people (11.8% on the Islands compared with 18.2% for Tasmania as a whole) and people older than 65 (25.1% compared with 17.2%). Cape Barren’s people are all Aboriginal, and Aboriginal people make up nearly 16% of the two Islands’ population overall. The social determinants of health are not equitably spread among the Islands’ populations. There are stark socio-economic differences, with pockets of serious disadvantage on Flinders Island and on Cape Barren Island. For instance, while Flinders Islanders’ median weekly household income is \$1,021 (close to the State’s median of \$1,100), on Cape Barren Island, this figure is \$537, and more people earn less than \$650 (gross) each week (30.4%) compared with Tasmanians overall (26.3%).

Table 1: Who lives on Flinders Island

	Flinders Island	Tasmania
People	906	509,965
Age	53	42
Aboriginal	15.9%	4.60%
LOTE*	1.55%	6.50%
Income**	\$1,021	\$1,100
Living in rented accommodation	16.3%	27.3%
Highest level of education, Yr 10	26.2%	17.4%
Home internet	76.1%	78.0%
Not in paid work***	7.4%	7.0%
Voluntary work	38%	21.30%

*LOTE = language other than English spoken at home. ** Median household weekly income. *** Full or part time paid work.

Income data needs to be considered in light of some higher costs: travelling from and to the Island(s) for any reason is expensive (though there are some subsidies), and living on the

Island(s) is also more costly in terms of fuel and some other costs (freight adds considerably to the cost of many items).

Along with income disparities, access to other social determinants of health (SDoH) are unevenly spread across the Island's population. Although Flinders Island has a well-equipped Multi-purpose Centre (medical and aged care services) and an Aboriginal health service, several services remain unavailable or inequitably available on the Island. The costs of accessing some health services (including some of those not located or delivered on the Island) can be burdensome. Health here is also affected by historical and continuing problematic relations between some European and Aboriginal residents that create barriers to anticipatory care. Recently, researchers have argued that the SDoH need to account for how racism affects the health of Aborigines (Carson, Dunbar, Chenhall, & Bailie, 2020; Priest et al., 2011; Walter et al., 2012). Finally, although a large proportion of Islanders grow, hunt or kill at least some of their own food, access to fresh food can be affected by the weather, if inclement conditions make flying freight in unsafe. You can read a more detailed community profile in the 2019 report (Appendix 4).

At Whitemark, there is a modern, well-equipped multi-purpose centre (MPC) providing acute and aged care beds, outpatient and emergency services, physiotherapy, some x-ray services, community nursing and other services. There is also an Ochre Medical Centre offering a range of services including bulk-billed consultation to Island residents. At Lady Barron, there is a comprehensive Aboriginal health service operated by FIAAI. Specialist services are provided to the Island's residents by visiting services funded by the Tasmanian and Commonwealth governments via the Bass Strait Island Agreement (BSIA), the Medical Outreach Indigenous Chronic Disease Program (MOICDP), the Rural Health Outreach Fund (RHOF), the Visiting Optometrists Scheme (VOS) and the Healthy Ears Better Hearing, Better Listening (HEBHBL) schemes.⁴ For other services, some emergencies, and between specialist visits, residents need to travel to Launceston, Hobart or mainland centres like Melbourne. Some costs of this travel are subsidised by the State government. In 2018, the Flinders Island Council commissioned FTI Consulting to prepare a report on the economics, business and social structure on Flinders Island. The report (FTI Consulting, 2019) found that:

- 93.53 per cent of residents had seen a medical practitioner in the preceding 12 months
- about a quarter of residents had seen a health practitioner 'off-Island' in the previous 12 months (the most commonly visited were dentists and ophthalmologists)
- some residents leave the Island to access services that are also available on Flinders Island.

The most common reasons for potentially preventable hospitalisations (PPH) for Flinders Island residents are chronic obstructive pulmonary disease, congestive heart failure, and cellulitis (related to cancer). Flinders Island also has had a much higher rate of PPH per 1,000

⁴ For details, see:

https://www.health.tas.gov.au/healthprofessionals/tazreach/current_tazreach_funded_services/tazreach_services_-_north

people (50.4) than Tasmania overall (21.2) (PHT data). Flinders Island residents have the longest length of stay when hospitalised of all Tasmanians (4.727 days compared with 2.654 days for Hobart residents) (Ahmed et al., 2017b).⁵ There are site-specific reasons that make these statistics less comparable than would be the case for other Tasmanian communities. The health indicators for Aboriginal Tasmanians, like their mainland Australia counterparts, “continue to compare unfavourably to those of other Tasmanians; this includes risk factors, morbidity and life expectancy” (Ahmed et al., 2017b, p. 62). Some health risk data is not available for Flinders Island, but we do know that in 2017, Flinders Islanders, compared with Tasmanians overall, were:

- Somewhat more likely to be obese (BMI) (30% compared with 24.3%)
- Much more likely to be drinking alcohol at levels causing lifetime harm (45.7% compared with 20.8%) (PHT data)

People are good judges of their health. Researchers have shown a relationship between people’s (including children’s) self-report of poor or fair health and an increased risk of death (McGee, Liao, Cao, & Cooper, 1999; Miilunpalo, Vuori, Oja, Pasanen, & Urponen, 1997; Riley, 2004). People in Tasmania’s north are reporting slightly poorer health than Tasmanians overall, but better health than is self-reported by Aboriginal and Torres Strait Islanders in Tasmania (Table 2).

Table 2: Self-reported health in 2019: Northern Tasmania, Aboriginal and Torres Strait Islanders (Tasmania) and Tasmania overall

	<i>Northern Tasmania (overall)</i>	<i>Aboriginal and Torres Strait Islanders, Tasmania</i>	<i>Tasmanians (aged 18 and over)</i>
<i>Excellent/very good</i>	35.7%	26.3%	37%
<i>Good</i>	42.0%	31.5%	41.1%
<i>Fair/poor</i>	22.2%	29.5%	21.7%

Source: Department of Health and Human Services (2020)

⁵ This measure may be problematic and inappropriate, since discharging a person back to the community is more difficult or dangerous where it involves a flight, and there may not be appropriate supports in place or available at home.

		Flinders	Tas	Flinders Local Government Area	
				Top 10 lists, Tasmanian public hospitals (2015-16) ⁴	
Demographics					
Population (June 2016) ¹		906	509,965	Potentially Preventable Hospitalisations	
Aboriginal population ²		15.0%	4.6%	Chronic obstructive pulmonary disease (COPD)	
Population 65+ years ²		26.7%	19.4%	Congestive cardiac failure	
Median age in years ²		53	42	Cellulitis	
Social determinants of health					
Median household weekly income ²		\$1,021	\$1,100	Angina	
Private dwellings without a motor vehicle ²		7.6%	7.5%	Hypertension	
Unemployment rate (September 2015) ³		6.9%	6.5%	Urinary tract infections, incl. Pyelonephritis	
Eligible population completed year 10 or higher ²		86.2%	86.3%	Ear nose and throat infections	
Risk factors					
Self-assessed health, fair or poor (2013) ⁴		-	19.0%	Pneumonia and influenza (vaccine preventable)	
Psychological distress, high or very high (2013) ⁴		-	11.4%	Iron deficiency anaemia	
Current smoker ⁴		-	15.7%	Pelvic inflammatory disease	
Insufficient moderate/vigorous activity ⁴		-	14.9%		
Inadequate vegetable consumption, <2 serves daily ⁴		-	91.0%	Charlson comorbidities	
Inadequate fruit consumption, <2 serves daily ⁴		61.0%	59.6%	1. Any malignancy, including lymphoma and leukaemia, except malignant neoplasm of skin	
Obese BMI ⁴		30.0%	24.3%	2. Chronic pulmonary disease	
Mortality [age standardised rates per 100,000 population]⁵					
All-cause mortality (2008-2012)		616.5	643.7	3. Metastatic solid tumour	
Deaths due to circulatory disease (2008-2012)		233.1	201.0	4. Congestive heart failure	
Deaths due to cancers (2008-2012)		134.7	190.1	5. Dementia	
Potentially avoidable mortality (2008-2012)		174.7	170.1	6. Diabetes without chronic complication	
Morbidity					
Persons aged 16+ with 3 or more chronic diseases ⁶		-	21.5%	7. Diabetes with chronic complication	
Children fully immunised at 5 years of age ⁷		-	92.4%	8. Myocardial infarction	
Potentially preventable hospitalisations, age standardised rate per 1,000 population (2011/12-2015/16) ⁸		50.4	21.2	9. Mild liver disease	
				10. Peripheral vascular disease	
				Issues:	
				Older, poorer population, with more Aboriginal and Torres Strait Islanders, and relatively similar rates of mortality to Tasmania, but more data is required around morbidity and health risk factors.	
				Primary diagnosis on admission	
				(J44) Other COPD	
				(M54) Dorsalgia	
				(C34) Malignant neoplasm of bronchus and lung	
				(G62) Other polyneuropathies	
				(Z38) Liveborn infants accord to plc of birth	
				(I50) Heart failure	
				(P07) Disrd short gest & low birth weight NEC	
				(Z48) Other surgical follow-up care	
				(O80) Single spontaneous delivery	
				(C78) Sec malig neoplasm resp & digestive organ	
				Allied health provided in hospital	
				Physiotherapy	
				Pharmacy	
				Social work	
				Occupational therapy	
				Dietetics	
				Speech pathology	
				Pastoral care	
				Ages, admitted patients	
				¹ Australian Bureau of Statistics, Regional Population Growth, Australia, 2016. Cat no 3218.0. ² Australian Bureau of Statistics, Census of Population and Housing: General Community Profile, Australia, 2016, Cat No 2001.0 (Canberra, Australia: 2017). ³ Primary Health Information Development Unit, Social Health Atlas of Australia: Local Government Areas; Based on the Small Area Labour Markets – Australia, Department (2018). ⁴ Department of Health and Human Services, Tasmanian Population Health Survey 2013 ⁵ Department of Health and Human Services Tasmania, Tasmanian Population Health Survey 2016, ed. and trans. Department of Health and Human Services Tasmania, 1 ed. (Hobart, Australia: Department of Health and Human Services Tasmania, 2017). ⁶ Department of Health and Human Services Tasmania, Epidemiology Unit Data (2017). ⁷ Primary Health Information Development Unit, "Social Health Atlas of Australia: Local Government Areas; Compiled Based on Data Provided by Australian Childhood Immunisation Register, Medicare Australia, 2015." ⁸ Department of Health and Human Services, Health data warehouse, 2011-2016	

Figure 1: Risk factors and potentially preventable hospitalisations 2017–18, Flinders Local Government Area

Methodology—why we did what we did

Action learning + systems thinking

UTAS needed to find out what the anticipatory care system looks like in each site, and to work with the lead organisations to see whether the system could be made to work better through local actions. One of the CCWG's project aims was to test whether using systems approaches could give us better or more useful insights into this complex system and better understanding of how social determinants of health play out.



The CCWG engaged The Australian Prevention Partnership Centre (TAPPC) and Dr Therese Riley (Systems Consultant) as partners to help us apply systems methods. This supported mutual learning among researchers, the DoH Principal Project Officer, and the local teams. This learning was about the anticipatory care systems themselves and about ways to investigate those systems. Together, we identified six preliminary system parts to investigate (Figure 2).

Figure 2: The preliminary system parts

The CCWG proposed action learning as an approach that could help us learn together about the systems and about opportunities for intervention. The four parts of action learning are 'observe', 'reflect', 'plan', and 'act'. The diagram below (Figure 3) shows the action learning process. Action learning was used to find out whether the suspected system parts were present, to define them, and then to learn how the parts might be linked to or affect one another, and to learn about and adjust actions.

What can we find out about this system? What seems to be working-and what isn't?

What has our observation shown us? Is our view accurate? What and who are missing?

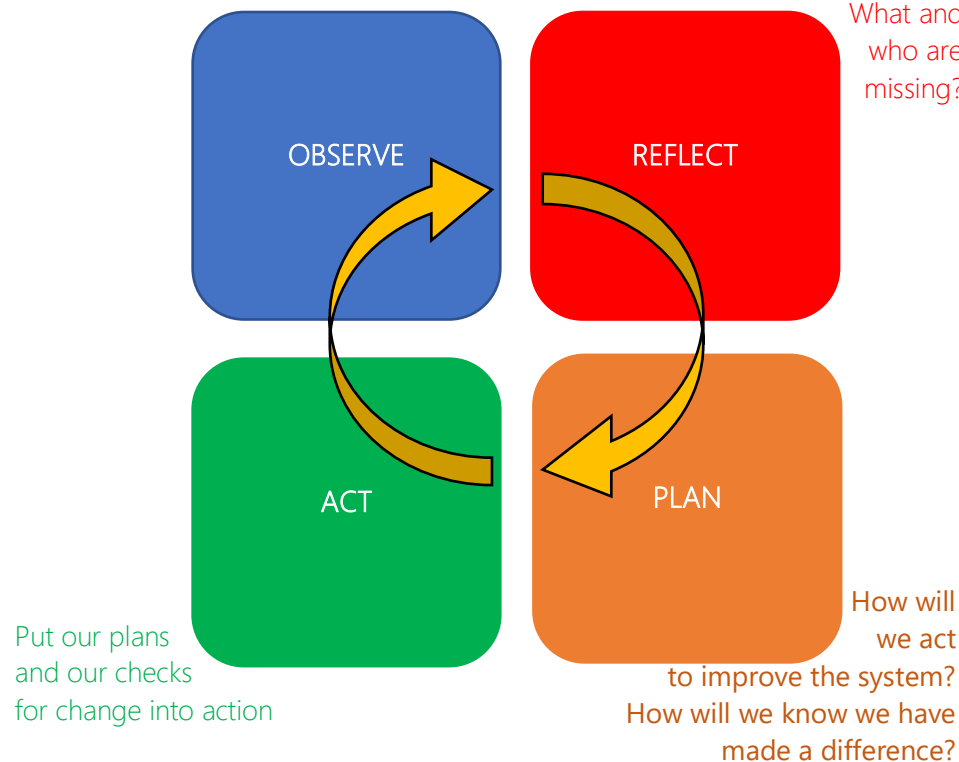


Figure 3: The action learning cycle

The theory behind action learning and systems thinking

A systems thinking approach looks at “all the connected and inter-related issues, at how changing one part will influence other parts and how relationships and behaviours change over time” (The Australian Prevention Partnership Centre (TAPPC), 2017, p. 3). The anticipatory care system is made up of multiple parts, interacting in different ways. We can use systems ideas to “. . . help us to conceptualise and work with complex issues” (Burns, 2007, p. 21) like anticipatory care. Systems thinking allows us to think about how anticipatory care operates, how the parts interact, and to learn what supports or hinders the system’s effectiveness. This ‘holistic’ approach means that the social determinants of health—as well as the structures and people—can be examined (Midgley, 2006). Once we understand the way the system works, we can plan actions to improve it (Hawe, Shiell, & Riley, 2009), and check on the effect of the actions taken (Trickett et al., 2011).

Interrelationships, boundaries and perspectives are important in systems thinking (B. T. Williams & Hummelbunner, 2010). In anticipatory care, interrelationships refer to the connections between health, social and community services, between professionals in the system, service users and local residents. Boundaries focus on who is considered inside or outside the system and the range of boundary judgements that are made by health

professionals, community, and researchers (see Ulrich and Reynold 2010). Perspectives pay attention to whose views or voices are deemed more or less important in determining the nature and extent of anticipatory care (see B. T. Williams & Hummelbunner, 2010). These ideas remind us that complex systems are dynamic and unpredictable (Midgley, 2010). (Appendix 2, taken from the project's PSO manual, gives some examples of interrelationships, boundaries and perspectives.)

Action learning and systems thinking are good partners (Burns, 2007). Action learning is part of a group of approaches that are participatory, collaborative, reflective and involve learning and action for change. Action learning, action research, collaborative enquiry and participatory research are related ways of working. These approaches are used to explore and—if necessary—change an existing system. To do that effectively, we need to understand the many worldviews and parts of a system (Dick, 2009); this is sometimes referred to as an holistic understanding. The processes of observation, reflection, planning and action, undertaken with the people in a system, mean we can gain that holistic picture, recognise opportunities for change, and see how change is affecting the system.⁶

Methods—What we needed to learn and how we gathered and analysed data

The site's lead agency is Flinders Island Aboriginal Association Inc. (FIAAI). At FIAAI, the lead is the Chief Executive Officer, Maxine Roughley. The FIAAI Health Services Manager was seconded (part-time) to manage the project and a community nurse, based at the MPC in Whitemark was seconded (part time) to the Project Support Officer (PSO) role. Flinders Island had an existing group, the Flinders Health Organisations Coordination Meeting (FHOCM), formed to better coordinate health services across the Island, as well as the HipSters health promotion team. FHOCM played the role of local advisory group in the OHOF project, with an executive group drawn from FIAAI, the MPC and Ochre Medical Centre. For the AC project, FHOCM was joined by the UTAS lead and the DoH Principal Project Officer. FHOCM and the executive group has met regularly over the life of the project. The lead, PSOs, and FHOCM members are the OHOF team. The team, with UTAS researchers and the DOH Principal Project Officer, worked using an action learning approach. The project roles are shown in the 2019 report (see Appendix 4). —

Action learning is a cyclic process that gives us repeated opportunities to learn, plan, act, and check on the effects of those actions.



Observe: What can we find out about the system? What seems to be working and what isn't?

In each project site, we began by learning about the local anticipatory care system: who lives here, what are their characteristics, including their current health, and what attitudes, relationships, organisations or structures may be affecting their long-term health. In this

⁶ Dr Therese Riley provided much of the material about systems thinking in this section.

'observe' stage, we looked for a wide range of information in order to include different perspectives. We used census data (Australian Bureau of Statistics, 2016b), health information from Primary Health Tasmania (PHT) and State of Health reports, previous and current research in other projects, community audits and surveys, and interviews with local service providers (Appendix 3 details data gathered, and you can read more about the process in our first report, attached at Appendix 4).

R

Reflect: What has our observation shown us? Is our perspective accurate? What and who are missing?

We analysed (reflected on) the information from the perspective of the six system parts and created preliminary local system maps. We included the local community in our reflections. To do this, the maps were turned into posters (see Appendices 9 and 10), and shared at a community workshop (at the end of March 2019). This was another way to include more perspectives. The analysis processes are described later in this report.

At the workshop, community members were asked what was working, not working, confusing or could be changed about the anticipatory care system, for each of the six preliminary system parts. They were invited to use sticky notes to add their responses (examples, stories, or problems) to the posters. Research team members made fieldnotes during the sessions and collected the posters and sticky-notes and the butchers' paper notes made by participants. Researchers also identified potential interviewees and focus group participants who then contributed to the observation and reflection stages. The research team, a researcher from the Sax Institute, and the DoH Principal Project Officer, Flora Dean, wrote out their notes after the workshop. All the data from the workshops was included in the ongoing analysis of the system.

We found strengths in the system, as well as barriers and opportunities. The analysis results, including a revised system map, and the barriers and opportunities, were reported to each site in mid-2019 (the report for this site is attached as Appendix 4) and discussed with FHOCM. FHOCM was then invited to use this information to begin the planning phase.

P

Plan: How will we act to improve the system? How will we know we have made a difference?

We used four questions to support the planning process:

- Given the findings, what are the 3 top priorities that you think Our Community Our Care should work on? This includes who the project will target.
- Is there something that is achievable and sustainable that can be tried/done to improve or address one or more of the issues identified by the research?
- What difference do you think the proposed action will make in terms of improving the health of individuals and/or the community? How will it contribute to the prevention/better management of chronic conditions?

- What are the ripple or flow-on effects of the proposed actions?

Actions planned needed to respond to local conditions, people, needs and boundaries. For instance, how might particular groups be reached?

For some individuals, a mailed letter might suffice; for some, an advertisement on the radio; others will need a recommendation from a close friend or family member; others will need more concerted efforts and some may not respond to any type of approach and only be contactable when they attend for another reason. (Watt et al., 2011, p. 6)

The planning process resulted in a set of proposed activities intended to enhance part of the system or reduce barriers to it working well.

Planning was supported and refined using a systems thinking tool, causal loop analysis. We ran causal loop analysis workshops at each project site. The participants were local AC project staff (lead and PSOs) and members of FHOCM. The aim of causal loop analysis is to make sense of the system parts, discovering how they are linked and affect one another (the interrelationships) (Figure 4). The causal loop diagram (CLD) process can be used for the whole system, or for parts of it. Making a diagram of this system and its links is also useful for checking the accuracy of the system map and for predicting and testing the potential outcomes of any planned actions. The process is outlined at Appendix 5. At each session, the group focused on a particular barrier or opportunity in the anticipatory care system, identifying the supporting and confounding factors (variables) and causal links. We wanted to learn, in this process, how strengthening one factor might affect others, and where we can intervene for the greatest impact.



Figure 4: Linking the system parts

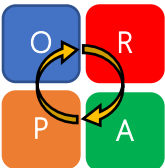
The PSOs, guided by FHOCM and causal loop work, made an action plan (see Appendix 7). The action plan⁷ set out:

- The FORM: A description of the activity, including information about the tasks/activities, as well as the timing, the responsibility, and the resources.
- The FUNCTION: Information about the intended outcomes, and the people it is intended to involve and affect, including a description of the deliverables/milestones.
- The possible RIPPLE EFFECTS: What might flow from the activity—the less-intended consequences (including risks as well as benefits), and
- The MEASURING: Measurements of effect for proposed activities; how will the activity's effects be measured, and how soon?

Causal loop diagrams were also used at the end of the Anticipatory Care project to reflect on the impacts of the activities on the system. We used a second systems thinking tool, systems traps (Meadows, 2008), in the PSO Community of Practice and with teams from across the AC project state-wide to look for and consider solutions to potential problems in the system and activities.

A Act: Put the plan—and the checks for change—into action

Planned actions were agreed to by FHOCM and implemented. In some cases, implementation involved mainly the local PSOs; in others, actions involved other people within or outside the lead organisation.

 Action learning is a continuous process

During the life of each action, PSOs, FHOCM and the executive reviewed progress, using the observe, reflect, plan and act process. Regular meetings between the leads, PSOs, UTAS researchers, DoH Principal Project Officer and FHOCM members tracked how the actions were progressing, flagged successes and difficulties, and negotiated next steps to improve outcomes. Some adjustments were made to adapt the activity to the local circumstances and experience.

⁷ The project action plan has been reviewed and revised as the project progressed.

Project structure and roles

The project structure, roles and relationships are given in Appendix 4.

Local activities

Some AC project statistics for the OHOF site

Data gathering and sharing activities	153 people
OHOF and research activities	
GAME On Flinders	143 people
Cultural competency training	48 people in 5 organisations
Alcohol Awareness	Information provided at multiple sites; District High School (Flinders and Cape Barren) staff and student participation; 4 service provider education sessions and a community awareness session scheduled
Flu vax clinic (Lady Barron)	64 immunisations completed: FIAAI and other community members, clinic staffed from three organisations
Weekly health meeting	Ochre Health Practice Manager, MPC Director of Nursing and Nurse Unit Manager, PSOs
FHOCM meetings	16 members, meeting two-monthly

All sites took many actions. Some of these were formally planned, and some took advantage of opportunities that arose. Activities are discussed in the Results section below, in the final report prepared by the OHOF team (2020). The box below presents some project statistics.



Analysis: Reflecting on what our observation has shown us

The ‘secondary data’—health statistics and previous research reports, for instance—were used to describe the context of the project. We then created preliminary system maps, and the community profile. Secondary data helped to inform the questions we asked in qualitative data gathering, and in the surveys. Some survey questions produced quantitative results, which were analysed statistically.

Qualitative analysis starts during the data gathering. Researchers conducting interviews, focus groups and observation are actively analysing what they are hearing, recording this analysis after sessions as fieldnotes. We also transcribed the interviews, focus groups and observations, qualitative survey responses, and reflections (e.g., from PSOs) and removed things that would link them with particular people (and, where needed, places). These documents were then entered into NVivo (version 12), a program that supports researchers to identify major themes (thematic analysis). Individual members of the research team are

working on particular sets of documents, but each researcher is also analysing documents from other batches, to check whether we agree with one another's understanding of the material (this multiple coding, also called inter-rater reliability, is discussed in Armstrong, Gosling, Weinman, & Marteau, 1997; Barbour, 2001; Kitto, Chesters, & Grbich, 2008).⁸ We have regular whole- or part-team analysis discussions about what we are finding in the data. This has been a complex and dynamic conversation.

Analysis will continue as we prepare the whole-of-project final report. We also review and revise our thinking in conversations throughout the project with the project lead, the DoH Principal Project Officer, Sax Institute and TAPPC researchers and Dr Riley, FHOCCM and the PSOs. These are all important opportunities for reflection.

Analysis informed our mapping of the anticipatory care system and identified opportunities for intervention in the system. We prepared a written report of the findings from the analysis to date in 2019 (see Appendix 4) and presented this to FHOCCM.

Our other main analysis method is causal loop analysis, which is described above (and in Appendix 5). Causal loop analysis brings together the themes in the quantitative and qualitative data, as well as enabling participants to add what they know or have experienced to the diagram.

We conducted two causal loop diagram sessions (in 2019 and 2020). At the first session, we worked on one of the opportunities for intervention in the system identified in our analysis. At the second, we asked participants to review the system—its boundaries and interrelationships—bringing their experience of the project to the analysis. The CLD sessions in community are part of our ongoing analysis. The research team created activity-specific, opportunity-specific, whole-of-site, and whole-of-Tasmania diagrams of the variables and causal links in anticipatory care (the whole-of-site and whole-of-Tasmania analysis will be reported at the end of 2020). The diagrams enable us to understand the present state of the system, how various actions may cause changes in and across the system, and to later check what, if any, changes have taken place.

Findings

The results reported here are for the pre- and post-activity action learning cycles. The post-activity results include what we learned about activities in progress. We report the analysis results under the following headings:

- Survey data
- Thematic analysis: Interviews, fieldnotes, focus groups, reflections, and observations
- Systems work and causal loop analysis
- Project processes

⁸ There are also arguments that researchers should “trust their judgements and be prepared to defend their interpretations and analyses” (Morse, 1997, p. 447) in the face of the push for inter-rater reliability.

The data gathered are described at Appendix 3. We reported on our use of health statistics and previous research (secondary data) in 2019 (Appendix 4). That material showed that some people living on Flinders Island have higher rates of chronic illness and potentially preventable hospitalisations than Tasmanians overall.

Context

FIAAI is well-placed to understand and address some of the cultural barriers to health on Flinders Island. It also takes an holistic approach to the wellbeing of its community, an approach that works to reduce the negative impacts of the social determinants of health. This includes operating a health service, aged care services, housing, education and training, and employment supports, youth services, cultural, craft and other activities, and running several businesses across the Island. FIAAI (and its staff) are an integral part of the Aboriginal community, and are responsible and answerable to the most local of concerns. As well, they have personal and historical links to local places and people. All these factors mean they are well-placed to work in ways that can impact on anticipatory care. FIAAI is also involved in the Flinders Health Organisations Coordination Meeting (FHOCM), enabling collaboration with other health providers on the Island.

Survey results

We designed the survey to learn about other perspectives of the system and what boundaries and interrelationships may be shaping it. Survey responses told us about how participants think about health, what elements in the system they use, and what gets in the way. Surveys were also a way to hear from people who might be unwilling to be formally interviewed about the anticipatory care system (see Appendix 3). Several approaches to gathering this information were suggested (for instance, a PSO in a different site proposed a way to gather information that did not require literacy).

For pragmatic reasons, an interviewer-administered pen-and-paper survey was developed, piloted in two sites (Clarence and Flinders Island), and revised to meet Plain English guidelines by the Clarence PSOs. This is an example of action learning; trialling the survey enabled the PSOs to see what changes could make the survey more useable. On Flinders Island, the PSOs used the original survey and some novel methods to gather data, including working with students at the District High School to talk about and record self-reported health (Illustration 1) and how the pupils think about health (see Illustration 2). The process of gathering responses across the Island also had other benefits. The PSOs were able to meet people in many settings, building relationships (including with the School), share information about the project, and get more information about what is available across the Island, and of how people use their community. This outreach has been valuable for building an understanding of the community and the anticipatory care system across this diverse site and for connecting with a wider range of community members. The results of the surveys on Flinders Island are reported in full at Appendix 6.



Illustration 1: School students self-reported on their health

Seventy-three adults and thirty-two school students completed the survey in 2019. This represents slightly more than ten per cent of the population, a very high response rate. The average age of community respondents was 56.8 years, which is older than for the Flinders population overall (53 years). Only about a fifth of respondents were men (though men make up a little less than half of the Island's whole population). More women than men responded to the survey in all the anticipatory care project sites.





Illustration 2: Examples of school students' posters about "What does health mean?"

Main findings from the Our Health Our Future survey

All general community survey respondent (n = 73) answered the self-reported health question (Figure 5). Excellent health was reported by 8 people (11%), good by 46 people (63%), fair by 18 people (24.7%) and poor by 1 person (1.4%). Grouped into two broad categories, 74 per cent rated their health as excellent or good, and 26 per cent as fair or poor. These results mirror those for the north of Tasmania more generally; in 2019, 78 per cent of Tasmanians, and 75 per cent of people in the State's north, self-reported their health as 'excellent' or 'good' (Department of Health and Human Services (DHHS), 2020). People in the school sample were much more likely to report excellent or good health.

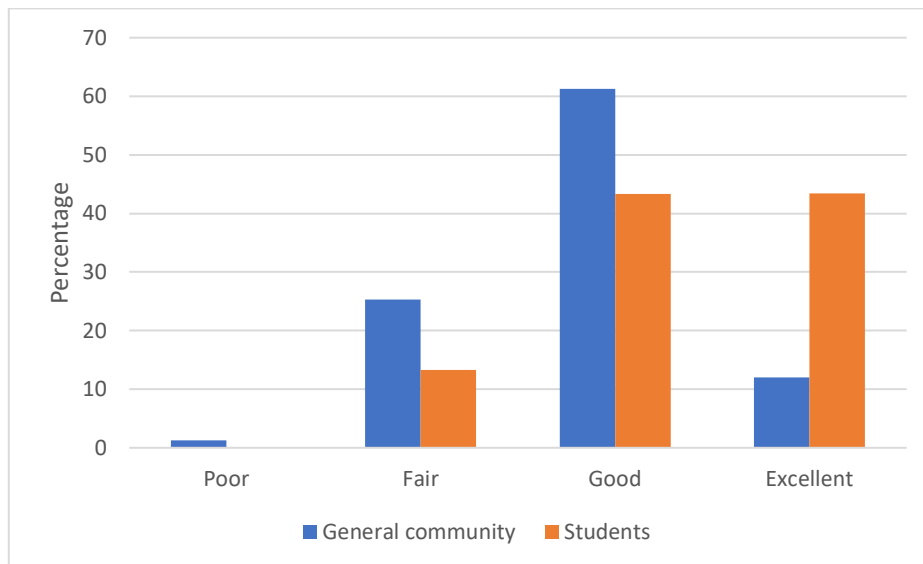


Figure 5: Self-reported health for general community and school samples

The mean self-reported health for Flinders Island survey participants (general community) is better (at 2.82) than for the other AC project sites (Clarence = 2.72; Ulverstone = 2.67; Launceston = 2.21).

Sources of support

We asked participants “Who do you talk to about your health? (your ‘go to’ person)”, in the categories of family, friends, people who are not family or friends, and health care professionals. About three-quarters of participants spoke to family members (sometimes more than one) about their health (75.3%; n = 55). About two-thirds of respondents talked to their friends about health; this included work colleagues or mates.

Most respondents spoke to health professionals (84.9%) and this included GPs (70.9%), as well as allied health professionals. Quite a large proportion of people said they had a family member or friend who was a health professional (58 people; 87.0% of people responding to this question). This fits with the fact that many people we interviewed or spoke with told us that Islanders commonly work in several roles, including in health.

Social and physical actions for health

Respondents were asked about the social activities they are involved in, and 72 people responded; only one person said they “*Stay mostly at home*”. People here reported higher numbers of social activities than has been reported in the other AC project sites. The average number reported by the general community respondents was 3.8; in other sites this average was 1.5 (Help to Health), 1.9 (Our Community Our Care), 1.7 (Connecting Care). This result is interesting, but it could simply reflect more time taken by the PSOs to gather the information. Five people recognised that work is an important social activity, including it in their answer. The largest single group was people who were doing five or more social activities (29.2% of respondents) (Figure 6). School group respondents were more active—socially and physically—than their general community peers.

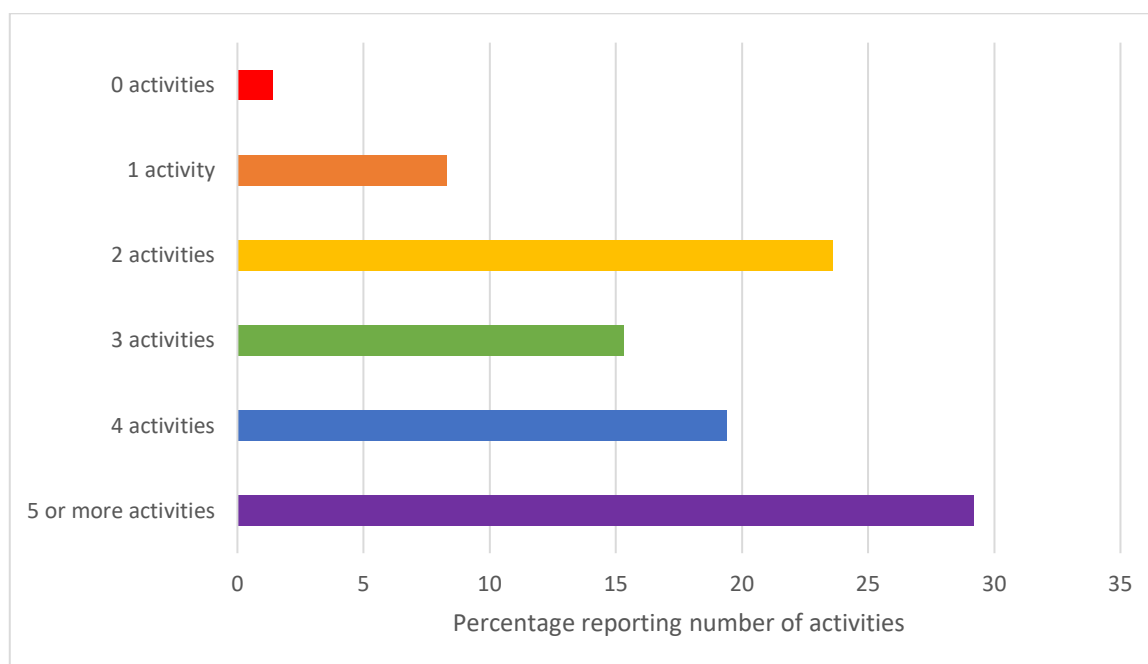


Figure 6: Number of social activities reported by respondents, OHOF

Seventy-one people reported on their physical activities (1 person did not report any physical activities, and one person did not answer this question). Fifty-five people reported doing physical exercise (walking, bike riding, gym), and nineteen people were growing, catching or hunting for some of their food. This was rarely mentioned in other sites. The most commonly mentioned activity was walking (including bushwalking), which was listed by 21 people (29.6% of respondents), followed by going to the gym or a formal exercise class (19 people), and bike riding (9 people). Figure 7 shows the main categories of activity reported.

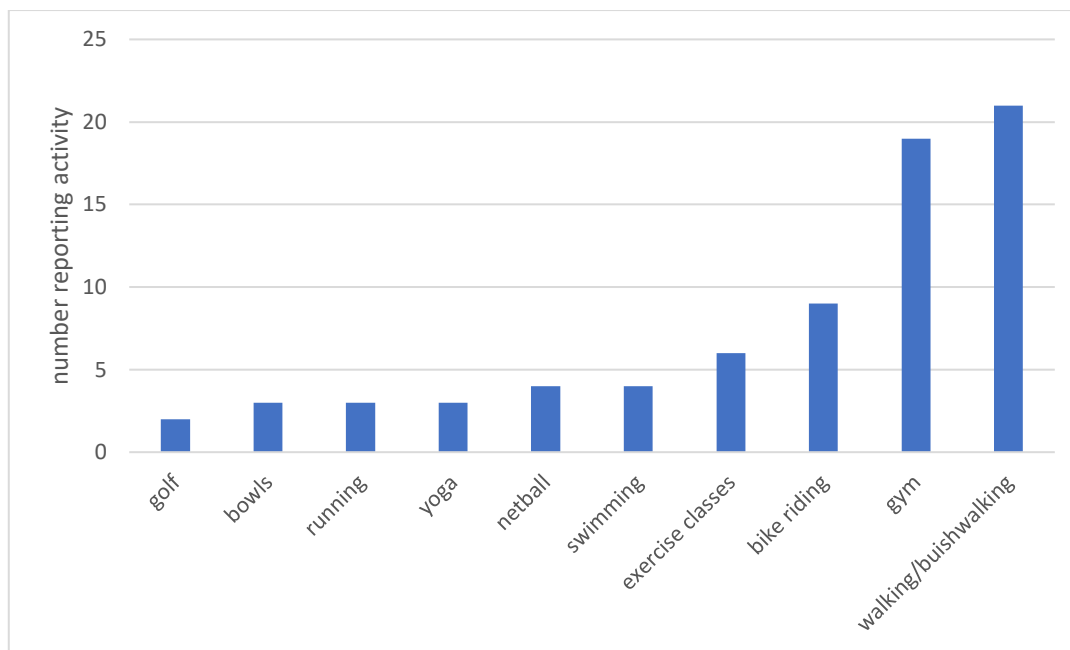


Figure 7: Main categories of physical activities reported

Eighteen people were doing no physical activity, fifteen people (20.5%) did one activity, twenty-six (35.6%) were doing two activities, and 14 were doing three or more (19.2%).

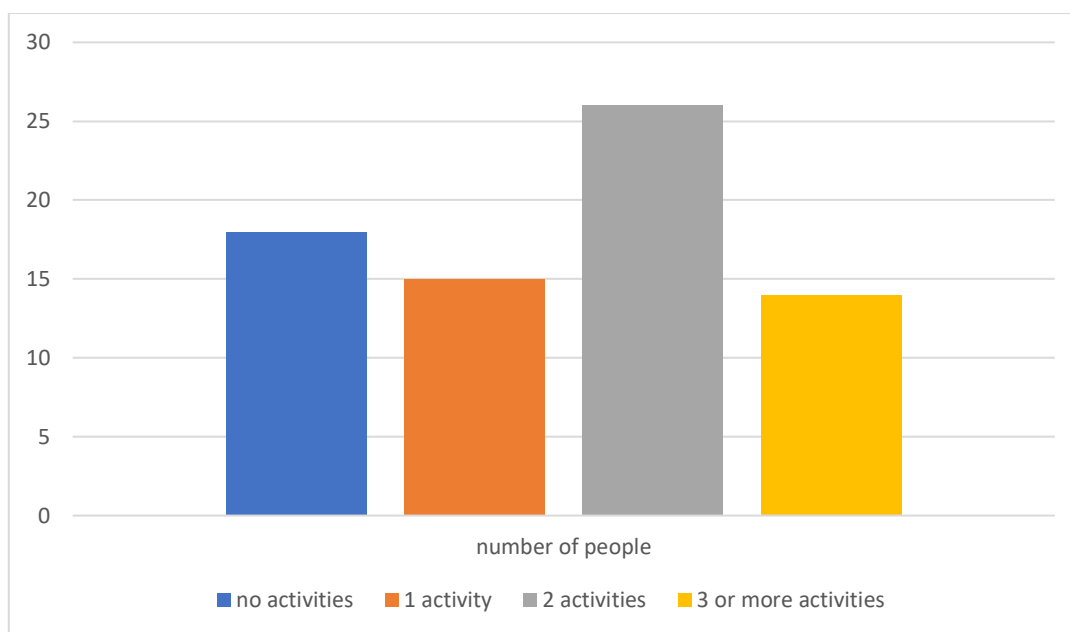


Figure 8: Number of physical activities reported per person in the community sample

For both physical and social activities, people doing more activities reported better health. Correlation is not causation, however; better health is likely to make social or physical activity more possible.

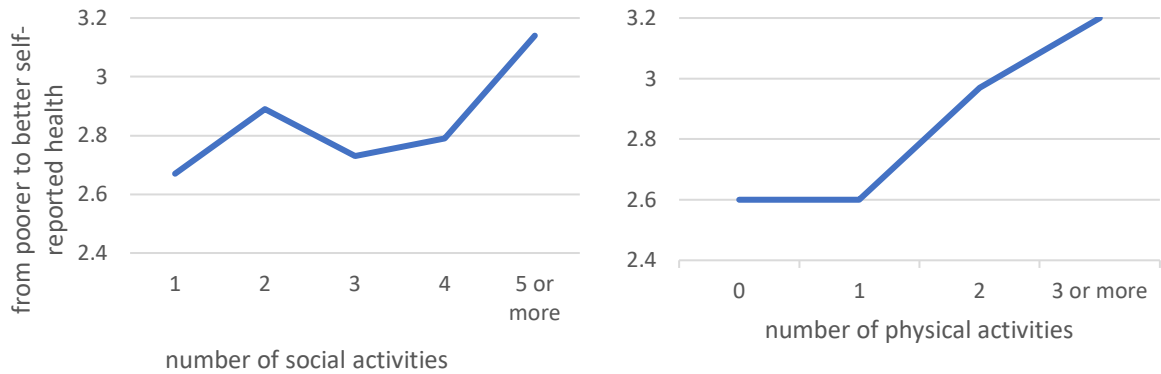
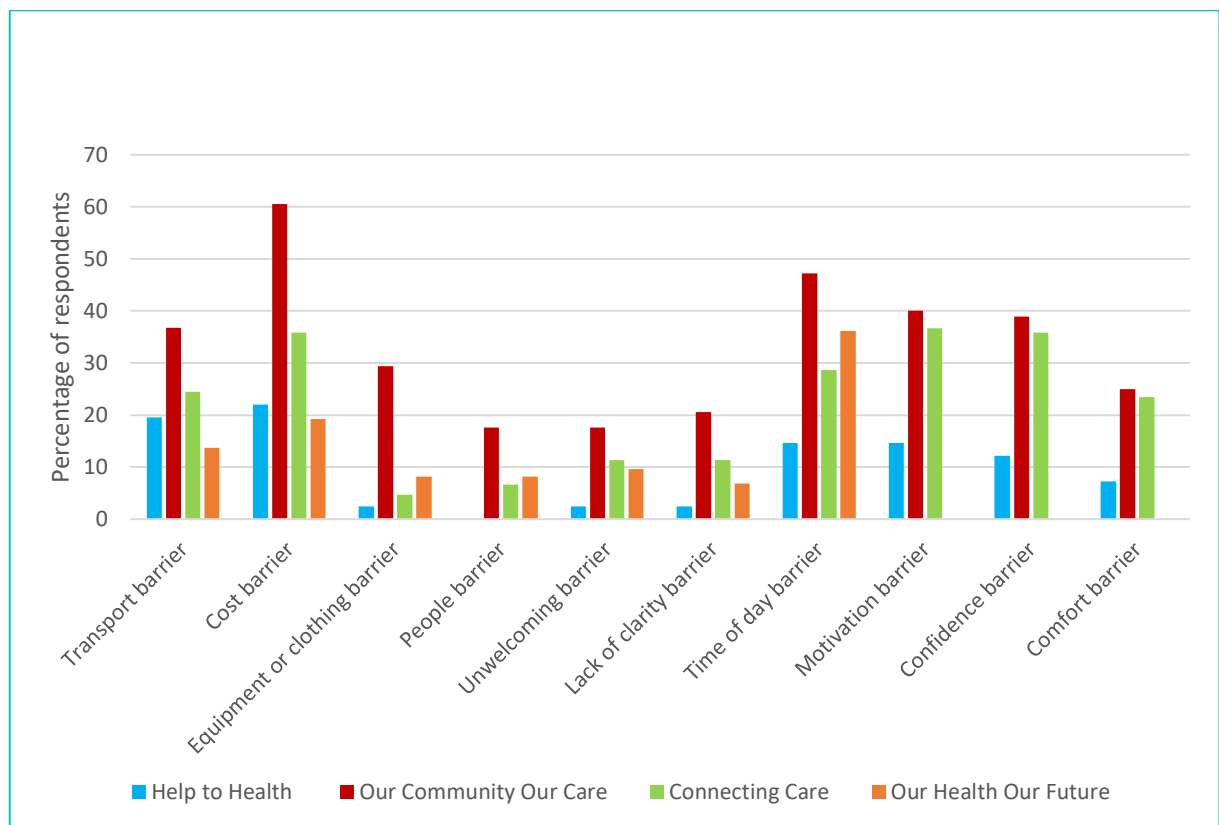


Figure 9: Number of social and physical activities and self-reported health

Barriers to maintaining your health

Participants were asked about things that get in the way of them maintaining their health. Time was the greatest barrier—time of day an activity was available, or conflicts with shift work. Cost also prevented people from being involved in health-benefitting activities. While scale varies, the patterns of response are remarkably similar for all four project sites (Figure 10).



Note: The OHOF survey did not include questions about motivation, confidence or comfort.

Figure 10: Barriers to using health supports across the four Tasmanian AC sites

These results are indicators only, although they are congruent with the qualitative findings for Flinders Island. While the sample was a good size, it was not representative of the community overall (including being older than the local population and having a much higher proportion of women). The full survey report is included as an appendix (Appendix 6); it includes the written- in comments.

Thematic analysis: Interviews, fieldnotes, focus groups, reflections and observations

We are analysing the qualitative data by themes. These themes were both ‘given to us’ (the research questions, the system parts and the AC framework) and emerge from the analysis. Although the survey sample was not representative, several of the themes and barriers participants identified there are also present in the thematic analysis.

Themes in the data

Anticipatory care relies on ‘routine encounters’ where there is trust and established relationships, a non-fragmented system, and equitable access to those system parts (i.e. affordable services, that are within physical and social or cultural distance of citizens, and that have ‘humane’ staff) (Watt et al., 2011). The systems parts we used enabled us to identify how these essentials appeared on Flinders Island. Having a non-fragmented system, supported by trust and established relationships was the over-riding factor here, affecting the anticipatory care system. Other important themes were the importance of belonging, and of the impacts of alcohol.

Service collaboration

Service collaboration and coordination was a prominent theme. Poor collaboration and its consequences were mentioned by participants who provide anticipatory care services, or who rely on them.

... if your question had to have been what do you think is the weaknesses of the system on Flinders Island, I would say a lack of communication and accountability between services. (Service provider)

I think there are relationships between individuals and sometimes they work amazingly well, but I don't think they're sustainable because I think they're based on individual relationships instead of systems. (Service provider)

Poor coordination plays out in several ways. People fall through the cracks, lose trust in the system, and have poor experiences, as the following example shows:

I also met [name], who told me [partner] was in a major hospital from [some months]. [Name] had called the hospital after partner's surgery—having waited seven hours for recovery time and so on. Name was told that they needed to have a password and unless they had it, could not speak to the partner or be told anything about their condition. Name had no password, but tried again, each hour for several hours, receiving the same response. Eventually, staff told [name] that the surgeon would call. He didn't. [Name] was very angry and upset (and still is). Next day, they agreed to let [name] speak to [partner], but they were so upset, and didn't want to (spoil partner's

mood). This sounds like a poor process at the [hospital], and one that [name] was not prepared for by any specialist or other person involved in [partner's] treatment. (Fieldnotes)

We also learned of a person being referred to a potentially life-saving service, but not having that referral followed up by the off-Island service for two years, and about regulatory or bureaucratic barriers between services on-Island and on mainland Tasmania, or in other states (this is important, since FTI consulting found that about a quarter of Island residents see health practitioners off-Island, FTI Consulting, 2019):

And the other little quirky issue I suppose that I had as well is going from Tasmanian healthcare to [other State] healthcare, is none of the actual letters were recognised. So I had to get, what's the word I'm trying to look for here, introductory letters that I used, had on the island that were written by my doctor saying, "Hey this [person] needs to see a specialist." I then had to go and see a local GP in [other State capital city] because they weren't recognised and just getting the copy of the letter, so reference letters, because they're not recognised in [other State]. Tasmanian doctors aren't recognised in [other state]. (Community member)

Where collaboration is successful, it relies on individual relationships:

So I think that a certain level of interaction becomes almost second nature. So because of the fact that we're allowed to—that we are personally looked at as people rather than just numbered employees, that also allows us the opportunity to look at every single client we come into contact with in the same light, is good modelling for one, if nothing else. And also the way that [FIAAI] operates is that you have the time to look at each client that comes into your care as a whole person. I don't think that any of us would ever say that we just had to rush someone through and deal with that, with the cough that they came in with that day... Or whatever. You know, everyone takes time. (Service provider)

Collaboration (and leadership within the AC system) between community members is also actively supporting people's health. A good example is the systems that operate at the Whitemark gym, and the Lady Barron Hall:

So there's a group of blokes and a couple of women but group of blokes come in they get on the bike, they're chatting away, they don't even know they're exercising. They do a half hour on the bike, you know, it's serious like[specific medical conditions]. Yeah, and they're coming and before they know it it's nine o'clock. They've done the weights, and ... a bit of boxing ... And then they're off for the rest of the day. Well and some more blokes started coming because it's now okay for blokes to come in.

During fieldwork, a researcher visited the gym. The gym-goers were very active, using the equipment themselves and helping others to do so. It was also clear that the gym was an enjoyable social experience, with a lot of comradery and joking amongst those present. Some community members, experiencing the benefits of their gym experiences, have become advocates and encourage others they know to come along—calling them and sometimes driving to collect and take home these newer participants:

Yeah these guys they'll know straight away who's been off for the surgery, they'll hound them and say if you know what's good for you and you want to live a long life—they just tell them how it is—you get to the gym when we're there.

These examples of local leadership build people's social wellbeing, but are also having chronic illness benefits. We heard from people using the gym that their individual risk factors (including being overweight, having high blood pressure, and consuming alcohol at risky levels) had been reduced by taking part in formal and informal sessions at the gym. And this reporting was supported by people in direct health roles:

... even the doctors say, we know who's going to the gym, because they come in, the blood sugar's reduced, blood pressure's better.

What gets in the way of collaboration?

Funding models

Participants identified several factors that act as barriers to effective coordination, with funding models prominent:

Each financial year it just changes; the pots of money get moved around [...] what I see is that for 18 months they might be employed by one organisation, and then it all comes up for review again, and then that organisation might get that money to provide the service (Service provider)

I think also a lot of people, including myself, for me to be here I need to have multi-funds to get me here. So I have to kind of have a bit of clinical work and a bit of health promotion and a bit of private work to actually sustain visiting and have enough funds to work here. So you kind of have to be broad, you can't always be specific. (Service provider)

Many of the Island's health and social care services (as well as other services) are provided through short-term competitive funding. During the project, we learned that the continuation of a number of FIFO services was uncertain, throwing into turmoil the workers and the clients who rely on those practitioners:

there's people here, like [FIFO service provider] who comes, [name] might have a contract for 18 months, and then that's got to be refunded and [name] doesn't know whether it is or not, and whether they're going to be able to come back. It's just—their work is affected because [name], [themselves] is now in turmoil because [name] doesn't know whether [they're] actually going to be able to provide a really well received service here, and to the point where they've got a waitlist and that could just be gone like that.

This model has multiple drawbacks. The relationships—with community members or clients and with other service providers—are disrupted:

So then when that funding finished and the organisation she worked for didn't get the funding that time, it was someone else, so all of a sudden, that stopped. And then it took a while, but I noticed there was this other person coming and sort of sitting in an office and not doing a whole lot. I then found out through asking "Who is that?" That's the new [person in role]. And I'm like, "Well, where are all the people?" Because we don't make the appointments, ...—that's their job. [And] people were used to making it in a different way—like the first [person in role] would say, "Okay, I'll see you when I'm here next, at 10.00 am on 15 February." So she booked ahead then. The new [person in role] came and she was doing nothing, and there was no one—like where have all these people gone who the first [person in role] was seeing? It was only through questioning I

found out that when the services changed, when they changed services, all those referrals—no information was passed on, so all those clients that [original person in role] was seeing, suddenly, just never turned up. And [new person in role] never—as an outsider it's like, well, where's your initiative to go down and find out from the GP who was seeing [...] but there was no real push from her to find that out. And apparently everyone had to be re-referred to a service that they were already having and really settled in, they just came in for their [illness] review. Now someone else was coming and so people never came back.

Short-term competitive funding damages not only the possibility of 'routine encounters' where there is trust and established relationships; it is also harmful for the service providers:

... [service provider] is stressed, because that's going to affect them financially because they may not have a job. It's just crazy. I just don't see the point in that sort of thing. And then someone else might get that bucket of money to come and provide that service, but then they have to start at the start again for a service that was already chugging along really well, why muck around with that.

So [connecting with other services is] important, but it's hard and we have to think creatively around how do we build that communication and that collegial aspect, because it can be very isolating over here as a [chronic condition] worker, so knowing how to support each other is important.

A second aspect of funding is the business models operating in some services, on-Island and FIFO. There have been periods during which the GP clinic was not staffed consistently, resulting in some coordination problems:

... if you've got a chronic illness you're exhausted by the story. And I think the other thing that you might be worried about risking is about the medication that you're being prescribed. So I think there's a school of GPs who would like to say, "You're on X-vee, we might just change that Z-dee and see how you go." That's all very well but in a fortnight when you haven't gone okay and you've got to go back [to a different GP] and say, "He gave me this and I was on that and now I'm not quite sure that I'm as well as I was", and the doctor you might go back to is the one who originally prescribed the first medication and then they've had a locum come and [...]—it's very untidy.

And some service providers do not consistently visit the Island:

We do have—thinking off the top of my head—I haven't got numbers, but we do have a significant amount of people that are on [chronic illness] medication and monitoring that is done via LGH but also through [specialist service] and all that, so you've got to go away. Sometimes you have a [specialist] come over but not very often, and then their visits are so fleeting that, unless you can get in, you're waiting till the next one. That's the thing as well. If you have a look in the Island News, for instance, it has sort of a timetable and some of the groups won't come over until they've got a certain amount. So Australian Hearing, for instance, won't come over unless they've got six people that they're seeing to make it worthwhile. (Service provider)

The difficulty is two-sided: clients, worried about their condition, or uncertain about their relationship with the unfamiliar specialist, might also cancel appointments:

We offer so many incoming specialists [...] We need to fill up all these appointments. And you've done it and come appointment day, cancel, cancel, cancel. So it's a big thing and you're aware of it. So you're constantly passing it on to your clients, constantly, no

matter if we're even getting a specialist tomorrow or—that how important it is to—how lucky they are, what you'd have to do to get an appointment in Tassie or in Melbourne. You'd have to wait and you'd have to pay so much. So that's a message I'm passing on constantly. (Service provider)

And can be reluctant for other reasons, including that they might be “not going to the doctor’s because they’re frightened of flying off to see a specialist or get a test done. Because a lot of them don’t want to fly off”. Such reluctance and delays are dangerous:

Or even, I’ve had people—[...] and they’ve come up to me and said, “What do you reckon? A doctor gave me a scan request, and I don’t think I’ll go.” It’s like, “How long ago? Are you happy to tell me what it’s for?” And they’ve been significant scans for abdominal tenderness, bloating, potential nasty diagnosis type stuff. “Oh, you’ve just got to get off to Launceston and it’s a hassle, and I’ve got the farm” or “I’ve got this, or that” and there was ten reasons, all no reasons. And they were kind of your blokes, your farmers. There was also an element of ‘if I go and there is something, that means if I have to have treatment I’m off island for a long time.’ Because they’ve seen people go through that for specific treatments, and I think that scares them from merely getting a diagnosis.

This means that some people are missing consultations that could help manage their chronic condition, and keep them out of hospital.

Participants also noted that the measures of effectiveness (and indicators that inform some funding decisions) are inappropriate. Measurements are not sufficiently subtle:

And so I guess to be able to better support and help people you have to be able to have that space, for some it's going to take six months, 12 months depending on your degree of trauma and history and we if we have not got the time or the you know the funding to be able to sit in that space and one of the big problems I don't like about the way that we are often forced to work with, you know the short funding is that we kind of expected to deliver and get certain outcomes, but we don't actually recognize a lot of the tiny little outcomes, tiny little achievements, goals that are being achieved and some of them are so tiny, but they're there. We should not be dismissing those because each little thing kind of builds on to something and then you know, you don't just get that big beautiful shiny [cure].

For some conditions, the improvements can be small and slow in coming, but necessary:

Yeah, so some of them and so if we were talking about individual changes, the beginning of change is going to start with the person actually being able to show up to a service [...]. So if we look at him, so for that person, for him to actually be able to come into [the consultation] and sit, [...] that’s massive [...] So we start there.

Such incremental change rely on continuing relationships between service provider and patient or client. They may not ‘register’ as meeting the applicable performance measures.

[Relationships are central to collaboration and coordination](#)

Relationships are, as the above shows, hampered by infrequent contact and disrupted or lost due to uncertain funding. For care coordination, the mixture of on-Island and FIFO services means that:

... actually getting everybody here of having a meeting at the same time is really difficult and so there is very little crossing over because often I’m on the off week to the [service provider], so we never ever cross over [...]. So that is a challenge. And then if

you do go back to Launceston and you're working in your other jobs and other places, you don't have the time or capacity to make a call and have those networks.

Even where relationships have been built, changes in service providers—“*someone else might get that bucket of money to come and provide that service*”—mean that, for each new provider, “*they have to start again*”. There are important costs to continuity of care:

It took me ages to realise there was a problem; I was just staying home and drinking; feeling lonely. [...] Getting the courage to come and see someone about it ... God, I hope they don't disappear!

Where relationships have time to develop, and providers connect well with community:

... at every level—I think that you can physically see anticipatory care happening here. Because everyone draws on everyone else's strengths and experiences to facilitate the best care, whether they be in mums and bubs, or whether they be in aged care. And regardless of what your job title says that you are a part of, everyone works together to make all cogs work.

I just think, in terms of, in this place, I think, as a community we work well together and we can provide those support mechanisms almost without thinking really, because just about everybody's doing something in the community anyway so you've got that—it's a fairly closed network really.

Belonging matters, and affects health and collaboration

A second prominent theme in participants' discussion of health and anticipatory care was a sense of belonging and the social capital that can develop. Many participants spoke about identity and used terms like ‘being proud to be a Flinders Islander’. Terms used to describe Islander traits included ‘unique’, ‘resourceful’, ‘talented’, ‘generous’ and ‘creative’. One person said that “*punching above our weight is definitely a way of describing our community*”.

People are very multifaceted here and I think they—and wear a lot of hats. A lot of people have two jobs, three jobs and that's just that small community, resourceful. You just get by; by everyone does lots of different things.

While many people spoke positively about what it means to be a Flinders Islander, some said there can be distinctions made between those who are ‘real’ Flinders Islanders and those who are not:

...by the same token, there's a little bit of we're real Islanders, you're not, That's the other side of that coin a little bit. Yeah, and that also fits in with you know, people will talk about that fifth and sixth generation thing.... I'm proud to belong here. I love it. You know most people love it.

I'll give you an example, if an Islander did something really stupid and dumb they'll laugh and it'll be forgotten about really quickly. If a non-Islander does the same thing it's remembered forever and if it's really dumb you'll get chased off the island.

And there was a sub-theme of division; participants identified some ‘factions’ for example between Lady Barron and Whitemark and tensions between those who want to see the

population increase (for economic reasons) and those who want to maintain the status quo. They also recognised that some people live on Flinders Island because they seek isolation, while others want to be part of a small community. People who live in very small communities on the Island commented on their social connections, and on the very active social lives they lead. They were aware, though, that it can be hard for new residents to feel accepted and one person spoke about her experiences of being excluded when she first moved to the Island.

One person made an interesting point about anonymity, saying *“In the city you can easily be anonymous. But you can’t really be anonymous [here] because it makes you feel isolated”*. Some service providers recognised that this required that they gauge people’s sense of isolation when doing home visits, even if the primary purpose of their visit was for medical reasons.

Aboriginality

Participants spoke about Flinders Island’s history and how this has impacted upon the Aboriginal community. Racism was present (either expressed or pointed out) in several interviews, and some participants spoke about racism toward Aboriginal people and felt that further efforts were needed to cement reconciliation. One participant commented about (as reported earlier in this document) how Aboriginal people appear in public: *“Some of the Aboriginal people, some of them, they’re definitely you know, head down. Yeah. Yeah, you can tell from the way they walk as they approach you, especially the women”*. Historical and current experiences of racism are impediments to benefiting from the anticipatory care system, and making collaboration between services and practitioners *“quite challenging”*.

Participants spoke about the need for cultural awareness when working with Aboriginal community members.

I think we—the strength is the fact that we look at it from an Aboriginal health perspective and they have a holistic understanding of—and a holistic definition of what is health. So it’s all those—it’s not just clinically focused and they certain—we all consider a person and their circumstances rather than the disease.

But there was resentment (expressed by some in the non-Aboriginal community) about the existence of the Aboriginal health service, despite the Island being well-resourced overall:

Well, we’ve got the Aboriginal centre with their own set up, so that’s stuffed everything up—if it wasn’t there we would have more facilities, or else they should force them to let us use that facility. It’s really put a wedge in everything.

Equally, though, there have been inequalities that damage coordination and collaboration—and the potential for relationships between the major services on the Island:

And I guess one of the other barriers is, the mainstream to get services over here, whether it’s dental or podiatry, or whatever, we’re never notified of those services, so all those appointments are taken up before we find out. I think they see it that because FIAAI has got a health program they don’t have to service the Aboriginal people; well we’re still human beings, we’re still part of this community.

... sharing information between [FIAAI] and Whitemark is an inhibitor. As you know, they only have the doctor there one day a month so patients often either hang on for a long time to see that doctor. Tests are done down there. Patients come to hospital and we don't know what's been done, what's not been done. We don't know any background about the patient. So, we're trying to work on that ... (Service provider)

Alcohol use—"Yeah it's just what we do here"

But yeah, when you see the amount of alcohol brought in from [alcohol retailer], it's staggering, absolutely staggering and at the post office and there's just floor-to-ceiling boxes behind the counter literally and you know, Christmas time or anything like 600 kilos a day of alcohol flying in to the post office alone. And that's the whole of December leading up to Christmas. It's unbelievable. But you know every time the plane comes in there's [alcohol retailer] boxes behind the counter. Yeah. It's a lot of alcohol.

We had some evidence from PHT data (Ahmed et al., 2017b) that alcohol use was at risky levels for some Islanders. It was also clear from the qualitative data (interviews, focus groups, reflections, observations) that alcohol is prominent in this community in ways that are not evident in the three other anticipatory care project sites (Clarence, Ulverstone, Launceston northern suburbs). In the following excerpts, the dominant themes are:

- Alcohol use is a social norm, part of the culture, an expected behaviour
- The notion that 'we all look after each other' is—perhaps—a rationale for it being okay to drink?
- There is some stigma attached to *not* drinking alcohol

It's ingrained, you know, and with the ladies it's, it's similar and, and I certainly enjoy a glass of wine and you can drink that much wine and I didn't realize it because people just keep filling up the glasses. Yeah, so it's just a real norm. I think that's a hard thing to tackle and some other stuff but it's worth having a go.

Alcohol was portrayed in the data as an important social lubricant; it brought people together. As one person told us, when they visited the Island for work they "Got in touch with men via the pub. Alcohol is a social necessity here". Numerous participants described how alcohol consumption was an expected behaviour at cultural and social events:

It's hard to socialize, let's say in life [on the Island] without it including alcohol and so for me, it would mean that I socialize not very much. Yeah, you know, so what does that mean for other people? I'm not sure. Yeah. Yeah, you know and it's hard because equally if you get a chance to be in Lady Barron on a Friday night, you know at 5:30, there's a whole lot of older people that come out of their house and get together and have one or two drinks and tea.

We make our own entertainment and what do we do when we get together with friends? We listen to music and drink and get merry.

I haven't been here that long, but I've never been to an event where there wasn't alcohol.

There is a huge normalisation of alcohol on this island. And there are kids – every day of the week after school that just mill around the pub in Whitemark after school.

A couple of people suggested this norm was typical for small or remote communities:

I don't think it's just Flinders. It's probably remote communities that have access to alcohol are more likely to be because it's part of like Australian culture is quite a drinking culture.

Apart from the 'minority' of drinkers who were considered to have a 'drinking problem', overall alcohol consumption was portrayed as being acceptable and as managed appropriately; the community:

really does look after itself as far as a lot of problems. I've always thought, you know, okay, I've been here been coming here for [many] years, even the drinking problem, you know, drinking drink driving and things like that that generally the community seems to look after...

And drinking was important in keeping people connected:

For a lot of those fellows [Secret Men's Business] is the one journey out of the house in a fortnight and it's all about the chatter and the natter and the having a beer and a sausage. Yeah, when it first started a few people took umbrage about the drinking. But it is way more. It's much more about the fellowship and the chatter and stuff.

Things like drink driving were not seen as a problem by some participants, since people on the Island "... all look out for each other. So it's okay". However, not everyone agreed. During a conversation about drink driving one participant said.

I don't think we necessarily manage it that well. They just dodge and weave and go around the back roads to avoid being caught ...Well, obviously, they're not having big accidents ... but some of them are big, just because there aren't deaths doesn't mean to say it's not a big accident, right and there's been a few big ones, right, and totally caused by drink.

Overall participants felt it was up to the individual to manage their alcohol consumption and there was a strong sense of self-reliance, since "... it depends on yourself how much you want to drink". Nonetheless, there was also a sense that the problem was so large and so embedded in culture that it was too hard to address.

People tentatively linked alcohol consumption with family breakdown, mental health problems:

... women will drink at the same pace as the men and until women [...] they get to a point where they've got children and they want to be more responsible and something changes for them. They are actually starting to want something different in their lives and identifying that alcohol is changing how they are, the way that they can be in the community, the way that they can be a parent and so they will stop or dramatically change their drinking behaviour. Then that becomes an issue for the men. Yeah, and so there are many relationships breaking down because of that.

I'm just thinking, you know people who have deep down problems turn to alcohol. But I do know, you know some people on the island who are very, very, you know, heavy drinkers.... And you wonder why, I do know a couple of the situations why these people are...But it's also just cultural.

and with smoking, “You can’t tell an alcohol story without a smoking story”:

I'm still smoking, but I've cut down on the smoking by not drinking, but I've no intention of looking at cutting that out yet!

This drinking culture was, as a health professional told us, “massive in terms of all these chronic conditions”. And other efforts, like “a lot of exercise isn’t really going to help if you’re drinking too much”. We also heard that *not* drinking was somewhat frowned upon. We heard, for instance, about people seriously involved in sport who:

trained usually an hour most days twice a week [and] wants two hours and three hours a day. So they watch what they eat. [...] We certainly enjoy a glass of wine or beer but we have all these alcohol-free days [...] they've certainly done dry July. [...] [Person] discovered no alcohol beer and the reason that no alcohol beer works is that [you] cannot go to a social event, cannot play golf, go to the clubhouse and have a non-alcoholic drink without the blokes taking the Mickey out of [you].

Finally, alternatives are hard to find or costly:

If there was sparkling water that was available, there are enough people that would be [inaudible] enough that we can drink water instead of wine. [...] I think [publican] has looked at the prices last time I went to the [hotel] and [my partner] would have a glass of wine and a pint or a big thing of water. Yeah, the water cost me seven dollars. [...] It's just a barrier. Yeah. That's \$15 a round.

Summary

Our analysis shows that a common thread links these analytical themes. Anticipatory care relies on trusting, long-term relationships, but relationships are too often disrupted by historical tensions, funding models, and a system fragmented by isolation, distance, and the mix of service models each with their own processes.⁹ Flinders Island residents are resourceful, many taking on multiple roles to support community members and institutions, and this does support collaboration. These themes overlap and affect one another, as shown in the causal loop diagrams.

We also mapped the data to the system parts—here are the summary phrases for them on Flinders Island:

People	Flinders Island is a remote, sparsely populated place with a resourceful community that experiences some divides. It is also important to recognise their diverse ways of thinking about and acting for health.
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⁹ Analysis of the data is continuing and will be reported in December 2020, and in research papers.

Infrastructure	Infrastructure includes services (e.g., MPC, FIAAI, transport to and from the Islands, etc.), people and their skills and knowledge, and the natural environment. Infrastructure can support health practices and behaviours but is not equally distributed, safe, or available.
Information and data	Information systems are crucial to the effective operation of anticipatory care in this remote community. This is especially so because of fly-in fly-out services (FIFO), and a scattered and socially, culturally and economically diverse population.
Beliefs and attitudes	Individual and organisational motivations, assumptions, and judgments (including cultural), and understandings of their role in the health system, shape policy and processes (including information systems), how people and organisations behave and what they expect of themselves and others.
Leadership	Leaders are influencers, providing opportunities and encouragement to others to participate in things that support health and wellbeing. They are also good navigators, and networkers who have credibility and expertise and are trusted. There are multiple examples on Flinders Island of leaders who have solved a problem and then shared that solution with others.
Relationships	Relationships rely on trust, longevity, and familiarity. The OHOF team built on established relationships and created new ones through new ways of working.
Place and belonging	Place and belonging have different meanings for Aboriginal and non-Aboriginal people on Flinders Island. The AC system will flourish where the importance of place, belonging and culture is understood, respected, and factored into service and infrastructure provision.
Process and policy	Local, state and national policies can support or impede the AC system. Policy-driven barriers on Flinders Island include the way some funding is provided, business models, the social safety net, and providing appropriate and connected services using on- and off-Island providers

Systems work and causal loop analysis

System parts

We want to describe the AC system and see how the themes identified in the data analysis appear in the system and therefore where local actions can have an effect on that system. Our

use of systems tools was informed by the data we gathered. The first round of analysis resulted in the initial system maps, using the identified six system parts. The system parts are:

People and health	People and health refers to the community and the residents' health profile, as well as to those involved in maintaining the health of the community.
Local infrastructure	The things—services, centres, businesses, programs, physical structures, environments—that support anticipatory care.
Data and information	Data and information regarding community members' health, and about health and community services: what exists and how it is shared.
Attitudes and actions	How residents and service providers think about health and the health system, and how these attitudes and beliefs affect what they do.
Relationships	What formal and informal networks and relationships support or hinder health in the community.
Leadership	People who are in formal leadership roles, as well as 'influencers' with symbolic power; people in 'authorising' roles.

We asked a graphic artist to create posters of each system part, for the Flinders Island community (Appendix 9 is the design brief for the graphic artist), and took these posters to the community forum on the Island at the end of March 2019 (see Illustration 3 and Appendix 10).



Illustration 4: Warning to workshop attendees, March 2019

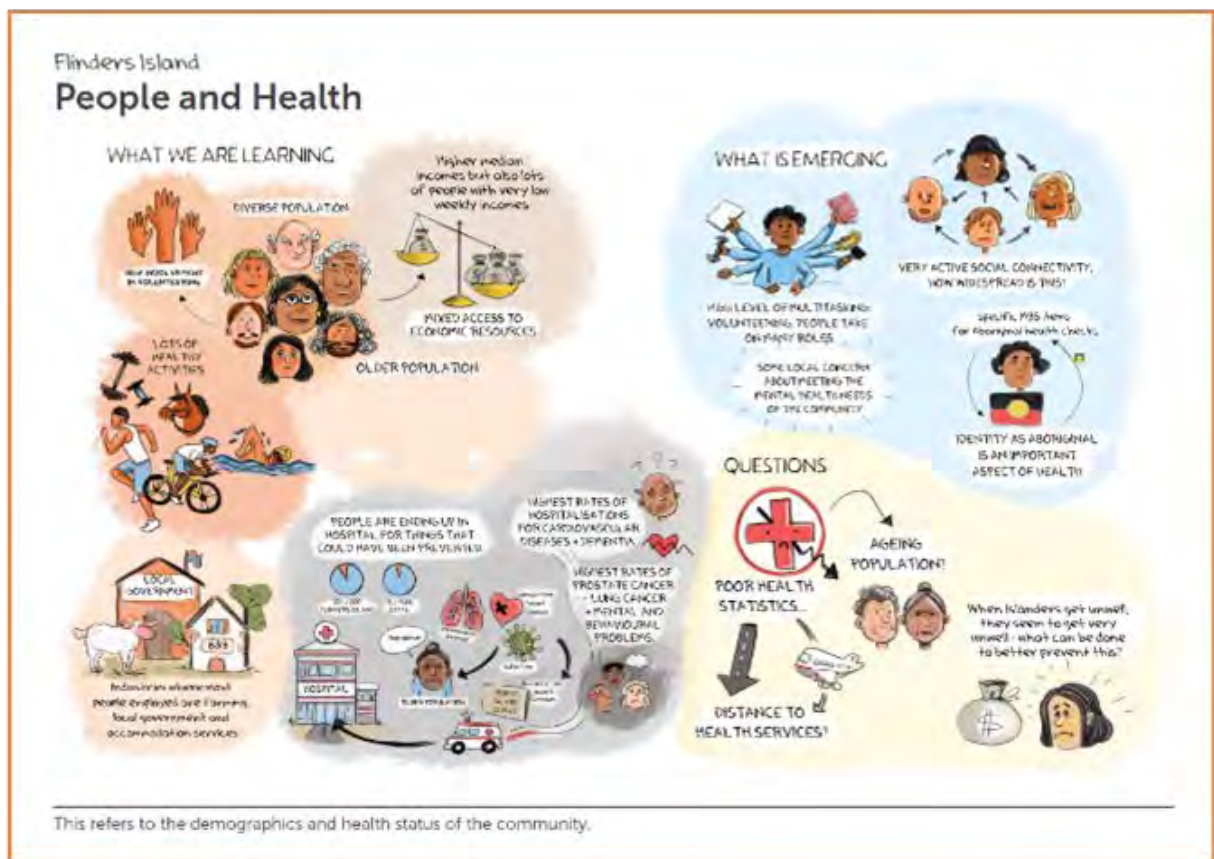


Illustration 3: Sample illustration of the preliminary system parts in OHOF (poster)

Twenty-five people came to the community workshops. They were local residents and people providing services into the community. Illustration 4 shows one of the hazards of Island life and of running a workshop on a sunny afternoon in peak snake season.

Analysis of the observations and notes made during the workshop (including summary documents and fieldnotes made by UTAS and Sax personnel, and by Flora Dean), combined with what we were learning in the other sites, led to the addition of two system parts: Policy and processes, and Place and belonging.

Place and belonging	The sense of belonging, identity, history/connection, roots, stories, stigma, neglect, pride, safety.
Policy and processes	Policy and bureaucratic processes, within organisations, and at the local, state and national government levels, that influence anticipatory care.

The system parts are a 'big picture' way of thinking about the AC system across all the sites. But we also wanted to look more deeply into the system to see where it was possible to change things locally (**research question 2**). To do this, we used the systems tool, causal loop analysis.

reflects both the specific challenges of a system that relies on on-Island and fly-in fly-out services, and the collaboration problems that we have found in all AC project sites. Service collaboration became the driver for the action planning here on Flinders Island, and for the CLD discussion; this included people’s ability to successfully navigate systems and services, identified as a key outcome in the CLD. This shows in the diagram we drew (Figure 11) with many arrows coming in to the variable “Service collaboration”.



Illustration 6: OHOF CLD session 1 participants

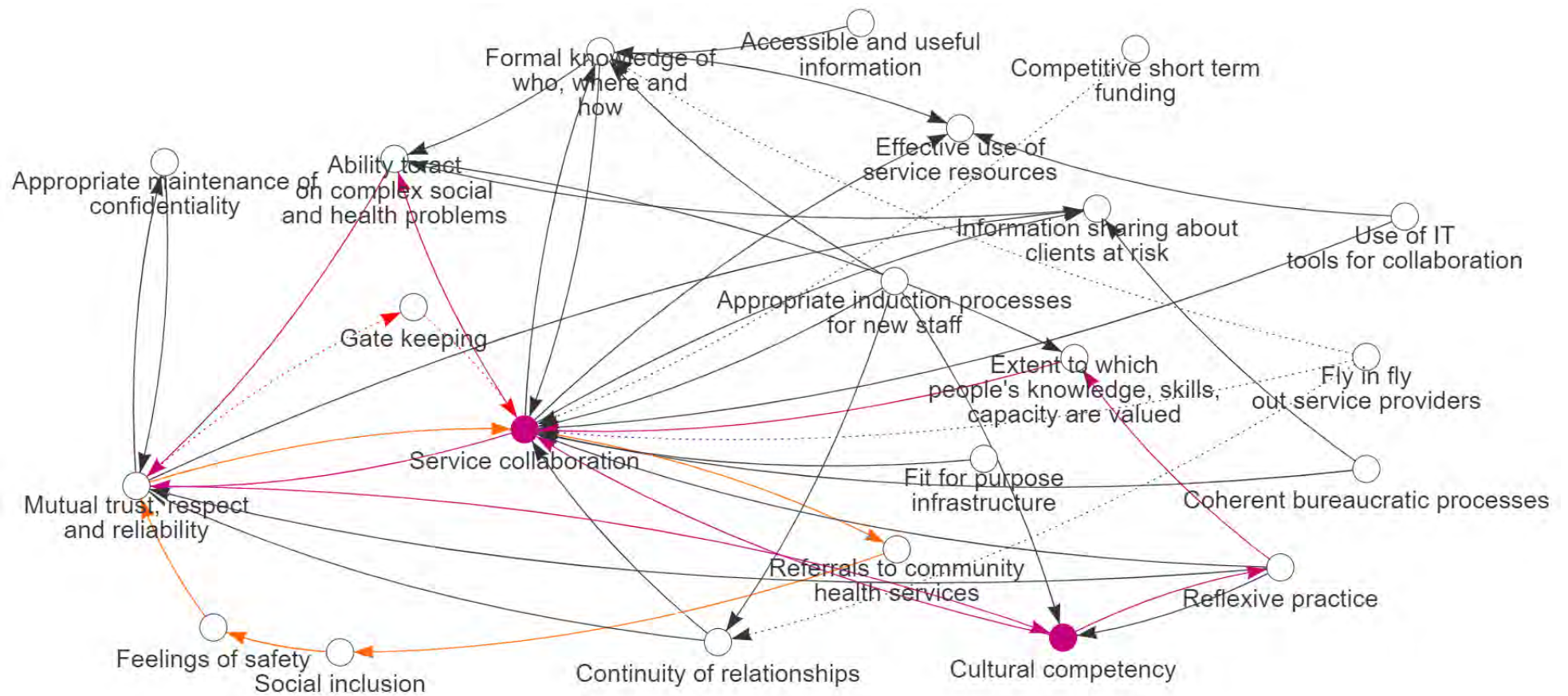


Figure 11: Causal loop diagram for Service Collaboration in the AC System, 2019

Drawing the CLD (Figure 11) was informed by stories or evidence from participants and the data. The need for all participants in the anticipatory care system to trust that system was apparent. The problems caused by racism were threaded through that data, and stories told during the CLD session brought it to the fore. How could collaboration—between non-Aboriginal and FIAAI services, practitioner and community members—happen, when there were historical and current instances of racism, and when many staff in on-Island and FIFO agencies had little awareness of the historical and cultural complexities of Flinders Island’s people? Further, while there was a cultural awareness element in the training or induction of practitioners in several roles, much of this is generic (homogenising all Australian Aboriginal peoples into a single cultural group) rather than locally-relevant, once-off, and not embedded in organisational culture.

This example (along with many others discussed at the CLD session) is represented in the CLD diagram (Figure 11). It shows the importance of cultural competency, along with relationship continuity, the extent to which people knowledge, skills and capacity are valued, and the importance of mutual trust. Thus, many interrelated variables play out to either support or block access to the AC system. That a dis-located workforce (through unstable FIFO provision, for instance) contributes to problems with collaboration is also evident.

Mutual trust, respect and reliability

Mutual trust, respect and reliability fosters relationships, and maximises capacity. It relies on continuity of staff, acknowledges history and develops over time and with supportive organisational culture.

[Results-driven action plans](#)

The PSOs worked with FHO CM to develop an action plan informed by the results reported above. The action plan set out proposed actions to enhance the AC system using four guiding questions:

- The FORM: What action are we taking?
- The FUNCTION: What are the intended outcomes from the action?
- The possible RIPPLE EFFECTS: What other effects could the action have?
- The MEASURING: How will we know it is working?

The OHOF action plan (Appendix 7) sets out the team’s activities, which focused on changes to the overall AC system through:

- Direct health impact and service collaboration—
 - sub-project: Alcohol Awareness program
- Social and physical health impact
 - sub-project: G. A. M. E. (gear access made easy) On Flinders

- Service collaboration
 - sub-project: Increase clarity and reliability of referrals
 - sub-project: Community groups booklet/online app
 - sub-project: Cultural competency training (and development of the training)

The local report prepared by the OHOF team (2020) describes all local activities.

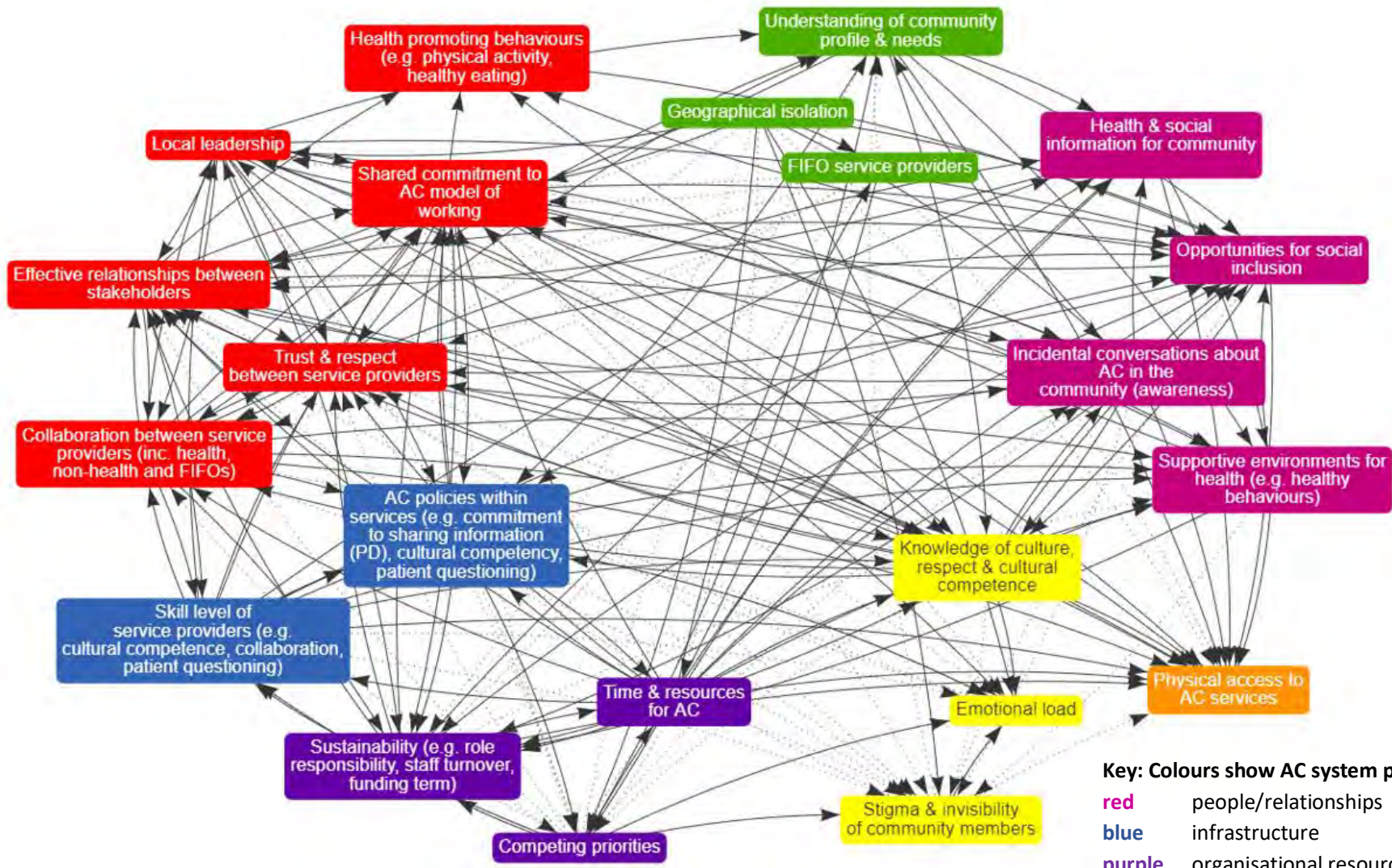
CLD 2 summary

Drawing the causal loop diagram can reveal the ripple effects and other measures of impact. At the second CLD workshop, in 2020, we wanted to see whether the local activities had altered the way the system looks and works here. This was an important data gathering session and added to the knowledge we have of the project activities and impacts from our other sources. The second workshop was held using the Zoom videoconferencing platform. The stories people told in the session were not the only way we learned about change in the local AC system. There was evidence in the language used and the ways in which participants framed issues and solutions indicated a shift in thinking from the first CLD session. It was also apparent that systems thinking and the causal loop process had been embedded in the way the project was undertaken.

All around it was just those relationships – it helped having those relationships already and building on that.

When we developed the first CLD in 2019, the need to enhance **collaboration** was a focus; this relies on greater cultural competency among services providers (on-Island and fly-in fly-out). Five project activities were implemented during the AC project to trail enhancing collaboration (they are currently at various stages of implementation):

- An information directory
- Cultural competency training
- Alcohol awareness campaign
- Game on
- Referral pathways



Key: Colours show AC system parts

- red people/relationships
- blue infrastructure
- purple organisational resources
- yellow attitudes and beliefs
- orange access
- pink health education/information/promotion
- green place

Note: Boundaries between parts are blurred

Figure 12: CLD of the main components of OHOF, 2020

The model in Figure 12 shows that there are many connections between different parts of the AC system and there are literally 1000s of loops in this model. For example, in this project, OHOF undertook a range of survey and other activities (including CLD 1), which led to an understanding of the community profile and needs. This enabled the OHOF team to:

- provide health and social information to the community (via the directory, in development; and through other mechanisms such as talks to groups, the community FB page, the alcohol education strategies, etc.)
- GAME On (most prominently the tennis equipment at Lady Barron), has encouraged and increased use of the courts, and
- opportunities for social inclusion (evidence of groups of people using the tennis court and equipment) and health promoting behaviours (e.g. physical activity, socialisation); monitoring this activity (e.g., 100+ people registered to play tennis), you developed a greater understanding of community profile and needs and what works to improve health.

We wanted to look at anticipatory care not just from people who have chronic conditions already but also looking at that younger generation and how you can maybe influence behaviours there.

Another example, in this project, **time and resources** were made available, which allowed for effective relationships between stakeholders to be formed, leading to:

- collaboration in the AC system (e.g. involving PSOs, FIFO AOTD worker, FIAA & Health Centre staff, etc.).

[the approach from this FIFO worker,] “how can I work with you and your community”, not “I’m bringing this into your community” was very important.

[Worker] wasn’t going into the office and shutting the door ... [They were] wanting, looking for a way into the community. ...

One result of this collaboration was

- local leadership actions—e.g. deciding to act on cultural competency, and adapting the CC training approach to maximise benefit to the community (and minimise risk)

... if mainstream is going to throw stats back at community members about [the problems], here’s your opportunity learn about why these things are happening.

- Cultural competency training and knowledge are likely to enhance the skill levels of service providers (some evidence still required), leading to
- an increase in knowledge of culture, respect and cultural competence (evidence needed)

An additional result is a likely shared commitment to the AC model of working, leading to

- organisations having AC policies that support and embed cultural competency:

Any service provider, where we have the largest population of Aboriginal people per head, should have an interest in being culturally appropriate. They’re dealing with Aboriginal people.

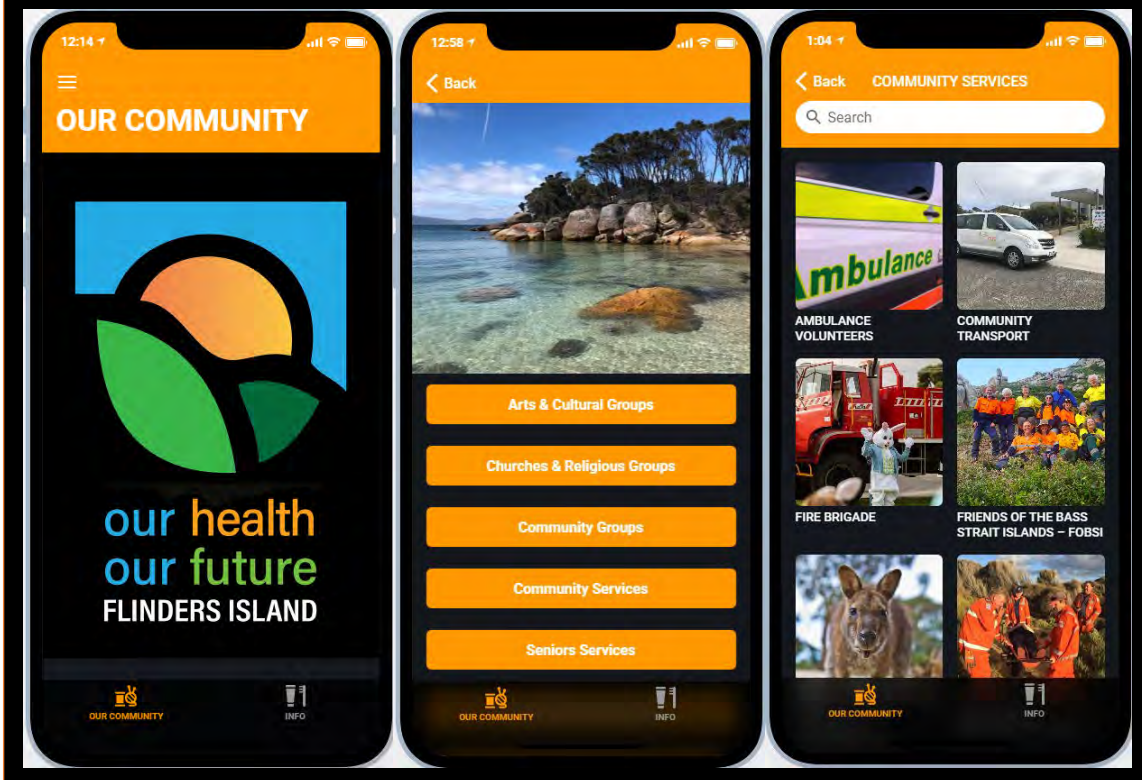
which then increase

- time and resourcing for AC.

These are examples of **reinforcing loops** in the system, where an increase in one variable, increases another and so forth, which reinforces an increase in the original variable (+).

Box: Community groups booklet/app

Information and how it is used and shared is an important anticipatory care system part. This information might be specific to health (e.g., statistics, or condition-related information) or about what resources are available to people to support their own health. Physical and social activities are part of staying well. OHOF has been working to support this part of anticipatory care, through a community booklet/app. Below are images from the app in development.



There are variables in the OHOF system that can undermine efforts. Examples include **stigma and invisibility of community members, emotional load, FIFOs and competing priorities**. Variables connected by dotted lines indicate a decrease in that variable. Part of the AC model on Flinders Island involves **resourcing (time & resources for AC) (+)** a workforce of **FIFO service providers (+)**; these workers experience **competing priorities (+)** as they come and go, basically just seeing clients; this prevents them from forming **effective relationships (-)** with other stakeholders in the AC system. This undermines a **shared commitment to AC (-)** on Flinders Island, as well as **sustainability (-)**, which balances the original position—the way **AC is resourced**. This is a balancing loop because there is no change to the original position of the variable (**time and resources for AC**).

Some of the variables in the system may be ‘uncomfortable’; **stigma** is an example. It is important to recognise that these factors are part of the system and that they arise from the complex interplay between many other variables; and, importantly, that it is possible to

change these parts of the system to make it more respectful and accepting overall.

Box: Cultural competency training

Cultural competency was identified as essential to collaboration across services, and more generally to the wellbeing of community members. The OHOF team identified five drivers: lack of cultural competency continues to impact on Aboriginal Islanders, regardless of intent; inter-generational trauma is being perpetuated, historical and ongoing denial of identity, the need for improved service provision, and respect. The training focused on seven elements (see below).



Participants commented:

Good to be reminded about the issues that are faced by Aboriginal Australians even today

We did [the training] together as an organisation ... it felt like it brought us a little bit closer as a team, as well ...

"felt safe going into that training, not having a lot of knowledge"

[We experienced] powerful and significant learning around inter-generational trauma—staff found the workshops moving, poignant and enlightening. [We] need to keep [cultural competency] at the forefront

If we look at where the **individual project activities sit in these models**, we can see that the process by which these activities may influence the system is not linear; rather that there are multiple factors at play concurrently that shape the effects that activities may have.

Importantly many of these effects would be difficult to capture via traditional evaluation methods. Figure 13 is an example (and see the box, above, about the cultural competency training). It shows the variables for which we have some evidence of effectiveness in relation to the cultural competency initiative (these are shown in red). Where we may need some further evidence, the variables are highlighted in orange. OHOF's local level evaluation may help answer questions like:

- have any organisations implemented policies to ensure culturally competent practice is reflected in daily practice?
- Did participants report an increase in knowledge of cultural competency as a result of the training; do people report reduced stigma/increased visibility?
- are health services providing supportive environments for health (in terms of culture)?

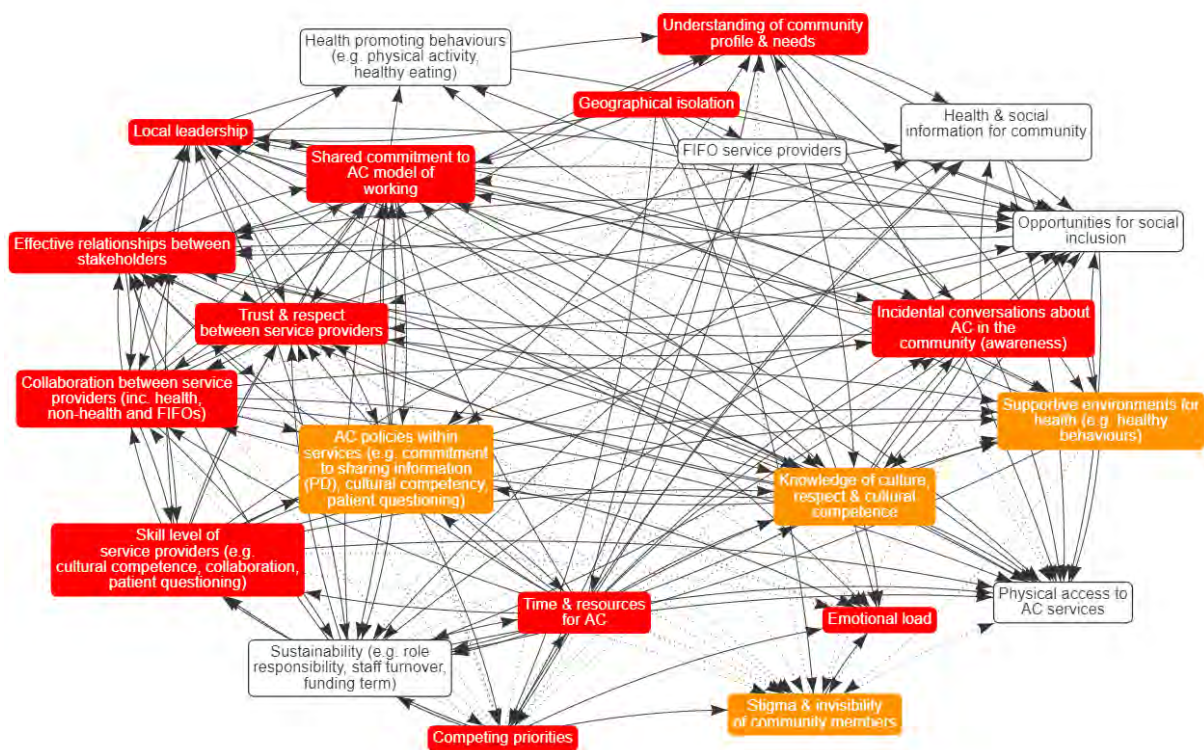


Figure 13: CLD for the impact of cultural competency training

What we learned about the project processes

The Sax Institute and the UTAS team are analysing the project structure, and local roles and ways of working. The Sax Institute's evaluation report will be delivered later in 2020. We report here on our understanding of the local project processes and roles through data gathered in:

- Attending, hearing reports about, or reading minutes of, FHOCM and project executive group meetings
- CLD, Systems Traps and other formal workshops
- Conversations with PSOs and project leads (including formal meetings, reflective conversations, and the state-wide PSO Community of Practice), and
- Conversations with service providers linked with OHOF activities.

We made fieldnotes about these interactions, and this material also informed our causal loop analysis.

Action learning and systems thinking were taken up by the OHOF team, and used to guide their planning, as well as reflection and adjustment. In the second CLD session, the reflective conversations and other data gathered included many examples of action learning. For instance, the groups information resource started life as a proposal for a printed booklet, but a new format (an app) was developed when it became clear that a booklet would be too inflexible for what is a rapidly changing groups and services landscape. A similar process of planning, acting, observing and reflecting shaped the GAME On program, as access to different sites required negotiation and adjustment. Plans for the delivery of cultural competency were also adjusted. This included delivering the training in different blocks to suit the ways in which people work, finding approaches that were respectful and did not burden the Aboriginal community, and then adjusting in light of the COVID-19 lockdown conditions.

Research activities and project processes

The following table (Table 3) lists the project processes, what worked about them and what did not.

Table 3: What worked and did not work about the OHOF project and research processes

<i>Activity</i>	<i>Who lead?</i>	<i>What worked about it?</i>	<i>What didn't work about it?</i>
<i>Timeline</i>	DoH	<p>Timeframes for the project were always a challenge, but this was well understood by all involved parties from the outset. Both the scope of the research and the project at each site was tailored accordingly</p> <p>The time for the project was extended, this supported us to deepen relationships and develop the activities further</p>	<p>Collaborative work relies on trusting relationships; these take time to develop. When this time is short, there is a greater reliance on long-term, well established relationships and connections of lead organisation, and with the community</p> <p>The short timeframe reduced opportunities to revisit the community and assess health or other impacts (including some system impacts and ripple effects), reassess situations and reorientate actions</p> <p>The short timeframe also factored into difficulty including people from marginalised groups in the interview and data collection process, since trust is needed if we are to gather rich information</p>
<i>Contracting between parties</i>	DoH, lead organisation/s, UTAS	Provided clarity about project goals and expectations	Some aspects of contracting were very time-consuming
<i>Ethics</i>	Social Sciences Human Research Ethics Committee	Provides accountability and guidance to researchers about how to do ethical work	Imposed some restrictions on the research component that may have reduced our ability to learn directly from some community members
<i>History of AC</i>	An approach from the British NHS	Takes a holistic and SDoH approach; highly suitable for the lead organisation (FIAAI)	Risk that too much effort is spent trying to reproduce a GP-centred model, which current Australian policy settings do not support
<i>Interviews</i>	UTAS researchers, PSO	<p>Support from leads to identify potential interviewees (this also helped build relationship between researcher/s and leads)</p> <p>Reached mostly 'usual suspects' very effectively</p> <p>Interviewees were willing and thoughtful</p> <p>Produced very detailed and 'rich' information</p>	Format only works for people who are confident, or where the interviewer could quickly establish a trusting relationship with the interviewee

		Could be conducted when the opportunity (e.g., an existing meeting or shared activity) arose	
<i>Focus groups</i>	UTAS researchers, PSO	<p>Allowed us to include people who were unwilling to be interviewed alone</p> <p>Group members prompted and encouraged one another</p> <p>Participants appeared to build new bonds over shared stories</p> <p>Could be conducted when the opportunity (e.g., an existing meeting or shared activity) arose</p>	<p>Method can result in one or two voices dominating the conversation (this was evident in some focus groups; a product of shyness but also of power dynamics)</p> <p>Can be hard to arrange</p>
<i>Observation</i>	UTAS researchers, PSO	<p>Increased collaboration between researchers and PSO</p> <p>Found new ways to learn about AC system and people's interaction with it</p>	Requires a lot of time, which was short
<i>Surveys</i>	PSOs	<p>PSOs were able to reach and hear from more—and harder to reach—people, some of whom completed a survey</p> <p>Gave us data about understandings and experiences, as well as barriers (in format directly comparable with other sites)</p> <p>Expanded PSOs' knowledge of the OHOF area</p> <p>PSOs found novel ways to gather survey data (e.g., at school)</p>	There is general scepticism in communities about 'yet another pointless survey'
<i>Community Consultation Workshops</i>	DoH and UTAS with support from TAPPC	<p>Brought together local residents and services; very positive experience for researchers (engagement, sense of community)</p> <p>Gave researchers an opportunity to become a little more familiar with and in the OHOF site</p> <p>Identified additional potential interviewees and focus group participants</p> <p>PSOs and OHOF team created a rich and evocative workshop environment (posters, photos)</p>	<p>Workshop location, format, language, and tools probably excluded some participants</p> <p>Risk that notes taken at group tables or added to posters can be heavily influenced by 'noisiest', most powerful, or most literate people there</p> <p>One intention was to ask participants to comment on how different parts of the system were linked; lack of time and difficulty of some of the concepts prevented this from occurring (this was a necessary adaptation for the group attending)</p>
<i>CLD sessions</i>	UTAS researchers	We were all learning as we went along: CLDs were a new tool and process for all involved (including UTAS) so it created a	CLD is visually complicated and initially off-putting

		<p>real opportunity for shared learning and co-design; there were no “experts”</p> <p>Process brought stories to the surface that enabled us all to better understand the AC system</p> <p>Process allowed for genuinely participative action learning</p> <p>Understood and used very effectively by OHOF team</p>	<p>Several workshops are needed to make this a fully participative process</p> <p>There is a risk that CLD sessions may be more heavily influenced by the people present than by what the UTAS team has learned by other means</p> <p>‘Ownership’ and perceptions of the usefulness of the CLDs varied</p>
<i>Systems traps session</i>	UTAS researchers	<p>We were all learning as we went along</p> <p>Brought members of the project community from across the four sites together</p> <p>Opportunity to learn how systems traps were appearing in sites, and how participants understood and were responding to traps</p>	<p>We were all learning as we went along</p> <p>Session was probably of variable value to the participants other than UTAS</p>
<i>Community of Practice</i>	UTAS researchers and PSOs	<p>Brought members of the project community from across the four sites together</p> <p>Gave us all opportunities to reflect together on what was working and what was not</p> <p>Enabled UTAS participants to hear how work in general and on particular activities was going</p> <p>Built trusting relationships between PO and PSO, between the four AC project sites, and between PSOs and UTAS team</p> <p>Shared problem solving</p>	<p>Logistics sometimes difficult</p> <p>Unsure whether too hierarchical (as in, too much UTAS and not enough PSOs) [analysis of session data is continuing]</p> <p>Disrupted by loss of some PSOs</p>
<i>PSO reflections</i>	UTAS researchers and PSOs	<p>Built relationship between PSOs and lead researcher</p> <p>Enabled lead researcher to hear how work in general and on activities was going, and do some shared problem solving</p> <p>Provided opportunities for critical reflection on UTAS researchers’ role and project processes</p> <p>Provided evidence of growing systems thinking by PSOs</p>	<p>Variable engagement and sometimes too many other commitments (on both sides)</p> <p>Took a little while to find best means for reflection for each person</p>

<i>Project activities</i>	Leads, PSOs	<p>Good evidence that local action can influence the AC system and address priorities for better function (see the AC Framework)</p> <p>Addressed some goals of AC system work</p> <p>Built on some effective and trusting collaborations with services and institutions</p>	<p>Heavy workload for PSO, and leads</p> <p>The COVID-19 pandemic restricted what was possible, making existing deadlines more difficult</p>
<i>Project Support Officers' work</i>	PSOs (supported by leads)	<p>Enthusiastic and skilled, with good existing engagement with community and services (broad range), on and off-island</p> <p>Had (and built) trusting relationships with leads, FHOCCM, and one another</p> <p>Engaged, observant, reflective, creative, skilled critical thinkers, and flexible (e.g., quickly understood AC in a broad and inclusive way, and saw opportunities to strengthen the system in small and larger ways)</p> <p>Training/ways of working that seek and build on strengths and relationships</p> <p>PSOs highly activist in seeking ways to reach the hard to reach, and develop new ways to gather data</p> <p>PSOs in substantive positions meaning they are embedded and can continue AC approach and some activities</p>	<p>Where they 'sat' in their respective organisations</p> <p>Sometimes confused accountabilities—working with both UTAS, their organisations and the OHOF team created tensions at times</p>
<i>Leadership Group (structure, makeup, how it worked)</i>	FHOCCM members (FHOCCM)	<p>We were all learning as we went along (opportunity for some)</p> <p>Membership somewhat fluid, with a core of health professionals/policy makers and administrators attending most reliably, and representatives from a range of services and the community attending as the need arose</p> <p>A core group of members remained committed and actively sought solutions</p> <p>Opportunity for UTAS to learn about community, services, and approaches</p>	<p>We were all learning as we went along (frustrating for some)</p> <p>Some FHOCCM members left during AC project, and others changed work roles (may have reduced time available for activities)</p>

Statewide AC Forums

Representatives from all sites, UTas, DoH, Sax/TAPPC	Opportunity for sites to share their work and learnings Built confidence for many who were unsure about the project and “how they were performing” Ideas for different activities were picked up and adapted/modified and implemented in some other sites	Time—not enough time to get through the set agenda Content and format of some presentations/sessions
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The impact of the COVID-19 pandemic on the project and this site

In early March 2020, the World Health Organisation declared that the outbreak of a novel virus, SARSCoV-2 (now referred to generally as COVID-19), had become a pandemic. National and state governments in Australia responded by ‘locking down’ communities so that social activities, travel and visiting most public places were prohibited.

The pandemic has had a profound effect on the world, and of course on this project. People in the four Tasmanian communities participating in the AC project are at risk of bad outcomes due to high rates of chronic illness (Lippi & Henry, 2020; Yang et al., 2020) and a range of socioeconomic factors (aging population, poor housing, high unemployment, inequitable access to healthcare). Project team members in all sites have reported that local residents feel anxious, isolated, vulnerable, and distressed, with measures to stop COVID-19 making it harder to take part in social and physical activities outside home. Some are also reporting that getting good quality food has become a bigger problem; this has been most prominent in communities already affected by poverty. These experiences have also been reported in the findings from Health Consumers Tasmania (Banks, Churchill, & Leggett, 2020a, 2020b) and The Tasmanian Project (see <http://blogs.utas.edu.au/isc/category/the-tasmania-project/>) surveys. Below we make some observations about the impacts of COVID-19, including policy initiatives, and how the local AC project responded.

Policy changes that could benefit AC systems

Policy and processes are a part of the system often outside the control of local services or people. COVID-19 has produced two national policy changes (which may be temporary) that are affecting the AC system (though we are still learning how). More medical consultations can take place using telehealth (that is, by phone or video-link), and the JobSeeker payment were increased for some months.

Telehealth consultations

Telehealth consultations with GPs, some allied health providers, such as dietitians, and some specialists are now more widely available. Health providers *can* apply bulk-billing to these consultations “where the service is provided to a concessional or vulnerable patient or a child under 16”

(<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/News+2020-04-20>). This could be an important shift that supports AC, but there are several potential I still in place.

Firstly, it is not clear who is being bulk-billed, other than those who already qualify for bulk-billing as ‘concessional’, ‘vulnerable’ or ‘aged under 16’, and there is evidence that GPs are offering bulk-billed telehealth only to existing patients. This means that those people who do not have a regular GP—often the already hard to reach and at risk—are unlikely to be benefiting.

Secondly, telehealth relies on technology and the familiarity and confidence to use the technology for this purpose. Some people on Flinders Island are poor, and have poorer access to the internet than Tasmanians overall (Tasmanian Council of Social Service Inc. (TasCOSS), 2019b), including because of the cost of mobile phone data, and poor reception. Some also have had less education, and there is some Tasmanian evidence that telehealth is more likely to be used by people who have more education (Banks et al., 2020b). About half of Tasmanians “do not have the literacy skills they need for work and life” (Tasmanian Council of Social Service Inc. (TasCOSS), 2019a, p. 10). This is likely to be affecting some people on Flinders Island, where about 16% of residents finished their education at Year 10.

Thirdly, telehealth—even where video is used—is an imperfect substitute for a face-to-face consultation where the doctor can assess not only what the patient tells them, but also other physical signs. For patients, the need to point at or gesture is part of communicating; this does not work on the telephone.

To date, there is no evidence that the introduction of more bulk-billed telehealth services is translating into more access to GP services. There are also reports (Daly, 2020; Knaus & McGowan, 2020; McKenna, 2020) that the reduction in numbers of people seeing GPs, including via telehealth, could force the closure of smaller GP clinics around Australia. This is not a good sign for AC in marginalised communities that struggle to attract GPs and/or where there is already a shortage of GPs.

Increased JobSeeker and other payments

The JobSeeker payment, formerly called ‘NewStart’, was increased in April 2020 by the addition of a ‘Coronavirus Supplement’. This roughly doubled the amount received by many people, including those on Youth Allowance, Parenting Payment, and some special benefits. Some OHOF residents are likely to now be benefiting from this increase (although its scaling back is also likely to cause hardship). The official unemployment rate in on Flinders Island was 7.4% at the last Census (in 2016), when Tasmania’s overall unemployment rate was 7 per cent (Australian Bureau of Statistics, 2016b). Unemployment has risen during and post-pandemic.

The increase to benefits is being scaled back over the forthcoming months (though things remain unpredictable). There are also suggestions that many people on JobKeeper payments (for workers in any business that has suffered a 30% or greater reduction in turnover during the eligibility period compared to the previous year) will not have jobs to return to when the pandemic is over. Participants in 2020 CLD sessions in other sites reported that increases to the JobSeeker payment, as well as people accessing JobKeeper, had changed the mix of people seeking emergency food relief. People for whom this change meant a rise in income were reported to be coping better, whereas new entrants onto either scheme, perhaps with mortgages or higher rents to pay, were now seeking help.

OHOF changes that could benefit the AC system

FIAAI stepped up through COVID into a greater leadership role.

The response to COVID-19 on Flinders Island showed that the AC system has been strengthened and was able to respond to the pandemic threat. The relationships, knowledge, skills and resources that have emerged from the AC project (and are now present in the system) are being adapted and applied to respond to the pandemic locally. The OHOF team supported the community through a variety of actions.

During the lock-down period, FIFO services did not visit the Island, making collaboration between on-Island services and staff even more important. Some FIFO services offered telephone consulting to clients, others—as was reported in other AC project sites—‘disappeared’. In common with Aboriginal Health Services across Australia, FIAAIs’ response to COVID-19 was rapid and effective. The day after WHO announced that the virus outbreak had become pandemic, FIAAI was already alerting people (including via social media) to the precautions they needed to take and what FIAAI could offer. This was the earliest action on the need to protect community across all four AC sites. Further, FIAAI-operated businesses on the Island were the first places requiring visitors to use hand-sanitizer. For the OHOF team, awareness of the dangers posed by the virus prompted them to find new ways to work across the Island during this threat. The PSOs met regularly using Zoom videoconferencing and phone calls. This collaboration was a source of support and information for both PSOs; they shared information about the pandemic and safety procedures, learning from one another during these ‘meetings’, something witnessed by the UTAS lead researcher in several reflective conversations. Such sharing meant their separate organisations (and communities) also benefited.

Two examples of new ways of working that were beneficial during the pandemic lockdown are the influenza immunisation (fluvax) clinic, and a social media video supporting people (and bringing them together) during isolation.

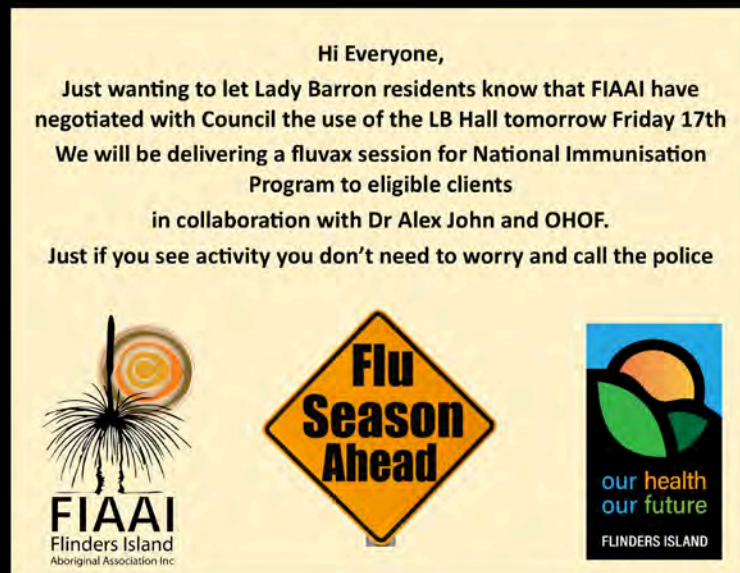
Fluvax clinic

The clinic was held at the Lady Barron Hall and organised so as to adhere to the physical distancing and infection control measures for COVID-19. Previously, immunisation has taken place in the health service rooms; for this clinic, Flinders Island Council approved use of the Hall. The session was staffed by the PSOs and other health professionals from FIAAI, the MPC, and the Ochre Medical Centre. This was a new way of working, not just because the pandemic required different structures, but because historically there had been limited collaboration between these three organisations. Further, FIAAI had not previously offered immunisation to people outside the Aboriginal community, but in this instance other eligible residents were able to access the service, building a new set of relationships with the broader community. The clinic reflects changes to several parts of the anticipatory care

system, to do with collaboration and relationships, physical access to services, sustainability, cultural competency, and understanding community needs.

Box: FIAAI fluvax clinic, April 2020

Influenza immunization is an important preventive health measure, offered each year by FIAAI to its community. The pandemic lock-down meant that new ways to offer the immunization were needed. FIAAI used its reach into community and its developing links with the MPC and Ochre Health to run a clinic at the Lady Barron Hall, for FIAAI community members and to other eligible Island residents.



Social media

Social isolation has been a significant problem during the period of pandemic lockdown and the subsequent travel restrictions. To counter this, FIAAI produced a video that brought together residents from across the Flinders Island community to celebrate the Island and Islanders, supporting solidarity, and sharing safety messages (e.g., re physical distancing, hand hygiene and so forth).



Illustration 6: Stills from the “Hello Flinders” COVID-19 video

Discussion—what does all this mean?

Chronic conditions affect too many people in the Our Health Our Future site. People here do not have equitable access to health services and some are much more likely than Tasmanians overall to experience the negative social determinants of health. This increases their risk of having chronic conditions, and results in high rates of potentially preventable hospitalisations (PPH). At the same time, the Island has well-equipped and staffed health services that are largely delivered at low cost to residents, and a long-term goal of better coordinating those services that are on Island and that fly in.

The OHOF project is a partnership between the OHOF team, UTAS researchers and the DoH. We worked together to explore first the nature of the anticipatory care system, and then whether we could strengthen the system locally so it could address problems that contribute to the poor health outcomes. To do this, we mapped the AC system here (*research question 1*), looking for successes and for opportunities for improvement (*research question 2*). We then planned actions to work for those improvements and, using action learning,

checked how those actions were working, revised plans and adjusted actions (*research question 3*). We also wanted to learn what role the local lead organisation—an Aboriginal association with a health service, FIAAI Inc.—plays in anticipatory care, and whether this can be strengthened (*research question 4*).

This final part of the report discusses our findings and observations in response to each of our research questions. We then reflect on the usefulness of the methods we used, action learning and systems thinking, and the barriers encountered. We conclude with recommendations for anticipatory care in this site, and for future work.

Answering the research questions

Significant finding 1: The holistic model operating at FIAAI is already responding to the impacts of the negative social determinants of health to reduce the risk of chronic illness and to manage existing conditions; this is a model that could beneficially be adapted for anticipatory care systems elsewhere.

Significant finding 2: Effective anticipatory care relies on the locally appropriate knowledge and attitudes of service providers. This is likely to rely on cultural competency being expected and embedded.

Significant finding 3: The OHOF work on Flinders Island has highlighted the importance of investing in the ‘soft relational infrastructure’ that supports anticipatory care, through outreach and collaboration.

Significant finding 4: The efforts of the OHOF team have begun to bridge some long held and entrenched divisions and has made steps towards:

- More trusting and collaborative relationships between services and community members on and off-Island
- Increased cultural safety and competency
- Greater understanding of the role of history, place and identity and how this shapes health and wellbeing.

Research question 1: Mapping anticipatory care here—How does anticipatory care look and function in an isolated and under-resourced community?

A more connected and safer system

The initial map, developed from pre-project scoping work by the CCWG, had six system parts: people and health; local infrastructure; data and information; attitudes and actions; relationships; and leadership.



Figure 14: Original systems diagram

The boundaries around the system corralled it as a mostly medical or health service system. This contrasts with our finding, from interviews, focus groups and survey data, that people think of health in very broad terms that include their capacity to do things that matter to them, and speak of their essential supports being provided by family, community, work, and so on. Perhaps especially here on Flinders Island, the anticipatory care system is built on local resilience and resourcefulness, on local organisations that know and work with their community, and on many community members' preparedness to take on multiple roles in support of the Island's needs. This is a resourceful community, where people:

Tie it up with wire, [and] hold it all together.

The system's function of keeping people well can sometimes be disrupted by a lack of appropriate and timely access to supports, by the negative impacts of the social determinants of health (including racism and social disconnection), and by the complexities of delivering coordinated health services to a remote, dispersed and diverse community.

At the project's end, the work of the Our Health Our Future team had strengthened some existing relationships among services and forged important new ones, as well as finding new ways to work that can embed these changes. This and the project activities have increased recognition of the roles played by a wider range of organisations, practitioners, and infrastructure in reducing community members' risk of developing a chronic illness and in supporting the better management of existing illness. The project allowed the OHOF team to develop and trial locally driven approaches. Through the AC project, the team has worked with parts of the system that were formerly not involved, and that now better understand their role in AC. This includes local government, the school, clubs, service organisations and volunteers. In making these connections, the OHOF team has also found new ways to work—and learn—with one another and with fly-in service providers. These relationships were formed in response to local needs for a stronger AC system, identified by PSO outreach and the engagement of FHOCM, and by the research.

Project driven changes to the AC system include increased:

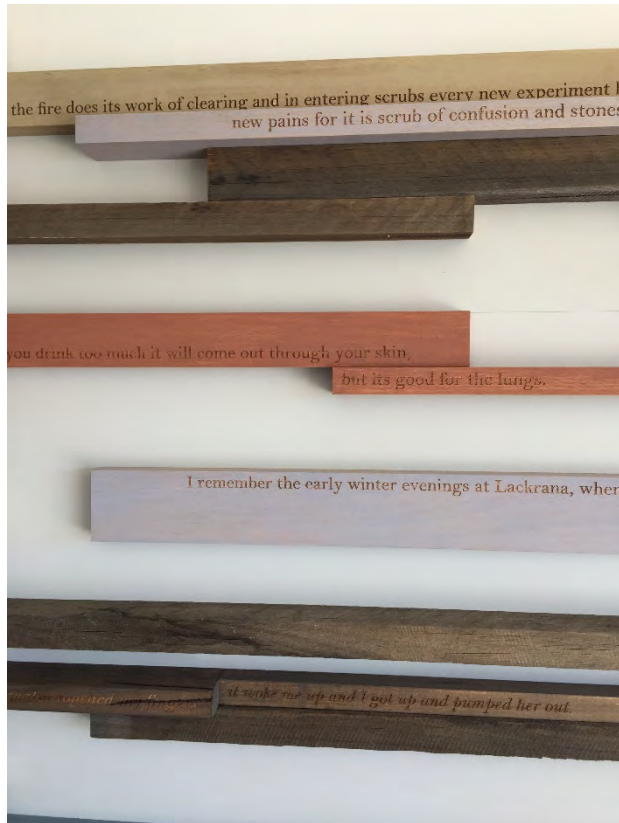
- understanding that AC involves a wide range of people and services
- inter-connectedness between services and people involved in AC across the Island (and extending to Cape Barren Island)
- collaborative relationships with shared goals, language, and ways of working for health advocacy, including with some fly-in-fly-out service providers
- skills for anticipatory care and strengthened relationships and collaborations among service providers such as FIAAI, MPC and Ochre; part of this is person-dependent through the PSOs and GPs, who are remaining in their substantive roles
- cultural competency among FIAAI and other services staff to work safely and effectively with community members
- engagement of some groups (including previously hard to reach people) in health-promoting activities
- awareness and support from a key funder of visiting services to the Island about the need to include collaboration in role descriptions for providers visiting the Island (and Cape Barren Island)
- service provider and community awareness of alcohol consumption as a key risk factors for chronic illness and initiated some changes in access to alternatives
- the effectiveness and authority of FIAAI in health and anticipatory care.

Over the life of the project, some inroads were made into engaging with neighbouring Cape Barren Island. Cape Barren Island was not part of the initial scope of the OHOF program but was brought in through OHOF activities that focused on collaboration. The OHOF team's work to negotiate the finely balanced relationships demonstrate the importance of projects providing sufficient time for this 'soft infrastructure' work.

An expanded set of system parts

Our re-drawn map of the AC system includes two additional parts: the importance of place and belonging and the impact of policy and processes (Figure 4).

Place and belonging



Place and belonging matter because people want to feel safe and familiar, especially when they need help or support. Without safety, people do not access services or places that could help them to maintain or build health. Place is also important because of its particularity: local experiences are tied to local contexts in multiple ways. This includes everything from the practical impact on access from the distance to a service, the costs of getting there, and fear of flying, the presence of attractive local beaches and walks and the importance of growing, catching or hunting your own food (as mentioned by survey and workshop participants), to the complexities of belonging, and history. People here are passionate about being Islanders.

Illustration 7: Island stories, Strzelecki Room, MPC

On Flinders Island, the history dimension of place and belonging take on extra relevance.

Cultural competency

Racism in health settings may contribute to poorer health through stress-mediated pathways as well as through reduced quality of health care and limited access to health services and other resources that protect and promote health (Kelaheer, Ferdinand, & Paradies, 2014, p. 3)

Health for the Aboriginal community on Flinders Island and Cape Barren Island is affected by the Islands' centrality to the dispossession, murder and criminal neglect of Tasmania's Aboriginal people post invasion in 1803. But the Islands are also central to their resilience.

Causal loop analysis made clear that the anticipatory care system on Flinders Island was being undermined by historical and—in some cases, continuing—racism. Some Aboriginal people expressed their mistrust of services other than those delivered by FIAAI, and we learned of instances in the mainstream system where they had been treated in ways that echoed historical injustices and racism. The OHOF goal of better collaboration between the different health and social services on the Island was not genuinely attainable while services

did not understand how – or denied the need – to offer appropriate services to Aboriginal Islanders.

Initially, OHOF planned to offer these services cultural competency training that would focus largely on the experiences and knowledge of local community members and be delivered face to face. The COVID-19 pandemic demanded changes to the design and delivery of the cultural competency training, but reflection by the OHOF team also identified the need to not place additional burdens – of recalling and sharing potentially painful stories, and of risking backlash – on community members, and so worked with a mainland Australian provider to design and deliver training that would be locally relevant but not burdensome. Emotional labour has overwhelmingly been expected of Aboriginal people when white Australians, sincerely or cynically, engage with cultural awareness. Initiating cultural awareness or cultural competency training for health and social care workers, however, also carries risks, including tokenism (tick-a-box one-off training that produces no change in attitude or action), the production of “essentialised, homogenised, stereotypical representations of ‘Indigenous culture’”, and can result in “Indigenous culture being seen as the problem” (Jennings, Bond, & Hill, 2018, p. 109).

This means that there is a great deal of work still to be done by non-Aboriginal Australians, from childhood onwards, to self-educate about the culture and history of Aboriginal people in Australia. It also means that any cultural awareness or cultural competency training needs to be part of employment induction, repeated, and mirrored in organisational culture, policy, and processes. Using the ACCHO approach, with its inclusion of the social determinants of health, is an additional way in which better health outcomes and appropriate interaction could be promoted (Carson et al., 2020; Priest et al., 2011; Walter et al., 2012).

Policy and processes

Policy and processes, whether at the organisational or governmental level, shape how the whole AC system functions but are largely outside the bounds of this AC project to change. During the life of the project, there have been policy and process changes at the local level. Local level policy and process changes that have supported anticipatory care include:

- greater engagement of Flinders Island Council in health
- potential for (former) PSOs taking week-about turns working from FIAAI and the MPC
- regular coordination meetings between Ochre, FIAAI, and the MPC
- inclusion of coordination and collaboration in the role expectations of TAZREACH-funded services to the Islands
- changes to GP provision at FIAAI

but there remain significant organisational and governmental policy and process barriers to the function of the AC system, including:

- short term competitive funding

- business models that do not support the ‘soft infrastructure’ of anticipatory care
- providing appropriate and connected services using on- and off-Island providers
- the social safety net.

The way these policy settings impact upon the AC system are discussed in the Barriers section, below.

Research question 2: Opportunities for enhancing anticipatory care [here](#)

The analysis showed opportunities for enhancing the AC system in the Our Health Our Future site. These were reported in 2019 (*Report to Our Health Our Future*, see Appendix 4), and discussed in the Findings section, above.

Research question 3: What actions were implemented and what changes have they produced?

The Our Health Our Future team developed four initiatives to enhance anticipatory care on Flinders Island; they have also made or advocated for structural changes. All the activities have supported the overall goal of increasing service collaboration. OHOF have also initiated new relationships, and are working on referral and discharge planning processes.

Initiatives:

- G.A.M.E. (gear access made easy) On Flinders: Provision of equipment for physical activities at two sites
- Alcohol Awareness: Increase awareness of the risks from alcohol use through public activities and (scheduled) service provider sessions
- Community Groups booklet/App: Increase knowledge about the opportunities for involvement across Flinders Island
- Cultural Competency training: Increase interest in and understanding of Aboriginal history of the impacts of discrimination and intergenerational trauma (see the OHOF Final Report, 2020)

Illustration 8: Reusable shopping bag featuring slogan from the alcohol awareness poster competition



Structural changes:

- Potential working from alternating workplaces (FIAAI, MPC); the PSOs were described to us as “a formidable duo – the benefits of that pairing we will continue to see for years”
- Regular meetings between FIAAI, MPC and Ochre Medical Centre staff

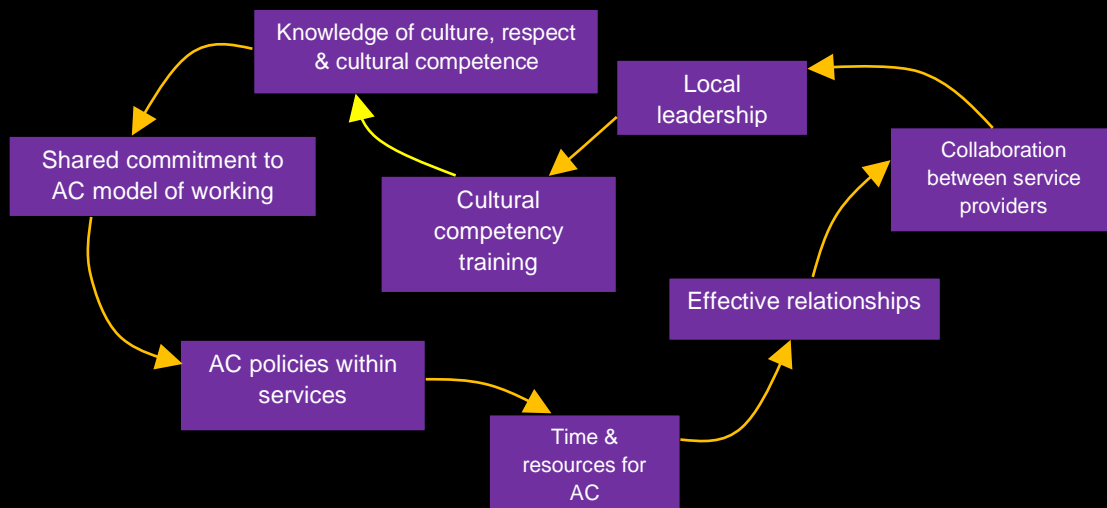
- New fortnightly GP clinic at FIAAI with local GP

Box: Collaborating

Several significant new relationships developed through the AC project. These include relationships between:

- the PSOs, leading to better links
- between FIAAI, the MPC and Ochre—evident in the Lady Barron Hall fluvax clinic and re-negotiated GP visits to FIAAI
- the PSOs and the visiting alcohol and other drugs worker, leading to engagement with
- the Flinders District High School and the Cape Barren School, and community

In all these examples, new ways of working have supported new ways of thinking which in turn embed an collaborative anticipatory care model across services. The diagram below, taken from Figure 12, shows this shift and probable consequences.



“[AOD worker] had that patch where funding was uncertain for her. She is just flying now. All the involvement with the school and Cape Barren. She is a real asset—she’s a poster girl for ‘this is a really great way to do it, to get involved’. The school has been important too. Also, she’s really experienced and knowledgeable. And she doesn’t want to sit in an office and just see people one on one. She has a really great relationship with the kids. We can’t underestimate the value of the poster competition at the show for the whole of community to get involved, and a great sense of pride in the community about the community’s children. It’s like alcohol is an adult thing, but it’s been flipped around—to get children’s perspective and how it affects them—meaningful and good to get it from the kids” (excerpts from fieldnotes and reflective conversations).

The project has found that these initiatives can improve the operation of the AC system for service collaboration on Flinders Island (Table 4). Activities or interventions are not the sole drivers of these changes, as the next section shows. The team’s way of working, and the philosophy and approach of the Project Support Officers have been important drivers.

Table 4: Impact on AC system of some OHOF project activities

GAME On Flinders	<ul style="list-style-type: none">• 143 people used the Lady Barron tennis courts GAME On equipment: personal social and physical benefits• Users include local residents and people using the port at Lady Barron• Implementation required negotiation with local government and Parks and Wildlife Service (increased awareness of anticipatory care; increased skills of PSOs)• Likely increased 'ownership' of the facility and local pride (no loss of GAME On equipment)• Proposed expansion to Cape Barren Island confirms growing collaboration
Alcohol Awareness	<ul style="list-style-type: none">• PSOs and AOD worker (fly-in fly-out) built strong and trusting collaborative relationship sharing knowledge, developing and implementing locally-relevant actions• Enhanced collaboration with school, and with Cape Barren community; greater understanding that school is part of the AC system• <i>"Engaged the learners"</i> (school principal), inspired the students over ten weeks—<i>"[students] transitioned to becoming educators across the community about alcohol awareness. A celebration of how our orgs can all work together for these outcomes"</i>• Flinders Island Show and poster competition (involving schools on Flinders and Cape Barren Islands) increased awareness about risks associated with alcohol, and further embedded AOD worker• Poster competition led to production of alcohol awareness 'merch' that is being used as prizes (for instance) for Parkrun, maintaining awareness• Some anecdotal evidence of attitude and alcohol provision changes• Further community awareness, school and services education sessions scheduled
Cultural Competency training	<ul style="list-style-type: none">• Developed carefully and respectfully with local Aboriginal community (e.g., yarning sessions); likely increased sense of being valued• Adjusted plans to reduce emotional and psychological burden on community• 46 participants from 5 organisations• Feedback suggests greater connection of FIAAI staff with one another and with community, and awareness among some other services of the need to keep cultural competency "at the forefront"

- | | |
|--------------------------|---|
| Referral pathways | <ul style="list-style-type: none"> • Links built with local services about referral processes—across the Furneaux Islands • Fortnightly discharge planning meetings with FIAAI, MPC and Ochre Medical Centre staff build on cooperation and coordination • A ‘united front’ on health presented to community (FIAAI, MPC, Ochre) • Outreach to Launceston General Hospital |
| Community booklet/App | <ul style="list-style-type: none"> • Engaged additional people in the OHOF team • Worked with local council, groups, and volunteer organisations: expands community knowledge about anticipatory care • Increased knowledge about community resources |
| Leadership Group (FHOCM) | <ul style="list-style-type: none"> • FHOCM engagement with OHOF team to develop and review actions • Some members very engaged and proposing and researching best responses to need (e.g., how could GAME On meet the needs of a range of age groups) • Supporting local advocacy (e.g., community transport scheme), information sharing (e.g., through <i>Island News</i>), and local capacity building (e.g., support for PSOs and other team members) • Continuation of some OHOF initiated changes |
| PSOs from FIAAI and MPC | <ul style="list-style-type: none"> • Substantive role and continuation of supports to embed AC awareness in employer organisations • Developed collaborative and trusting relationship, with flow-on effects to wider collaboration between organisations |

Box: Alcohol Awareness

The Alcohol Awareness project had both clear concrete outcomes (e.g., numbers of people involved in poster competition, and awareness sessions) as well as ‘soft infrastructure’ gains for the anticipatory care system. Participants’ comments reflect these gains:



AOD worker sharing the ‘beer goggles’ experience at FIAAI

*“This project has made a massive difference. Until the project, I think there was a fear ... —‘Who is this person coming here, wanting to **do to us**’? It’s usually ‘play by the rules, or we’ve got nothing to offer you’. But [now] ... we’re walking alongside and linking with other professionals all across this community”*

“[There are now] lots of conversations around the traps around reasonable drinking. Even if it doesn’t meet the guidelines, they are thinking, ‘Maybe drinking before 5 is not a good idea’”

“[The program] inspired the students over ten weeks ... [they] transitioned to becoming educators across the community about alcohol awareness. [This is a] celebration of how our organisations can all work together for these outcomes”

Research question 4: What role does the local lead organisation—Flinders Island Aboriginal Association Inc.—play in anticipatory care, and can it be strengthened?

... that sort of goes across the breadth of what [FIAAI] does, because there’s so many facets of the work that’s done here. So at every level—I think that you can physically see anticipatory care happening here. Because everyone draws on everyone else’s strengths and experiences to facilitate the best care, whether they be in mums and bubs, or whether they be in aged care. And regardless of what your job title says that you are a part of, everyone works together to make all cogs work.

FIAAI is a community-controlled organisation, with clear accountability to the local Aboriginal community. Their central role in the Aboriginal community is acknowledged by a broad spectrum of the Flinders Island community, and its CEO is recognised as an effective advocate for Aboriginal people. FIAAI has previously trialled new ways to support community health; the Tasmanian arm of the national “Tackling Indigenous Smoking”

campaign, using local people as the campaign's face, is an example (Illustration 9) (the program has been evaluated: Mitchell, Bandara, & Smith, 2018).



Illustration 9: FIAAI Tackling Indigenous Smoking poster, Whitemark, 2019

FIAAI has a whole-of-life way of thinking about wellbeing that seeks to improve the social determinants of health. Thus, their role includes the medical, alongside country and culture, housing, education and training, employment and so on. This meant they were already prepared for thinking about a broad and inclusive system that reduces risk of chronic illness:

...the way that FIAAI operates is that you have the time to look at each person that comes [in] as a whole person. I don't think that any of us would ever say that we just had to rush someone through and deal with that, with the cough that they came in with that day. Or the [work] problem that (name) brought in. Or whatever. You know, everyone takes time

The AC project was intended to learn more about how the anticipatory care model (largely developed in the United Kingdom) might operate in Tasmania. In the UK model, anticipatory care is built on 'routine encounters', a non-fragmented system, and equitable access to a range of services (Watt et al., 2011). It also places GPs at the centre of a web of health and social services. FIAAI's way of working does not focus on GPs, but does share key anticipatory care characteristics:

- community members are likely to have 'routine encounters' with FIAAI staff, including health staff, through formal and informal encounters at FIAAI or in the community, supporting relationships and longitudinal knowledge
- FIAAI's suite of services and supports mean that engagement is potentially less fragmented than would be the case through other provider models
- Health and other service interactions with community are not time limited (as they are in many GP consultations elsewhere), and preventive health checks are a norm

- FIAAI is funded in ways that support community members to have equitable access to a range of services

Nonetheless, there have been historical problems with coordination—and instances of discriminatory and unsafe interactions—with other services. FIAAI’s history demonstrates its willingness to tackle challenging circumstances.

FIAAI is a member of the FHOCM group, and the two collaborated in the OHOF project. The OHOF executive group brought together the CEO of FIAAI, the Director of Nursing at the MPC (John Louden), the Ochre Medical Centre practice manager and a consultant with experience in working with Aboriginal communities. Through OHOF project processes, FIAAI and FHOCM established shared goals—primarily focused on the identified need to better coordinate services to support Islanders’ better health. Participants in the leadership group were clear that while there were risks in taking on the anticipatory care project, there were also risks in not doing so; they embraced the opportunity to make a difference for the Island:

That the project was allowed to be very Flinders-esque—that was brilliant. That sort of project money coming in so often comes with strings attached that actually remove the capacity to do a local thing. But that didn’t happen ... what OHOF did ... it really was allowed to be what Flinders wanted. ... It changed how FHOCM has worked over that time ...

[there was] the thrill of people feeling things are possible as a result of the project

The OHOF team employed a project manager and a project support officer (PSO), seconding the FIAAI Health Service manager and MPC community nurse, respectively, into these roles. This was an astute decision, linking the two major health providers on the Island. The project role distinction was sometimes blurred, with both taking on PSO tasks, like outreach, data gathering, planning and review. There were advantages of the choice of these two staff:

- during and after the project, the PSOs retained their substantive roles, making embedding and sustaining changes more straightforward
- both staff were already well-known in their respective communities and their collaboration made them more familiar across services and supported collaboration between their organisations
- were energetic, creative and respectful in their outreach and engagement for anticipatory care
- their training (as Registered Nurses) meant they shared many ways of thinking, and also shared new knowledge gained during the project.

During the project, FIAAI’s role became particularly important when cultural competency (or its absence) was identified as a barrier to anticipatory care on Flinders Island. FIAAI, working with the consultant, scoped the possible approaches to cultural competency

training, drawing on community expertise. This involvement also enabled the OHOF team to recognise that engaging external trainers would reduce the emotional and psychological burden on local community members, while still allowing for the inclusion of local stories and knowledge.

Medical services (GPs) have historically been seen as central to AC; in this community we have found that there are many other services that can play a part; indeed, FIAAI already operates a version of anticipatory care through its holistic service, which seeks to address many of the social determinants of health. We propose that this way of working may be an ideal model for an anticipatory care system. This has been made more apparent during the project and the COVID-19 pandemic, as FIAAI, the MPC and the Ochre GP clinic have found and embedded new ways of collaborating.

[We are] proud as an Island—I think we do utilise our resources, but certainly the service providers are really passionate about the community they live in, and the significance of relationships and how that has far-reaching consequences. The existing groups—they are really doing great things and ensuring that service providers are working together or trying to work together!

FIAAI's role in anticipatory care is already strong. It can be further supported through resourcing to develop and deliver locally-appropriate and safe cultural competency training for on-Island and FIFO services across the anticipatory care system, and by partnering organisations embedding cultural safety in their ways of working and delivering services. There is also a need for better financial support for access to off-Island services. FIAAI needs to be 'at the table' in decisions affecting their community and the anticipatory care system on Flinders Island.

Barriers

The effectiveness of the OHOF actions and activities has been affected by local circumstances, and by policy and process problems. The local barriers relate to physical access and the costs associated with providing or accessing preventive health services in a remote location, and to the continuing impacts of discrimination, stigma and history on Islanders. There remain significant policy and process barriers to the function of the AC system, including:

- short term competitive funding
- providing appropriate and connected services using on- and off-Island providers
- business models that do not support the 'soft infrastructure' of anticipatory care
- the social safety net.

Short-term competitive funding

Even this project is hilarious, because we've been given 18 months. The state government had the money for four years before we even—and every time a new

service comes, there's a three month setting up period, and then there's the wind down period. Out of that 18 months, you might get six months, and a whole shitload of money has gone to waste. Why would you not just keep that chugging along. (Service provider)

It is clear across all the AC project sites that short-term competitive funding is damaging and limiting to the AC system. Short-term funding refers to project- or activity-specific funding, for periods as short as six months to two years. This sort of funding means that work needed to create the right environment for the project intervention—linking people, gaining knowledge and informing people, reducing fragmentation, and building relationships—has often just started to take effect when the money runs out. And that destroys relationships, causes fragmentation, and undermines efforts to make larger changes to policy settings, for instance. It also leaves people feeling that they don't matter and reduces trust. Competitive funding pits potential collaborators against one another, and takes resources from the on-the-ground service or activity to pay for developing funding submissions and evaluations (in other words, to compete). The risk of losing competitive advantage discourages sharing, reinforces silos, and can prevent the all-important trusting relationships—between services and between services and community members—from developing. This undermines the AC system. The competitive environment also tends to gradually reduce the pool of organisations being funded (what the systems thinker, Donella Meadows calls “success to the successful”, Meadows, 2008), since better-resourced organisations have more capacity to prepare applications. This risks reducing the diversity of voices in the field, reducing opportunities for mentoring new leaders or collaborators, and reducing opportunities for new—and potentially better—approaches to develop.

There is increasing evidence (from this, and other, work, e.g., Kavanagh, Shiell, Hawe, & Garvey, 2020) that to support local preventive health and wellbeing initiatives, communities—through carefully selected lead organisations—need to be funded and provided with resources (e.g., information, training/skills development, access to decision makers, as needed). The aim of funding should be to set broad goals, focus on outcomes rather than outputs and activities, and then allow communities to get on with it, with funders acting as partners in the process. Projects or actions should focus on ways of working (e.g., partnership, trust, consultation, learning, sharing power, building on strengths), with funders acting as partners in the process.

Shifting national and state policy is a large task, but local sites can advocate for changes to this policy approach and can—as OHOF initiatives are showing—demonstrate the effectiveness of collaboration; FHOCM has an essential role in sustaining collaboration and in lobbying for new funding models that do not undermine relationships across the anticipatory care system.

Providing appropriate and connected services

The anticipatory care system relies on the collaboration and coordination of multiple services, operating across the determinants of health (i.e., health, housing, employment, education, etc.). FHOCM is one of the groups on Flinders Island that has been working to improve such coordination. FHOCM includes people working in social work, physiotherapy, mental health and psychology, and aged care, and representatives from FIAAI, the MPC and Ochre Health, local government, and the District High School. The list does not include some specialist services (e.g., dentist, and medical specialists), nor some of the less directly 'medical' parts of the system.

The Island's remoteness and service delivery model makes for some coordination difficulties, despite FHOCM's efforts. For instance, some visiting services treat the absence of any booked consultations as an opportunity to miss their scheduled visit, curtailing the opportunity for Islanders to make relatively impromptu appointments. This problem is driven by funding models. This was a concern expressed by several of the project participants. There is also the difficulty that if a local, or locally delivered service is staffed by people with whom a resident is uncomfortable, there are many fewer options, especially for poorer Islanders, to go elsewhere for help, or get a second opinion. Finally, practitioners who fly in and out are generally focused on visiting or offering consultations with specific clients and may have restricted time to form relationships with on-Island services and staff. This means that on-Island providers may have no idea about a person's needs, should an emergency arise; on the other hand, it also has the important function of maintaining the confidentiality of clients in a small community. A balance needs to be found between confidentiality and trusting other service providers.

Some of these policy-driven barriers could be addressed. For instance, the OHOF work has encouraged TAZREACH to adjust its role descriptions for practitioners travelling to the Island to explicitly include outreach and collaboration with other services. This will require factoring in additional time to build relationships with other parts of the anticipatory care system. The matter of missed scheduled visits is more difficult to address, since it is shaped by business models operating in some medical and allied health services.

Business models

Flinders Island, alone among AC project sites, does not have significant restrictions on access to bulk-billed medical consultations. However, the business models operating in several FIFO medical services (including specialists and psychologists) rely on a form of 'billable hours', meaning that time not spent in consultations is not budgeted for. On Flinders Island, as elsewhere, this model means that there is no paid time for outreach, for community engagement, or for forming and sustaining relationships with other service providers in the local anticipatory care system. There is some engagement with FHOCM by some FIFO providers, but they represent a minority of such services.

The second evident problem is, as noted above, that of services only arriving when there are sufficient appointments. This further reduces opportunities to collaborate or coordinate with other services, or to become a trusted provider. Lack of presence or engagement also means that there can be delays to diagnosis and treatment, and no incidental opportunities for reminders, that may be dangerous to the health of community members. Problems caused by business models that measure effectiveness only in terms of clients seen, or treatments administered (Medicare item numbers) are also present in the other AC project sites.

It is clear from the AC project that the anticipatory care system relies on both hard *and* soft infrastructure. The presence of a variety of services and supports (the quantifiable hard infrastructure dimensions) is only effective if accompanied by the relationships and other qualitative dimensions of service provision that make them truly accessible and cooperative. Soft infrastructure includes not only relationships, but also hope and trust, identity and world-view, safety, self-efficacy, governance and cultural symbols:

Culture and identity provide the basis for marginalised groups to build capacity and to sustain and participate in successful programs (Morley, 2015; Stewart, 2005). Safe spaces allow community members to engage with difficult issues and work collectively to overcome obstacles and translate new knowledge into action (Campbell et al., 2007). Individual and community narratives motivate and sustain action for change (Rappaport, 1995), while trust is a precondition for engaging in collective processes (Kawachi et al., 2014; Ostrom, 2000). (Kavanagh et al., 2020, p. 3)

Many services in the AC system measure only the hard infrastructure dimensions of their performance, a practice encouraged by funding and other policies. The absence of attention to soft infrastructure, and to small but important change is damaging the potential of the AC system, and the multiple parts of that system.

The social safety net

Poverty affecting how some people use the formal health system, as well as their access to health care resources. Failures in the social safety net, including social welfare payments and associated policies and processes, are also placing significant stress on recipients and can reduce their trust in services and make them unwilling to engage. We have seen in all sites that a lack of confidence or motivation are significant barriers to health-benefitting behaviours; some are related to mental ill-health, but they may be exacerbated by policy settings or punitive processes. Policy that leaves people poor and processes and rules that are sometimes punitive add to existing mental distress in communities, undermines cooperation and collaboration, and safety. National and state policy settings are not something the OHOF community can shift during the life of this project, but they shape how the system overall works and who it reaches.

Local actions can change internal organisational rules and processes. Services can develop coherent processes that make the systems safer for all its users. By coherent, we mean processes that are easy to follow and make sense, that are delivered locally or by accessible

means, and that use language that the audience are familiar with. Services can also adopt processes and rules that reduce stigmatising encounters and increase trustworthiness and safety for users and providers. Cultural competency is part of such change.

The usefulness of the methods

Action learning

Action learning was a good fit for the AC project here; much of this learning took place in the PSOs sphere but extended to those people who worked on particular initiatives. The OHOF team followed its cycles of Observe, Reflect, Plan, Act to develop and adapt the actions and activities they undertook. The PSOs in particular were alert to change or the impacts of actions, gathered new evidence or options (including from the ongoing research component), reflected, and consulted on how to respond to what they were learning.

For the UTAS researchers, too, the action learning approach was effective overall, not least because action learning builds in periods of reflection that allowed us to revise the ways we were working. A good example of action learning was how the PSOs found novel ways to survey school students, and the adaptation of cultural competency training to maximise benefit and minimise risk to participants, particularly Aboriginal participants. The OHOF team also identified how best to continue AC project ways of working during the COVID-19 lockdown and into the future.

The community workshop, in 2019, was broadly effective, and made more so by the use of local images and posters about 'being healthy' created by school students. These contributed to the sense of a local project and may have been good prompts as people thought about the AC system on the Island.

It was not always easy for the research team to know the best way to communicate our analysis/reflections for the planning or other parts of the cycle, or how to bring in the systems thinking aspects of the project. And we did not always manage to avoid academic jargon.

Time, repeated contact (especially with the PSOs) and mutual reflection and support helped us build increasingly trusting relationships between the OHOF team and the UTAS researchers. It became easier to work effectively, to reflect together and understand what we were learning. The PSO Community of Practice appears to have been valuable as a place where PSOs from all four sites reflected together on what was being learned and how barriers or problems might be addressed. Systems processes were a focus of these sessions, and a separate Systems Traps discussion was joined by members from all four teams, where participants shared examples of the Traps and potential solutions to them.

We know our own capacity has been built, and this has also happened in the OHOF team.

Although both action learning and systems thinking were being trialled in this project, the ways in which they were applied were not prescribed by the CCWG in the original project design. This was both a weakness and a strength. Early in the project, researchers and the OHOF team felt some uncertainty about how to proceed, what, when, with whom and how to share what we were learning, and how to surface and incorporate local ways of working into the wider needs of the project. Action learning models demand that the participants shape the project, but there was relationship work to be done to develop the level of trust between OHOF executive, PSOs, DoH Principal Project Officer and UTAS necessary for that agency to be taken on. We think that this work was largely well-achieved, with the UTAS team feeling a sense of shared work and learning with the OHOF team. Community of Practice meetings were beneficial in this.

Systems thinking and tools

Systems thinking was warmly welcomed by OHOF team members. Causal loop diagramming engaged participants in telling stories, which then informed how we understand the AC system and helped those present identify opportunities for change. This process also addresses a concern some researchers have with action research—that it is not genuinely participative, but instead runs the risk of imposing researchers’ evangelical activism on communities. A second valuable systems thinking tool is ‘systems traps’ (Meadows, 2008). UTAS and the OHOF team have used this tool to identify and find ways around real and potential stumbling blocks. In fact, the OHOF team were ready adopters of the systems processes (e.g., CLD) and thinking, using it to determine what to act on, and how best to act.

The systems processes can be very complex, and the language of systems thinking and CLD is not plain. A further risk is that the CLD process is shaped by the people present, by data gathered in other ways, and by particular perspectives on AC (e.g., the theme of the need for greater individual responsibility in health). If these sources are weighted towards the loudest voices (and missing the hard-to-reach), solutions can only ever be partial.

We need to find ways to introduce ideas such as systems thinking and tools such as the CLD process early and to encourage their use—or to build locally-relevant tools that can serve a similar purpose. If we can do that, it may be possible to reach more community members, learn much more about their experiences of the system first-hand (rather than through interpreters like researchers or members of the local site team), and thus support both genuine participation and local solutions.

Summary

In the OHOF site, actions and activities have enhanced each of the elements that Watt and colleagues (2011) said are necessary for anticipatory care. The project has increased trust and built relationships, gathered and made use of high quality data, worked in ways that reduce fragmentation of the system, and made access more equitable. Work by the OHOF team has

fostered collaboration across multiple sectors, increased FIAAI's reach into the Flinders Island community and parts of the system, and increased understanding that tackling chronic illness is a complicated social endeavour, not one that rests solely with medical and health services. Further, there are structures in place that can be sustained and used to build on the changes.

The AC Action Learning Project on Flinders Island has resulted in increased:

- understanding that AC involves a wide range of people and services from different sectors
- cooperative and collaborative relationships between a greater range of people and services at multiple levels
- capacity (knowledge, skills, and capabilities) in key players and organisations to support safe access to the AC system
- networks, with shared AC goals, language, and opportunities for health advocacy
- clear evidence for the importance of better inter-personal connection between the multiple health and social wellbeing services on the Island or delivered by visiting practitioners to the AC system's function
- support for the holistic model of wellbeing delivered by and through FIAAI.

Limitations

Time

- time limits mean that we cannot prove or be definitive about the health benefits delivered by the project
- more time is needed to further develop connections with health service system providers (e.g., visiting services, mainland services used by Islanders, including hospitals or specialist services)

Participation

- although the lead organisation and collaboration with services extended the reach of the project into some of the more marginalised members of the community, there are people and services that were difficult to hear from; in some cases this is likely to have been deliberate (i.e. Island residents who want to remain isolated/private)
- some of the methods we used were not accessible to some participants (and potential participants).

Potential and future direction

- FHOCM has shown capacity as a vehicle for connecting services, and leaders, to keep a focus on health goals, and to drive health changes for this community
- the opportunity created through AC funding to develop the OHOF initiatives has led to the identification and trialling of cultural competency training. There is scope to further localise this training, to roll it out more widely, and to provide follow up support to

embed new and safer ways of thinking and working; such changes need to be properly resourced

- the actions taken have set up foundations that could be built on with the right resourcing. The CLD also shows new areas of interconnectivity (and therefore potential impact) that provide future potential system focus points.

Recommendations

The AC project has demonstrated that enhancing the AC system is possible at the local level through local initiatives. The project has planted the seeds of new ways of thinking and working; we make the following recommendations to support long-term benefits to AC and the health of this community. There are opportunities to maintain and build on what has been gained.

For local action

The PSOs on Flinders Island were already embedded in the community; the AC project supported them to reach beyond their usual roles, develop a strong collaborative relationship, increase coordination between FIAAI, the MPC and Ochre Health, and collaborate with off-Island service providers more effectively:

- Maintain the OHOF-instigated coordination between the FIAAI Health Service Manager and the MPC community nurse, including through shared workplaces, information sharing and work collaboration, and embed this coordination via role descriptions
- MPC and FIAAI to further explore and formalise where possible staff rotation/co-location arrangements, shared position descriptions and information sharing.

Partnerships and collaboration across the system are essential. FHOCM has a recognised role in building and sustaining collaboration across Flinders Island and with off-Island services, and in shifting attitudes to support AC. They can also—perhaps particularly through the (former) PSOs—reach out to the least connected people and services to understand local needs, people, and situations so that responses can be relevant, accessible, and meaningful:

- FIAAI and the MPC have supported the outreach, coordination and collaboration of the PSOs during the project; this needs to be sustained through their continuing substantive roles.

Collaboration and coordination are essential to the anticipatory care system, and some steps have been taken by service provision policymakers (e.g., TAZREACH) to embed these activities and ways of working:

- On- and off-Island service providers should incorporate outreach and collaboration as key tasks for all service providers working across the Furneaux Islands (including through FHOCM) and find ways to coordinate with one another to support the anticipatory care system

Performance measures or Key Performance Indicators (KPIs) have historically ignored qualitative measures of ‘soft infrastructure’ and change in favour of quantitative ‘number of services’ measures. These cannot adequately reveal how the AC (or other health and wellbeing) system is performing.

- Revise health and social care service KPIs to reflect externalities, soft infrastructure, and experiential dimensions of performance

For local, state and national policy action

All levels of government have a role to play in efforts to alleviate chronic illness.¹⁰ These recommendations to build on the gains from the AC Action Learning Project—and to spread those gains more widely—rely to a greater or lesser extent on recognising that shared role and shifting policy:

- State and federal governments need to recognise that the Aboriginal Community Controlled Health Organisation (ACCHO) model, with its holistic approach guided by the social determinants of health and cultural competency is an appropriate framework for anticipatory care, and develop policy that supports this model being applied more widely
 - The ACCHO/social determinants model demands a whole-of-government approach to preventive health
- Cultural competency training should be part of the induction and regular professional development for services across the anticipatory care system; it needs to be driven by local palawa, who are adequately resourced to develop and deliver locally relevant and safe programs
- Local, state and federal governments need to develop KPIs that reflect externalities, soft infrastructure and experiential dimensions of performance
- Factor the importance of place and belonging (including cultural concerns) into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision, town planning, and social housing and, potentially, mirroring or adopting the ACCHO model
- Flinders Council continues to be an active partner in improving health and wellbeing

Short-term project-specific funding models are damaging the AC system. To better support the health and wellbeing of the community, we need:

- To replace competitive funding models that reduce connection and collaboration between parts of the AC system with models that promote and support collaboration
- Flexible funding over longer periods
- Funders to set broad goal/s (e.g., improve health in this community) and allow communities/leads in consultation with their community to determine what success looks like, how it will be measured, and how to allocate and manage the funding
- Funders to work as partners, providing guidance and monitoring of process (e.g., community engagement, how resources are being utilised/targeted, without being prescriptive)
- To trust local communities to identify their own priorities and develop strategies to address those priorities.

¹⁰ These roles will be explored more fully in the final report.

For future work on anticipatory care and preventive health

Gains from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project. An overarching aim of the AC project was to use a systems approach to identify strengths and weaknesses in AC systems and to co-design community specific responses. Assessing the longer-term health dividends is beyond the scope of the study. Therefore:

- A longitudinal study is needed to determine the level of benefit from the changes to the local AC system.
- Further flexible resourcing should be provided to build on this work.

Action learning and systems thinking have been effective here, but both rely on time and trusting relationships:

- Provide sufficient time in future anticipatory care work to develop relationships with local teams and communities, and to adapt processes and tools to maximise participation, and
- Introduce systems tools early and encourage their use—and adaptation—to suit local users. This could support the inclusion of more community members, first-hand learning about local systems (rather than through interpreters, such as researchers or members of the local site team), and thus support both genuine participation and local solutions.

There are clear mutual learning benefits for the university, the DoH and the OHOF team in the approach taken here to working to enhance anticipatory care. The contributions made by each group are particular and cannot readily be ‘swapped’. The ideal of equipping local communities to replicate the approach without these supports burdens them. Similarly, university researchers cannot ever become expert enough about a local site to work in ways that are inclusive and appropriate without partnering with locally embedded organisations:

Future preventive health (including anticipatory care) projects should build in opportunities for mutual learning between community, university, and relevant government personnel.

Appendices

Appendix 1: The OHOF project site



Source: google maps

Appendix 2: Interrelationships, boundaries and perspectives in systems thinking

What is the systems approach to evaluation?

A systems approach is about seeing the bigger picture. It does this by paying attention to how parts of the system interact with each other and this can explain why things are the way they are. A systems approach comes with tools and methods and a perspective called 'systems thinking'.

There are three ideas that are central to systems thinking: *perspectives, boundaries and interrelationships*. Perspectives recognize that how we 'see things' is only one perspective on a problem and there are many more. Boundaries encourage us to ask who or what is included in our understanding of the problem? Who is missing and why? Interrelationships ask us to always pay attention to the connections between things. Changing these connections can create powerful system change.

Hypothetical example

The problem: Local health advocates are concerned that many young mothers are bottle-feeding rather than breastfeeding their newborn babies. The World Health Organization recommends exclusive breastfeeding for the first 6 months after birth.

Business-as-usual approach: Taking their usual approach, the health advocates decided to give the mothers health education material and point out the benefits of breastfeeding and the downside of bottle-feeding. They believe the problem is a lack of health information. If the mothers knew the benefits of breastfeeding they would change their behaviour.

Systems approach: Alternatively, the health advocates could have taken a systems approach. This would encourage them to step back and consider what else might be going on? Using systems thinking the health advocates may seek multiple views or perspectives on the issue (from mothers, work places, community members, family).

They could ask:

- About boundaries—What parts of the system are important?
- About interrelationships—How do the parts—such as norms and beliefs about breastfeeding and motherhood, environmental conditions and so on—interact?

And they would try to understand what opportunities for change have been revealed.

In doing so, the health advocates may begin to understand the challenges young working mothers face when trying to breastfeed at home and express milk at work, with few breaks and no fridge. They may come to discover that beliefs about motherhood prevent changes to work place practices and so young working mothers stop breastfeeding. They now have a deeper understanding of the problem.

In the Box example, the systems approach has redefined the problem. It is no longer only an issue of the health literacy of mothers. They draw in multiple perspectives on the issue, extend the boundary of the problem beyond the clinical encounter and seek to understand the connections between factors affecting the issue. This revealed a systemic problem—that work places are not conducive to breastfeeding because people believe that new mothers should be at home with their baby. As a result it is too difficult for young working mothers to breastfeed newborn babies. This insight and learning opens up a different set of opportunities to intervene to improve breastfeeding rates.



Systems thinking can help us better understand complex problems; where boundaries are unclear and solutions are either too simple (and often unlikely to work) or the course of action is not clear. Chronic disease prevention is a complex problem unlikely to be solved by a single solution.

Why give systems thinking a go?

Rates of chronic disease are on the rise. Diabetes is the fastest growing chronic condition in Australia. Many public health researchers, policy makers and practitioners lament the lack of progress in reducing rates of chronic disease. Some believe its because we are blinkered in how we understand the complexity of these problems. We tend to only focus on individual behaviour and fail to see the complexity of people's lives that influence the decisions they make about their health. Systems thinking offer a different way to think about problems and potential solutions. There are also some promising studies showing the benefits of taking a systems approach. In one study, the authors reviewed type 2 diabetes programs and found that those that applied complexity (or systems thinking) principles in their design such as interconnectedness, were associated with better outcomes for patients. That paper is attached.

What does a systems approach mean for the AC project?

The Anticipatory care projects take the local AC system (rather than an individual) as its starting point. Research is currently underway to surface local practices and identify important parts of the system such as the AC workforce or the range of programs and initiatives currently being implemented. It will surface new and missing perspectives on anticipatory care and elevate local knowledge to create a more comprehensive picture of the system. It will extend traditional "health service" boundaries to include community infrastructure such as community houses, schools and social services. A more comprehensive picture of the AC system will also surface new and unexpected opportunities to intervene to strengthen relationships, draw new players into the system, modify practices to be more inclusive and so on.

Along with systems thinking, various tools and methods will be applied to the AC project such as systems mapping. But most importantly, it is built on the premise that knowledge about the local AC system can only be created from within the local AC system and this is where the most relevant and potentially long-lasting solutions will emerge.

Source: *Therese Riley, in Anticipatory Care: An action learning project in Tasmanian communities of place and culture—A manual for community project support officers (UTAS, 2019, pp. 17–18).*

Appendix 3: Data sources in the Our Health Our Future site

We used quantitative and qualitative data sources.

Table A3a: Quantitative data—from existing sources

<i>Source</i>	<i>What</i>	<i>How used</i>
<i>2016 Census data</i>	Population profile statistics for Flinders Island: ages, sex, diversity, employment, income, education, volunteering, households, etc.	Data is being used to understand the demographics of the area. This data also enables comparison with Tasmanian averages, and with the other project sites.
<i>Primary Health Tasmania, the Australian Health Atlas</i>	Health status and health behaviours information for the area (e.g., smoking or physical activity rates, prevalence of diabetes); data on location of GP services	Data is being used to map health status and behaviours and to compare this with Tasmanian averages and with other project sites.
<i>UTAS literature review</i>	Location of non-GP health or wellbeing services; availability of bulk-billing; numbers of GPs; research findings about the area (e.g., Ryan Talsma’s consultant report, emerging literature on local government, the Healthy Islands Project, etc.)	Published research reports and other literature is being used to collate what is known about the presence of the social determinants of health and use of services, for instance.

Table A3b: Data gathered in the OHOF area by UTAS researchers, to June 2020

	<i>Participants/documents</i>
<i>Interviews and focus groups</i>	29 people
<i>Community workshops</i>	25 people
<i>Survey</i>	120 people
<i>CLD workshops</i>	12 people
<i>Reflections with/by PSOs</i>	27 documents
<i>Fieldnotes (from community and CLD workshops, and other meetings, site visits)</i>	32 documents

A note on surveys

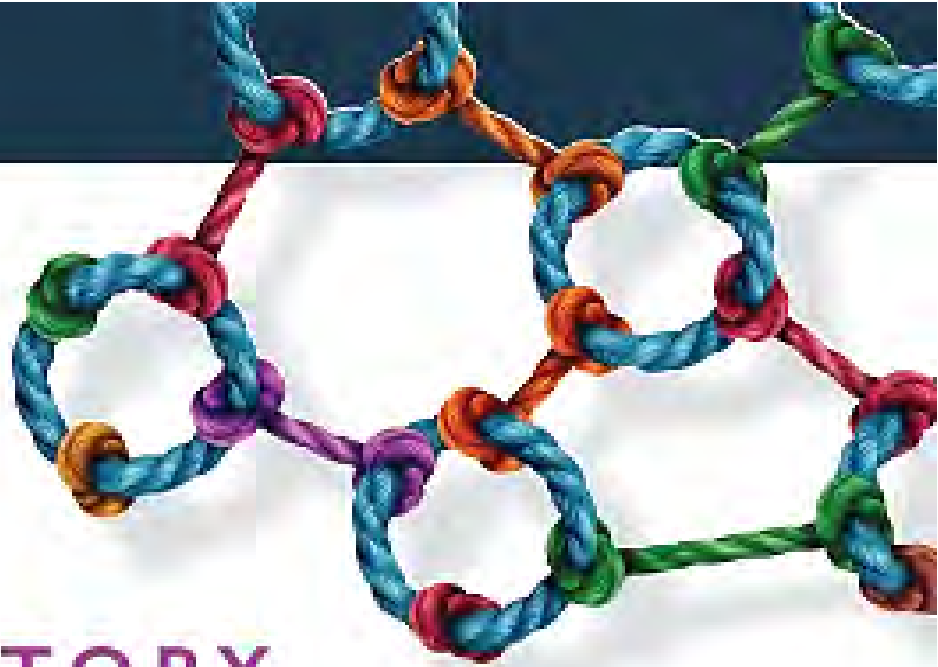
We needed to understand how people in the AC Action Learning Project communities experienced anticipatory care, and the health system more broadly. Interviews and focus groups were appropriate for some members of the community; they rely on potential participants being identified, those people trusting in the process and having time, skills and desire to participate. However, we needed to find out how people who are ‘hard to reach’ experience the system, and this is also the population for whom interviews or focus groups are least appropriate (Rockliffe, Chorley, Marlow, & Forster, 2018). We discussed ways to engage with this group with the leads and PSOs, and surveying was suggested.

A survey was designed and trialled. There are personal and infrastructural constraints on surveying, including literacy, access to the internet and to data.¹¹ This meant that the surveys were handed out—mostly by the PSOs—for completion at various places in the communities, rather than offered online. After a short period, the PSOs and the research team reflected on how this process was going and the survey was revised, in keeping with action learning processes (by the Clarence H2H AC project team), to use Plain English and more tick-box response options. We also decided that the survey should be interviewer-administered. There is good evidence that using ‘peer interviewers’ (in this case, the PSOs) or people already embedded in a group or community can increase engagement (Bonevski et al., 2014; Devotta et al., 2016). In each site, the PSOs had connections into the communities. The surveys asked people for quantitative and qualitative answers.

PSOs were encouraged to support and prompt participants to provide detail about the sorts of people and places that are involved in their health behaviours and care. Conducting surveys significantly increased PSOs’ engagement with community, and familiarity with different community settings.

¹¹ Some novel methods were proposed (by a PSO in the Launceston site) that would not require literacy; they were not pursued.

Appendix 4: Previous report (2019)



ANTICIPATORY CARE PROJECT

ACTION
LEARNING TO
IMPROVE HEALTH
IN TASMANIAN
COMMUNITIES

Our Health Our Future

PRELIMINARY FINDINGS FOR FLINDERS ISLAND

Report prepared by U Tas Institute for the Study of Social Change, May 2019



***Institute for the
Study of Social
Change***

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Anticipatory Care: An action learning project

Report on the findings in Community 4: Our Health Our Future

Prepared by UTAS Institute for the Study of Social Change researchers: Dr Susan Banks (Project Chief Investigator), Dr Robin Krabbe, Thérèse Murray, and Miriam Vandenberg (Researchers)

The project aims and structure

In Tasmania, the number of people with chronic conditions such as cancer, heart disease, diabetes, arthritis, stroke and asthma has continued to increase over the years. This project will identify and support new models of anticipatory care as an approach to the management and prevention of chronic conditions.

Anticipatory care is a population approach to health care that identifies and engages people who are at risk of developing chronic conditions with the aim of preventing or slowing health deterioration. Through relationship building and by recognising the social context in which they live, people are supported to be 'co-producers' of their health.

The Tasmanian Department of Health (DoH) has received funding from the Australian Government to conduct research to better understand and learn from communities about different ways anticipatory care happens and what works well and why. Over the next 18 months, we want to work with some Tasmanian communities to apply an action learning approach to anticipatory care to:

- Increase our knowledge and understanding of how anticipatory care occurs in different communities
- Better understand the enablers and barriers to anticipatory care experienced by communities
- Increase our knowledge and understanding about how communities and health services can work together to engage 'at risk' Tasmanians in primary and preventative health care, including assessment and management of their health needs.

(Anticipatory Care, Project Guidelines, 2018)

Roles of the participating organisations and groups

The project is a collaboration between the Department of Health (DoH), the University of Tasmania (UTAS), and lead organisations in four Tasmanian communities that were selected by DoH because of their chronic health and preventable hospitalisations profiles.

The University of Tasmania is working with each community lead organisation through the 'local project lead' (in this case, Alison Oliver) and the Project Support Officer/s (PSO) (in 'Our Health Our Future' this is Fiona Turley). UTAS is also

working with each community directly through data gathering (e.g., interviews, focus groups, workshops, observations) and through the Local Advisory Groups.

The project design, processes and effectiveness overall are being evaluated by The Australian Prevention Partnership Centre and the Sax Institute. The structure of the project, and the broad roles of the participants are shown in Attachment 1.

Attachment 2 illustrates the task of the community lead organisations, University and evaluation partners. The project processes are summarized in Table 1 below.

Table 1: Project processes in brief

1.	DoH identifies appropriate project sites and engages a local lead organisation
2.	Lead organisation appoints Project Support Officer(s) and recruits a representative Community Reference Group
3.	UTAS commences mapping anticipatory care in each community, with the help of the PSO
4.	PSO supports UTAS research and works with lead organisation to engage the community in the project and enhance anticipatory care
5.	UTAS reports findings of the mapping process at community forums/workshops and seeks response from the community there and more broadly
6.	UTAS collates and analyses all data about the nature and experiences of anticipatory care in each community and reports local findings to each CRG
7.	CRG determines how the findings (and DoH funding) can be used to develop a project or projects to support and enhance anticipatory care in the community, with a particular focus on those people who are most at risk of developing a chronic illness
8.	Project partners (lead organisation, including project lead and PSO/s), and CRG implement action (with UTAS support as needed)
9.	UTAS continually monitors impacts of the action, reporting to the CRG and lead organisation to support adjustment (as per the action learning methodology)
10.	UTAS reports outcomes and overall findings to the CRG and lead organisation, the community, and the government

The research questions

There are overall research aims (see Box, above) as well as specific research questions. The research questions (RQs) are:

Mapping anticipatory care:	What does anticipatory care look like in each community? What are the shared elements and what are not? What is working, and who is it working for? What is not working, or who is not benefiting?
Opportunities for enhancing AC:	What elements in the existing system can be influenced (and are they within the capacities of local actors)? What gets in the way?
Actions and outcomes:	What actions are the sites implementing? What changes have the actions resulted in—what differences can be seen at individual, organisation, service and community levels?

There is also a research question tailored to each community. In Ulverstone, this question is:

Our Health Our Future RQ	How does anticipatory care look and function in an isolated community?
---------------------------------	--

The research approach and methodology

Health can be thought of in a variety of ways and from a number of different perspectives. This multi-factorial perspective fits with the definition from the World Health Organisation that health is "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*". Some people, within and outside the health system, think of health as measurable by the presence or absence of a diagnosable condition; we can (often) determine whether a person has high blood pressure, diabetes, a tumour or a cold, for instance. Health can also be about the actions people take to maintain or improve their wellbeing: like doing sufficient physical activity, not smoking, eating a range of nutrients and not too many of them, and so on. Increasingly health is also understood to have psycho-social and socio-economic dimensions. The 'social determinants of health' is a framework that brings together the evidence that health is shaped by exposure to disease and by social, economic and psychological risks over a lifetime.¹² These quantifiable and experiential aspects of health are reflected in the Anticipatory Care project's Discussion Paper (January 2018), which states that the characteristics of anticipatory care include:

- "Reaching people who need care most (for example, through effective community partnerships and outreach models)
- Early identification and assessment of future risk (for example, by combining assessment of psychosocial as well as physical and biomedical risk)

¹² Sir Michael Marmot's work was first reported in the Lancet:
[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(05\)71146-6/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)71146-6/fulltext)

- Enabling people to improve their health (for example, by joining up health and social services to address social determinants of health and using self-management approaches)
- Improving the personal experience in the healthcare system (for example, through integrating care, care coordination and supporting consumers to navigate health systems)
- Planning care using local health data and consumer input (for example, by using population data, shared client records and consumer involvement in planning)” (pp. 5–6).

To map the existing anticipatory care system in each community, we therefore need to rely not only on statistical information about people’s circumstance and health status, but also on finding out what people’s experiences of health and the health system are, and what attitudes people have to their health. Collecting and analysing this information will also enable us to see whether there are any opportunities for change, and to measure improvements resulting from actions each community takes in this project.

A note on Action Learning

The research process is continuous over the life of the project (see Attachment 4); we want to understand what the initial situation is, use that to inform planning for change, and then monitor what happens when the actions are put into place. This is a cyclic process of observing, reflecting, planning and acting.

Data Sources

UTAS researchers are responsible for the bulk of the data gathering in this project and for the data analysis and reporting. Where individual, identifiable information is provided, the usual approach to confidentiality has been applied. Similarly, responses to focus group issues, workshop data and reference group advice have been aggregated into themes by way of established academic practices to avoid the identification of individuals. The UTAS procedures have been approved by the Tasmanian Social Sciences Human Research Ethics Committee [H0017669].

Two complementary data gathering approaches are being used in this project.

Quantitative data sources

Quantitative data enables counting and measurement and can answer questions like “How many?” and “Where?”. Table 2 lists the main quantitative data sources. This information is being used to help create a statistical picture of anticipatory care in the

area; it was also used to select the ‘Our Health Our Future’ area as one of the suitable project sites. Some parts of this statistical picture are provided at Attachment 5 and were reported in the March 2019 Community Workshop posters.

Table 2: Quantitative data—from existing sources¹³

<i>Source</i>	<i>What</i>	<i>How used</i>
<i>2016 Census data</i>	Population profile statistics for the ‘Our Health Our Future’ area: ages, sex, diversity, employment, income, education, volunteering, households, etc.	Data is being used to understand the demographics of the area. This data also enables comparison with Tasmanian averages, and with the other project sites.
<i>Primary Health Tasmania, the Australian Health Atlas</i>	Health status and health behaviours information for the area (e.g., smoking or physical activity rates, prevalence of diabetes); data on location of GP services	Data is being used to map health status and behaviours and to compare this with Tasmanian averages and with other project sites.
<i>UTAS literature review</i>	Location of non-GP health or wellbeing services in the ‘Our Health Our Future’ area; availability of bulk-billing; numbers of GPs; social research findings	Published research reports and other literature is being used to collate what is known about the presence of the social determinants of health and use of services, for instance.
<i>FTI Consulting</i>	“Study of Economics, Business and Social Structure on Tasmania’s Flinders Island”	Additional recent data.

Qualitative data sources

Qualitative data is about the nature of a phenomenon. It is used to answer ‘how’, ‘why’ or ‘what is that like’ questions. Table 3 (below) sets out the qualitative data gathered so far. It is used to find out what an experience is like, how people

¹³ The Patrick Street Clinic is also using quantitative data from its records in this project. The findings from that work will be reported in the overall Study findings.

understand something or what it means to them, or what motivates or prevents a behaviour, for example.

UTAS researchers are using qualitative data to find out how people in the ‘Our Health Our Future’ area experience and understand health, the health system in general and anticipatory care in particular. We are gathering qualitative data using interviews, focus groups and observations, as well as at community workshops (the first of these was in late March 2019). In each of these processes, the researcher also takes notes about the session and these fieldnotes are included in the overall data. Interviews have been conducted with 13 individuals; focus groups have been conducted with 16 people, and 25 people attended the first community workshop. [Note: 6 of those attending have also been interviewed]. Fieldnotes have been made by the UTAS and Our Health Our Future team about informal conversations and observations made in various public settings, and the UTAS team are also conducting community audit work (e.g., observing what events or services are advertised and where, where people are active physically or socially in the community, etc.); this includes on social media. Observation fieldnotes were made by researchers at the March workshop, to capture what topics people responded to, as well as to record any stories or examples that were discussed at the tables, but not shared via post-it notes or feedback to the wider workshop.

Table 3: Data gathered in the Our Health Our Future area by UTAS researchers

<i>Participants</i>	<i>Interviews</i>	<i>Focus groups</i>	<i>Workshop</i>	<i>Surveys</i>
<i>Total = 174</i>	13	16	25	120

Interviews and focus groups gather in-depth information and are usually between 45 minutes and 2 hours in length. They are opportunities to gather detailed information. Data gathered at the Community Workshop is less in-depth (see Attachment 6 for summary material from the workshop), but gives an indication of the prevalence of particular concerns or views among those present. To date, more in-depth qualitative data has been gathered from people in roles with a link to anticipatory care and health and wellbeing more generally; we are working to broaden this to better reflect the breadth of knowledge and experience in the community overall, and to include more people who are living with higher than average risk of developing a chronic illness. This includes older people, and people of all ages who experience socio-economic disadvantage and/or isolation, or who rarely or never use existing formal health and wellbeing supports.

Survey data

Finally, the project PSO is gathering survey data. While surveys often gather quantitative data (e.g., the national Census), this survey combines quantitative and qualitative questions. We want to find out not only “What”, “How many” and “Where”, but also experiential information, like how people think about health, who they go to for different sorts of information or help, why they go there or what barriers they encounter. For this reason, the survey is being administered by the PSO, who is encouraged to prompt participants to provide detail about the sorts of people and places that are involved in their health behaviours and care. The survey is part of our efforts to include people who are ‘hard to reach’, a key parameter of the project brief. The survey is useful because for some people non-identifiable surveys are less daunting than a recorded interview or focus group, meaning they are more likely to open up and provide useful information about the barriers they face. Often people are embarrassed about their own difficulties in overcoming social, economic, psychological or physical barriers; this personal information is sometimes crucial in informing researchers about the less obvious barriers encountered by marginalized individuals (with often significant consequences for their health). The survey is also intended to gather data from people in other groups or categories that have not so far been included. Two further functions of the survey are to increase the PSO’s engagement with the community¹⁴ and to enable UTAS to build ‘social network maps’.

Data analysis and synthesis

Bringing together the data that has been gathered and working to make sense of it is a complex task. The statistical and literature review material has been collated and used to:

- (1) describe the human, informational and infrastructural elements of the anticipatory care system, its potential users and the community
- (2) help in the design of the qualitative data gathering (e.g. to inform questions and prompts about particular aspects of anticipatory care)

Qualitative data are being analysed thematically. This involves researchers reading and rereading all the material and noting common themes. In the analysis, we have been coding for predetermined themes. Examples of these are:

¹⁴ PSO engagement with all parts of the community will support implementing actions to enhance anticipatory care.

- How people define anticipatory care
- The system parts (i.e. how people explain or understand the system and its sub-parts)
- Who plays what roles in anticipatory care
- What supports anticipatory care and what barriers to anticipatory care exist

We are also alert to themes that emerge in the data, to surprises or anomalies, and to ways in which the themes are related. The findings from the quantitative and qualitative analysis are also considered together, to reveal similarities and contrasts, and to build as complete a picture of the anticipatory care system as possible. This method has enabled us to add to the statistical map of anticipatory care, to understand more about and more accurately define the factors (system parts) that contribute to anticipatory care, and to reveal how individuals and organisations experience and understand health and anticipatory care in the 'Our Health Our Future' area.

Results of initial work to understand what the data is telling us

UTAS is reporting these findings as part of our role in providing evidence to the local community, through the Local Advisory Group, to support planning for enhancing anticipatory care in the 'Our Health Our Future' area.

Our first report of the findings was made at the March Community Workshop, where we reported what we knew so far, using the idea of system parts. Anticipatory care can be understood as a system, made up of linked sub-systems. For the workshop, researchers worked with a systems theorist to identify six system parts: People and health, Infrastructure, Attitudes and Actions, Relationships, Leadership, and Health Services Information.¹⁵ Since the workshop, the observations, table- and post-it notes and the 'dotmocracy' exercise outcomes have all been transcribed and added to the project data.

Synthesis findings

The analysis and synthesis findings show that there are system parts (individual, infrastructural, attitudinal, and informational) that research participants recognized as working (e.g., the men's group, the 'can do' attitude of some locals, the gyms), as well as things that do not work or are confusing (e.g., the 'using off-Island medical services' experience, and information sharing between services). There are also contradictions, for instance that some people report that the Islands are well-

¹⁵ Workshop participants responded to what was working, not working, confusing or could be changed about those system parts. This information has been included in the data analysis.

provided with visiting services and specialists, but that there are problems with their coordination and information sharing. It was clear from the data synthesis that two additional themes were important: “Place and identity”, and “Policy”. How residents and service providers think about Flinders Island shapes actions or behaviours. And policies and systems can be transparent and coherent, or complicated, opaque and impede the use of a service or services. We have used the findings to identify what makes the system parts effective or what stops them from working, and identified six overarching themes, one clear health risk concern, and some possible opportunities for intervention. There is overlap between these themes and the system parts.

Six themes and one concern

Beliefs and attitudes	<p>Individual and organisational motivations, assumptions, and judgments (including cultural), and understandings of their role in the health system</p> <p>Beliefs and attitudes shape policy and processes (including information systems), how people and organisations behave and what they expect of themselves and others</p> <p>Examples from the data include “We’ll find a way”, “Shame, stigma and racism are affecting provision as well as use of services”, “There are too many people who don’t take responsibility for any part of their health”¹⁶</p>
Information systems	<p>The gathering and sharing of information and whether it is relevant to the sharer and the audience and is in an accessible form</p> <p>Information systems are crucial to the effective operation of anticipatory care in this remote community. This is especially so because of fly-in fly-out services (FIFO), and a scattered and socially, culturally and economically diverse population</p> <p>Examples from the data include “It’s hard to know who is which service’s client; what if there is a crisis?”, “Locums provide a second opinion, but they also don’t know the patient”, and “People love that they are part of the Tackling Indigenous Smoking campaign”</p>

¹⁶ These examples are not direct excerpts from the data, but are encapsulations of multiple instances in the data.

Policy	<p>Policy is shaped both by policy-makers' beliefs and attitudes, and by the beliefs, attitudes and processes or practices of the 'street-level' bureaucrats who implement it. Policy is increasingly favouring short-term competitive funding models</p> <p>Policy can create opportunities for equality of access, but can also promote barriers to sharing, cooperation and collaboration and result in 'hand-balling', mistrust, and fragmentation¹⁷</p> <p>Examples from the data include "I've been on short-term contracts for x years; you don't know each year whether you'll be back", "It's taken a long while for me to feel strong enough to access this service and trust the person ... what if they don't keep funding it?", and "Funding models across Island services are not equivalent; it's hard to attract people if you can't offer the same conditions".</p>
Place and identity	<p>Place and identity is about the connections people feel to an area or a facility. It includes feelings of pride, of belonging and being an insider (or not), of what rights one might have, of security and of feeling that others share that attitude or understanding</p> <p>Place and belonging are linked with people's likelihood of using a local service (and their sense of safety there), and wanting to support or nurture local infrastructure and relationships</p> <p>Examples from the data include "This place is paradise, and/but ...", "Us Islanders are resourceful, resilient and tough", "I don't want to end up [at that service]; I don't belong there", "This is a small place—that can be a support or damning", and "It can take a long time as a FIFO to be accepted here"</p>
Infrastructure	<p>Infrastructure includes services (e.g., MPC, FIAAI, transport to and from the Islands, etc.), people and their skills and knowledge, and the natural environment</p> <p>Infrastructure can support health practices and behaviours but is not equally distributed or available</p>

¹⁷ Misinterpretation of privacy legislation is an example, such that consent to share information to better manage or prevent illness is not sought.

Examples from the data include “We’re pretty lucky here in our health services”, “People are doing so much to make things work here—for the love of it”, “There are multiple complexities and costs in going off-Island for health and wellbeing”, but “There are lots of people (more likely male) we never see”.

Leadership

Leaders are people who are influencers, providing opportunities and encouragement to others to participate in things that support health and wellbeing. They are also good navigators, and networkers who have credibility and expertise and are trusted

Leadership can be linked with a role, but leadership can also come from a person who solves a problem and then shares that solution with others

Examples from the data include “I discovered how much better I feel doing this activity, and have gee-ed up other people in my situation to join us”, “There was a real need for this, so someone had to start it!”, and “We are a long way from the seat of power—how can we get closer?”

Alcohol norms

There is evidence that use of alcohol is affecting people’s health on the Islands. This evidence comes from both PHT data and from the interviews and focus groups. Alcohol behaviours may be a cultural norm, but are possibly also linked with mental distress and isolation

Recognising and acknowledging this health risk is difficult if excessive drinking is a social norm. Further, seeking and receiving help for the behaviours and their drivers is complicated by those social norms, by shame and stigma (especially if help is sought from familiar community members), and by short-term provision of FIFO AOD services

Examples from the data include “Drinking is how we socialise; but we look after each other and don’t let people drive if they’ve had too much”, “The police might be turning a blind eye; no-one wants people’s reputations hurt by being booked”, “It took me ages to realise there was a problem; I was just staying home and drinking; feeling lonely”, and “Getting the courage to come and see someone about it ... God, I hope they don’t disappear”

For the purposes of planning to enhance anticipatory care, it may be useful to concentrate on the 'biggest' idea, along with small changes that may require relatively few resources, but enable practice to change, bringing thinking (and attitudes and beliefs) along.¹⁸ Our analysis shows that the common thread links coordination, coherence, connection, and collaboration and the problems of a system that is fragmented by isolation, distance and the mix of service models each with their own processes. These factors also limit opportunities for policy makers to be informed and encouraged to act. At the individual level, isolation is also playing a role in mental distress and in alcohol behaviours.

Opportunities for intervention

It is difficult to impact directly upon the larger system parts within the scope and timeframe of this project. However, the analysis suggests there are opportunities to make a difference by adjusting *processes*, and by ensuring that there is *access* for community members.

The strengths of the present anticipatory care system in the Our Health Our Future site are to do with relationships of trust and collaboration, but failing relationships are also at the heart of the barriers to anticipatory care. Therefore, *process*, *access*, and *relationships* are possible foci of plans and actions by Our Health Our Future's Local Advisory Group and executive.

Processes

Processes shape how the parts of the anticipatory care system interact, as well as their accessibility and value. They are shaped by attitudes and beliefs, by policies, by leadership and by relationships. Processes:

- can be incoherent—messy and disordered, and/or hard to understand
- may make work inside a service (or a silo) more cohesive, efficient and effective, *but* prevent those outside from collaborating and cooperating and getting what they need
- can make things accessible, or exclude people and ignore or devalue diversity
- can support relationships and leaders, or make them invisible

An example of a process intervention to support the anticipatory care system and the essential relationships would be position job descriptions that factored in the

¹⁸ Acting your way into new ways of thinking.

importance of outreach and collaboration, as well as requiring skills in ‘emotion work’.¹⁹

Access

The findings show that exclusion or restriction, isolation,²⁰ and emotional and physical risk are barriers to effective anticipatory care. These are all problems of access.

The data provides several examples of the ways in which people are excluded or restricted from activities and services, as well as where accessibility could be enhanced. Examples include:

- removing physical barriers like doors that are too narrow to admit a wheelchair (lack of transport is also a physical barrier)
- making sure any information provided is responding to a community need, and uses language or images that meet the needs of the intended audience
- making processes clearer
- making sure options are culturally, emotionally and psychologically safe. Safety includes ensuring that people feel welcome and individually cared about, and do not feel anxious because of a lack of useful information, uncertainty about the physical environment or the risk of being stigmatised.

Relationships

Relationships appear to be the core of effective anticipatory care here. Relationships play out in the presence or absence of trust between Islanders and between Islanders and services. Relationships are the foundation of coordination and collaboration, both of which rely on an appreciation of and respect for one another. They can be the difference between a policy implemented as a blunt instrument, or rolled out with care for those it will impact upon. Further, relationships can be supported by processes, and are foundational to access, safety and connectedness.

A note on completeness

There are participant types and areas of anticipatory care that we would like to gather more information about; the qualitative data at present is somewhat weighted

¹⁹ Emotion work (and emotion labour) refers to the work a person does to maintain a particular demeanour to support an interaction.

²⁰ Social isolation in the Our Health Our Future project are linked with the role of being a carer for a partner or family member, with the loss of that person, but also with stigmatized behaviours or conditions and with racism.

towards people in formal health or community services roles. We need to hear more from people at most risk of developing a chronic illness. The experiences and potential solutions they will offer may be very different from those that health and community services personnel report or expect.

Therefore, in reporting the findings above, we have paid attention to themes that were the most prominent, or that have also been found in the other project sites. As data gathering and analysis continue, the updated findings will be reported to the LAG for use in the planning or modification of actions to enhance anticipatory care.

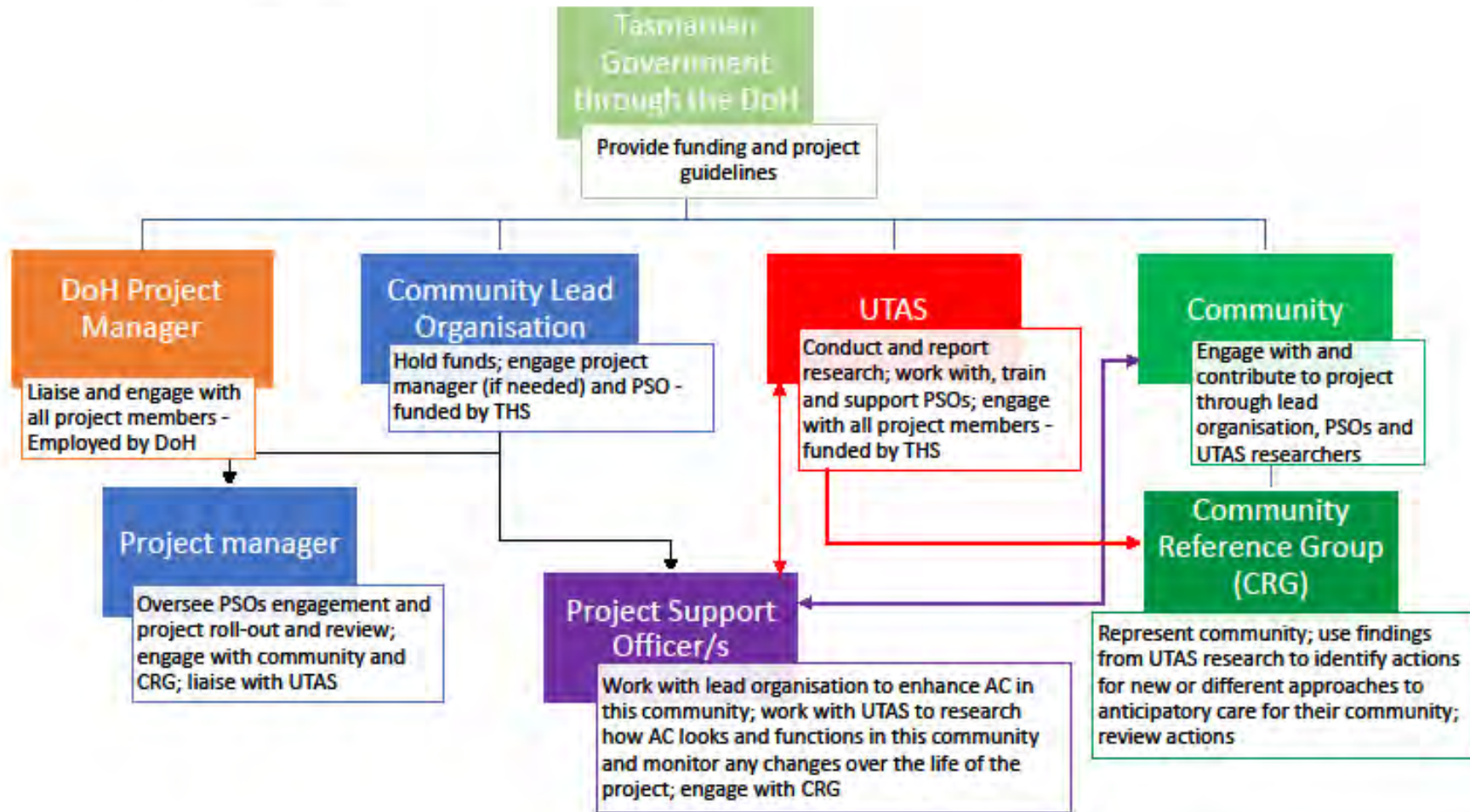
Next Steps

The next step in the project is to use the findings to decide on actions or interventions that can make the greatest difference. The following questions may be a useful decision-making guide:

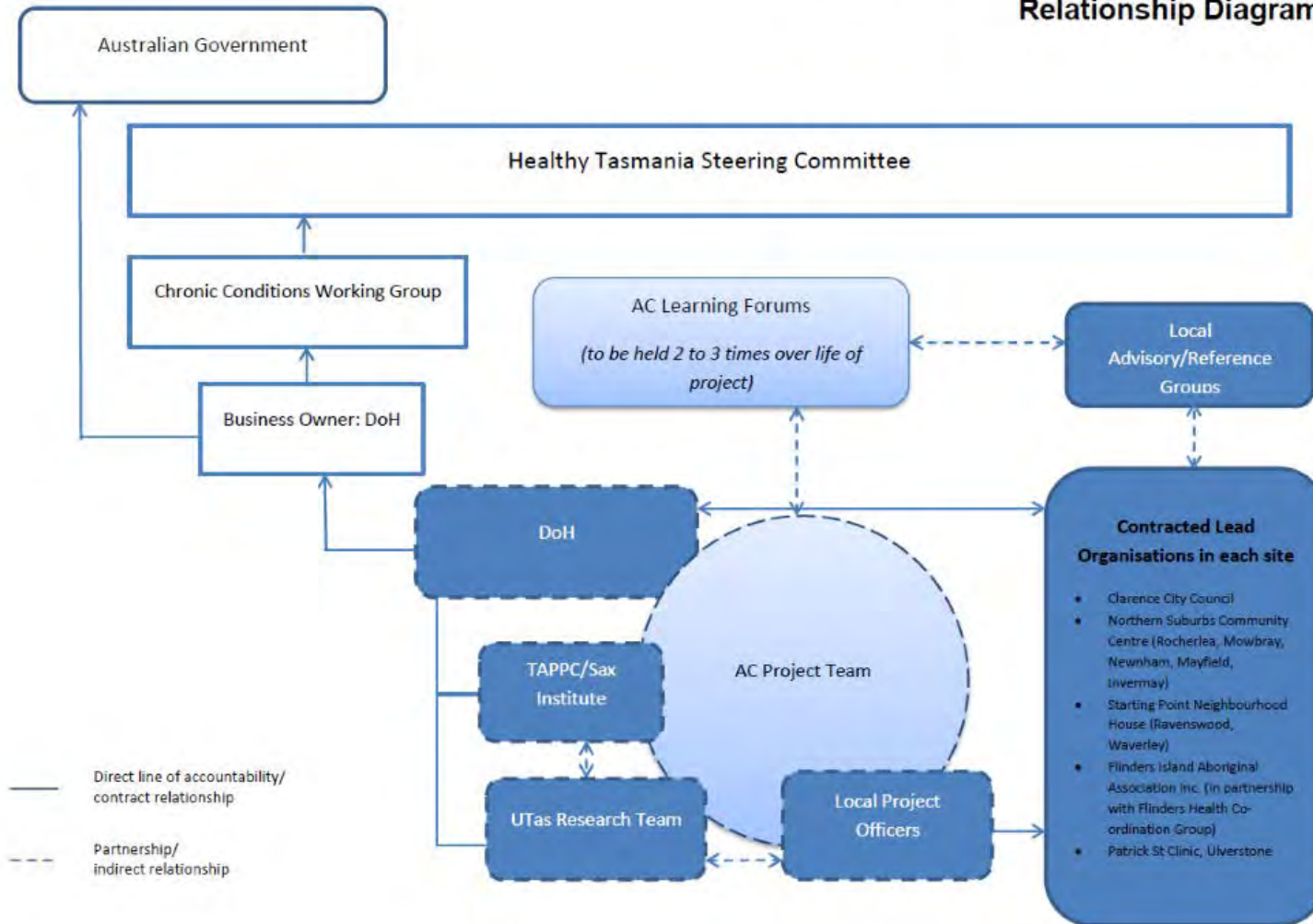
- Given the findings, what are the three top priorities that you think Our Health Our Future should work on? This includes who the project will target.
- Is there something that is do-able, achievable and sustainable that can be tried/done to improve or address one or more of the issues identified by the research?
- What difference do you think the proposed action will make in terms of improving the health of individuals and/or the community? How will it contribute to the prevention/better management of chronic conditions? and Who will it make a difference for?
- What might be the ripple, or flow-on effects of the proposed actions?

Action plans need to take into account the available resources and feasibility, and how those actions will contribute to the health of individuals and the community, and to the prevention or better management of chronic conditions. Actions can be thought of in terms of form (what the action is), function (why those activities or actions are taken), and ripple effect (what are the flow-on effects and who might experience those ripples).

Attachment 1: Anticipatory Care project roles and relationships



Tasmanian Anticipatory Care Project: Relationship Diagram





Attachment 3: The anticipatory care framework

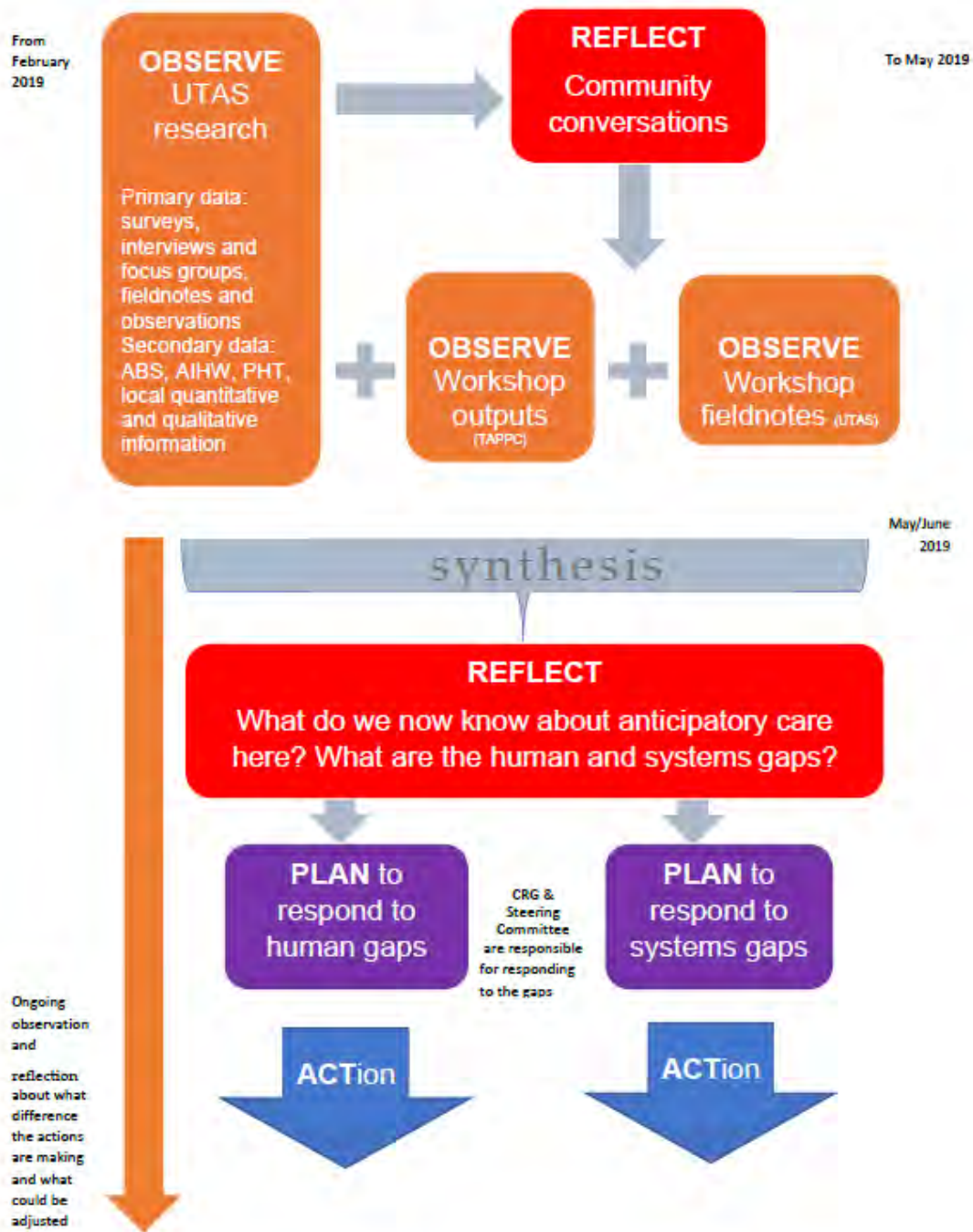
Priorities	Description	Elements	Enablers/ supports	Consumer outcomes	Population outcomes
<p>Outreach to people who most need care</p>	<p>Focus care on individuals and their carers who are hard to reach and who have the greatest need in the community</p>	<ul style="list-style-type: none"> → Use proactive outreach strategies → Use population and disease registers and do 'case finding' → Develop partnerships with community → Seek opportunistic ways to engage people in their health care 	<p>Governance and leadership</p> <ul style="list-style-type: none"> → Support and leadership → Joined up health and social services (acute to community) → Local area coordination → Partnerships with services who can outreach → Consumer engagement <p>Health workforce</p> <ul style="list-style-type: none"> → Identify needs and attitudes → Training and resources (health promotion, self-management) <p>Health literacy</p> <ul style="list-style-type: none"> → Easy to understand education resources <p>Data and information</p> <ul style="list-style-type: none"> → Health literate organizations <ul style="list-style-type: none"> → Data sharing agreements → Community health profiles → Local community knowledge <p>Technology</p> <ul style="list-style-type: none"> → Patient registration → "flagging" systems → EHealth Resources → funding models → Screening & assessment tools → Chronic Disease self-management programs <p>Research & evaluation</p> <ul style="list-style-type: none"> → Action Learning projects → Monitor patient outcomes and population → Effective outreach models 	<p>My community encourages me to adopt a healthy lifestyle.</p> <p>I am supported to make good proactive choices about my health and wellbeing.</p> <p>I am able to participate in purposeful and meaningful activities.</p> <p>My informal carers are recognised as an important support element in my life, and are included in my care.</p> <p>I can access and use tools to make decisions about my health.</p> <p>Any illness I have is picked up early and I get help managing it.</p> <p>My healthcare is tailored to my needs.</p> <p>Everyone in my care works together as a team, considering the many factors that keep me healthy and well.</p> <p>With my consent, my care team can easily access information about my contact with different parts of the health system.</p>	<p>Tasmanians have good physical health.</p> <p>Tasmanians have good mental health.</p> <p>Tasmanians at risk of poor health or living with chronic conditions are supported to stay well for as long as possible.</p> <p>Tasmanians are supported to overcome addictions.</p> <p>Tasmanians are supported to overcome crises, addictions and adverse life events.</p> <p>Tasmanians have a voice and choice in decisions about their health and wellbeing.</p> <p>Tasmanians can access the support they need in a timely manner from a well-working service system.</p> <p>Tasmanians are aware of important public health issues.</p> <p>Tasmanians have resilience to overcome adversity.</p>
<p>Early identification and risk assessment</p>	<p>Work with people to assess and anticipate risk: life circumstances and psychosocial factors ↔ lifestyle factors ↔ clinical risk factors ↔ impact of disease</p>	<ul style="list-style-type: none"> → Develop long term trusting relationships → Identify individual care needs (psychosocial and physical health) → Use many ways to engage people in assessment (e.g. proactive, system reminders and opportunistic screening) 			
<p>Enable people to improve their health</p>	<p>Strengthen personal skills and create connections with social and community services to enable people to influence the determinants of their health</p>	<ul style="list-style-type: none"> → Strengthen health literacy and consumer engagement → Develop self-management skills → Provide evidence based care across the disease prevention continuum → Help people address psychosocial and physical care 			
<p>Improve the personal experience in the healthcare system</p>	<p>Develop teams around people with support and planned pathways of care to respond to their prevention needs at different life circumstances and different stages of disease</p>	<ul style="list-style-type: none"> → Multidisciplinary team based care → Include informal carers → Integrated and coordinated care → Support care pathways which are easy to navigate → Use shared health records 			
<p>Plan care using local health information and consumer input</p>	<p>Use local health information, consumer records and consumer input to identify local health needs and focus proactive care</p>	<ul style="list-style-type: none"> → Use local health data and practice, population and disease registers to identify health need → Provide proactive care focusing on need → Involve consumers in the planning of services 			

Attachment 4: The action learning process in the Anticipatory Care project (example)

Action learning involves cycles of observation, reflection, planning and acting.

Cycle 1 – Anticipatory Care Action Learning Project: Connecting Care – Ulverstone (observe, reflect, plan, act ...)

This is an outline of the first action learning cycle in each site. Observe, reflect, plan and act are continual; new observations and reflections spark new planning and adjusted action



Attachment 5: Indicative statistical material about the Our Health Our Future project area

Table 1: Demographic data for Flinders Island and Cape Barren Island, Census 2016

Characteristic	Number	Percentage (in municipality)	Tasmanian comparison
Population total	906	(0.17% of state)	509, 965
Female	412	45.7%	51.1%
Male	490	54.3%	48.9%
Median age (national = 37)	53 (57 on CBI)		42
Pre-school age (0–4)	54	5.96%	5.6%
School age (5–19)	107	11.8%	18.2%
Working age (18–64)	505	55.7%	57%
Post-work (65 –84)	227	25.1%	17.2%
85 and older	15	1.66%	2.3%
Aboriginal people	148	15.89% of municipality (100% CBI)	4.6%
Female	66	44.6%	50.9%
Male	82	55.4%	49.1%
Median age (national = 23)	49		24
Language spoken at home			
English (only)	839	90.3%	88.3%
Other	14	1.55%	0.2%
Children per family (all families)	0.4		
Children per family (families with children)	1.7		
Housing			
Private dwellings (occupied)	590		86%
Separate house	385		87.6%
Owned (outright or mortgaged)	172		69.2%
Rented or other tenure	148		30.7%
Average people per household			2.3
Median weekly household income	\$1,021 (\$537 CBI)		\$1,100
Median monthly mortgage repayments	\$758		\$1,300
Median weekly rent	\$100		\$230
Health care card holders (% of pop)		11.9%	9.4%
Average motor vehicles per dwelling	1.48		1.8

Private dwellings without a motor vehicle	27	6.9%	6.9%
Internet accessed from dwelling	290 ²¹	(no internet = 23.9%) (Ahmed et al. 2017)	78.0%
Work (aged 15 and over)			
Worked full-time (paid)	156	30.1%	52.3%
Worked part-time (paid)	72	14%	35.0%
Away from work (“not in labour force”)	126		5.7%
Unemployed	7.4		7.0%
Did voluntary work through organisation or group	293	38%	21.3%
Education—highest level attained			
Nationally, 22% of people have a Bachelor or higher qualification and 15.7% have completed year 12.			
Eligible population completed year 10 or higher	705		86.3%
Bachelor or above	28		16.2%
Advanced diploma/diploma	10		7.5
Cert IV and III	76		17.7%
Year 12	277		12.0%
Year 11	77		4.7%
Year 10	237		17.4%
Year 9 or below	106		10.3%
No educational attainment/not stated	3		0.4%
Religious affiliation			
No religion	395		37.8%
Anglican	227		20.4%
Catholic	102		15.6%
Presbyterian and Reformed	14		3.8%
Uniting	29		
Travel to work			
Car, as driver	251		65.3%
Car, as passenger	22		5.8%
Bus	0		2.4%
Walked only	38		3.0%

Source: Australian Bureau of Statistics (2016a).

²¹ The Online Access Centre or Service Tasmania, in Whitemark, both have computers with Internet access and printers for public use.

Table 2: Bass Strait Island Agreement (BSIA) Services (2017-18)

Service	Location	Visits per annum
Physiotherapist	Cape Barren Island	22
Exercise Physiologist	Cape Barren Island	12
Women's General Practitioner	Cape Barren Island	4
Suicide Prevention	Flinders Island	12
Health Promotion	Flinders Island	7
Physiotherapist	Flinders Island	48
Podiatrist	Flinders Island	9
Mental Health Worker	Flinders Island	22
Diabetes Nurse Educator	Flinders Island	12
Health Promotion	King Island	28
Mental Health Worker	King Island	22
Dietitian	King Island	1

Source:

https://www.health.tas.gov.au/healthprofessionals/tazreach/current_tazreach_funded_services/bass_strait_island_agreement_bsia_services

Table 3: Health risk data for Flinders Island and Tasmania

	Flinders	Tasmania
% self-assessed fair or poor health		
% current smoker		15.7
% daily smoker		12.1
% smoking during pregnancy		13.8
% low birth weight babies		7.1
% overweight/obese BMI		60.1
% Obese BMI	30.0	24.3
% Alcohol consumption levels causing occasional harm => 4 standard drinks at least yearly	46.5	45.0
% Alcohol consumption levels causing lifetime harm => 2 standard drinks at least weekly	45.7	20.8
% insufficient moderate/vigorous activity, <150 min moderate/75 min vigorous/week or combination		14.9
% insufficient muscle strengthening activity, <twice weekly muscle strengthening activity		70.2
% inadequate fruit consumption, <2 serves daily	61.0	59.6
% inadequate vegetable consumption, <2 serves daily		91.0
% persons with three or more chronic conditions		21.5
COPD [avoidable] deaths (ages 45-74)		13.7
diabetes [avoidable] deaths		7.9
suicide and self-inflicted injuries [avoidable] deaths		13.3

Source: Ahmed et al. (2017a); PHT (n.d.)

Note: Data for this table is usually provided by GP clinics; FIAAI has provided indicative data (included in the 'Design Brief' document)

Table 4: Top ten PPH admissions and allied health provision, for Flinders LGA 2015–16

Potentially Preventable Hospitalisations	Primary diagnosis on admission	Allied health provided in hospital
Chronic obstructive pulmonary disease (COPD)	(J44) Other COPD	Physiotherapy
Congestive cardiac failure	(M54) Dorsalgia (back pain)	Pharmacy
Cellulitis	(C34) Malignant neoplasm of bronchus and lung	Social work
Angina	(G62) Other polyneuropathies	Occupational therapy
Hypertension	(Z38) Liveborn infants accord to plc of birth	Dietetics
Urinary tract infections, incl. Pyelonephritis	(I50) Heart failure	Speech pathology
Ear nose and throat infections	(P07) Disord short gest & low birth weight NEC	Pastoral care
Pneumonia and Influenza (vaccine preventable)	(Z48) Other surgical follow-up care	
Iron deficiency anaemia	(O80) Single spontaneous delivery	
Pelvic inflammatory disease	(C78) Sec malg neoplasm resp & digestive organ	

Source: PHT (n.d.)

Attachment 6: FLINDERS ISLAND—Our Health, Our Future—Workshop identification of priorities for action

Below is a summary of the big local concerns that have been identified from the consultations and research.

	ATTITUDES AND ACTIONS	INFRASTRUCTURE	PEOPLE AND HEALTH	RELATIONSHIPS	LEADERSHIP	HEALTH SERVICE DATA & INFORMATION
BIG LOCAL CONCERNS	<ul style="list-style-type: none"> • Better communication and information sharing (including between the MPC and community) • Access to records/discharge (hard to keep track of patient records and information) • Systems to support info sharing across community nursing, Ambo's FIFO, MPC, mental health • Mental health workers are all FIFO • Post acute/transitional care currently not available • Referral processes—tracking and follow up (long wait times) • Brokerage funds to support care 	<ul style="list-style-type: none"> • FIFO challenges; short term, hard to plan; prevents relationships building, trust • Problem of business-driven health e.g., can't have phone consults for repeat prescriptions, referrals • Accommodation on Island isn't adequate • Cost to get to Launceston prohibitive • Transport on Island e.g., bus transport needed and better knowledge about availability of bus; eligibility • Lost work time • Accommodation costs • Gap between what you pay and what you get back, even with private health • Time and costs to leave Island • Single meds outlet • Never off duty • Cost of medications 	<ul style="list-style-type: none"> • Repeating stories to different health workers • Getting care off island—dental, allied health—have to do lots of things each trip • Men not accessing services or not early enough • Local transport doesn't work • Pharmacy – expensive, long waits; access to generic brands • Allied health and dental access • Dental health—lots of people with dental problems • Alcohol, smoking 	<ul style="list-style-type: none"> • FIFO • Access to pharmacist • Volunteer fatigue/burnout • Lonely and expensive to have to go off Island for treatments • GPs may not have enough time to do everything • Pregnant women have to leave Island • Too much workload for some people • Conflicting medical advice • Confidentiality 	<ul style="list-style-type: none"> • Lyn—FIFO GP but here consistently • Informal leaders in community groups • Social supports—men's group • Repeating stories to different doctors (FIFO and referring pathways not well managed) 	<ul style="list-style-type: none"> • Communication—both on and off island services; documentation/ systems not linked • Poor follow up • Difficult for older people to grasp technology—My Aged Care • Late night discharge in Launceston—no accommodation • Financial and emotional stress of going away e.g. pregnant women • Wait lists for mental health/psychologists • Confusion re: referral systems • No feedback on referrals to physio, psychologist

	ATTITUDES AND ACTIONS	INFRASTRUCTURE	PEOPLE AND HEALTH	RELATIONSHIPS	LEADERSHIP	HEALTH SERVICE DATA & INFORMATION
BIG LOCAL CONCERNS	<ul style="list-style-type: none"> • Accountability and planning for/by/with FIFO • Waiting times for scripts • No home-based care after hours e.g., health care in the home, palliative care, hospice in the home—unnecessary hospital admissions • No permanent GP on island • Ambulance staff don't have details (health records) of clients they go to • Housing availability • High load on well-known community members (locals) 	<ul style="list-style-type: none"> • No access to specialists services; hoop jumping to access • Lack of housing rentals; cost of housing • Child care • Locked up school facilities 	<ul style="list-style-type: none"> • 		<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •

High priorities from community workshop ('dotmocracy'—more than 3 votes) were:

- Better communication and information sharing
 - Access to records/discharge
 - System to support information sharing
- After hours home based care
- Post acute/transitional care
- Improved communication about housing options available on mainland
- Housing availability and affordability on Island
- Referral processes—follow ups; information to patients about what/how/when
- Communication both on and off island services; documentation systems not linked
- Get FIFO pharmacist visiting regularly

Below is a summary of things that are working or could be further strengthened to support the health and wellbeing of the community.

	ATTITUDES AND ACTIONS	INFRASTRUCTURE	PEOPLE AND HEALTH	RELATIONSHIPS	LEADERSHIP	HEALTH SERVICES INFORMATION
THINGS THAT COULD BE STRENGTHENED/ BUILT ON	<ul style="list-style-type: none"> De-normalising smoking—huge progress FIAAIS social model of health Locals people know—helps everyone connect Regular visits provide choice Online bookings Personal connections Palliative care room at MPC Lots of visiting specialists Responsive medical services Knowledge sharing MPC outpatients—seen quickly Positive relationships between FIAAI and MPC Reminder texts for specialist appointments Multiple de-fibs on Island Local islanders in MPC 	<ul style="list-style-type: none"> MPC (small hospital and GP clinic) very good 	<ul style="list-style-type: none"> Strong sense of community, lots of groups for social connection People make things happen Community understands mental and social health Great community organisations; strong social connections Free GP consults Blue form (to go to Launceston for specialist appointment; use this change to do shopping, dentist, allied health visits) Airfares and accommodation subsidised Great sense of community Great aged care facility Gun club, churches, golf, bowls, lions, markets, CWA, art gallery 	<ul style="list-style-type: none"> Heart health program at gym; social space as well as health benefits Social aspects of going to gym Specialists who will ring clients—don't have to go off island Men's secret business RAW 	<ul style="list-style-type: none"> Free access to GPs Informal leaders in community groups Social support—men's group Physio working well Lynn (GP) Meals on wheels Can see GP quickly if there is big problem Influencers are people who initiate running groups, movie nights, sit and be fit, Tai chi, eating with friends Running festival Community shed; secret men's business—incorporate small section re health/social issues; empower men to talk about health, health checks 	<p>Well serviced with visiting services</p> <p>Good access to local GPs</p> <p>RFDS programs</p> <p>Can ring MPC for info</p> <p>Well service with visiting health workers</p> <p>Mental health</p> <p>Optometrist</p> <p>Podiatrist</p> <p>See GP same day</p> <p>On to one phone calls with specialists</p> <p>Info on visiting services in Island news is good.</p>

Below are topics that have been identified as areas for further investigation.

THINGS FOR FURTHER
INVESTIGATION

- Work life balance
- A& E Encounters
- Tackling health on own—maintaining things is hard
- Create vulnerable persons register
- Improving accountability and local planning of FIFO services
- Screening and health tips by age groups
- Funding follows client not locked to service provider (brokerage model?)
- Could school facilities operate like the gym?
- Is there a government subsidy for expectant mums?
- Health website for Flinders

System Thinking & Causal Loop Diagrams

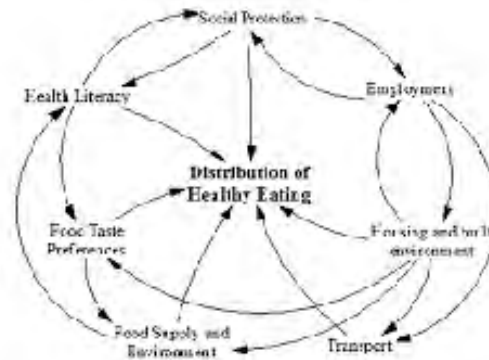
WHAT!

Systems Thinking is a process that can help us understand how different things are related to each other to create a whole.

In the case of Anticipatory Care (AC), Systems Thinking can be used to identify different parts of the AC system in each community, how these parts relate to each other, and if there are patterns across the system.

Systems Thinking is sometimes described as 'big picture' thinking.

Causal Loop Diagrams are a tool that can help tell a clear story about [this?] complex reality.



AIM

We would like to invite you to help develop a Causal Loop Diagram to clarify and communicate the interconnections between different parts of the AC system in your community.

HOW

Collaborative group modelling—we will work together to identify different parts of the AC system in each community, the casual connections between different parts that system, feedback loops and potential leverage points.

We will draw on our collective knowledge and understandings gained throughout the project to date.

HOW DO WE DO THAT

We will spend about two hours together working our way through an interactive and creative process. We will consider:

- Why are we doing this? What is the key question and the outcome we are interested in?
- What are the boundaries of the system? Note: we can't draw the whole system.
- What is our sphere of influence?
- What are the key drivers of the outcome we are interested in—the key parts of the system?
- How do the different parts influence each other? And how might they be influenced?

WHAT NOW

We will make a time with teams in each community to undertake this process.

If you'd like to find out more about Systems Thinking and Causal Loop Diagrams, here are some useful links:

- [Systems Tools for Complex Health Systems: A Guide to Creating Causal Loop Diagrams](#)
- [Introduction to Collaborative Conceptual Modelling](#)

Appendix 6: Survey results, OHOF

The survey was conducted over 2019, with two groups: the general population, and pupils at the Flinders Island District School. There are 73 people in the 'general population' group and 32 in the school group. Not all participants completed all survey questions.

Because the methods for these groups differed, the results are reported separately.

In conducting the survey, the PSOs were able to meet people across the Island, to get a sense of how people use their community and health resources. This outreach has been valuable in building an understanding of the community and the health system here and for connecting with a wider range of community members, including through the schools (on Flinders and on Cape Barren).

Age

Mean age for general population participants is 56.8 years, with the youngest person being 14, and the oldest 85. The median age is 61, which is higher than for the Flinders and Cape Barren Islands statistical area as a whole (median = 53), so the survey respondents are older than the general population. In the school sample, the median age is 12.3 years.

Home location

Participants were drawn from many parts of the Island, as shown in Figure 1. We grouped home locations broadly to avoid identifying individuals.

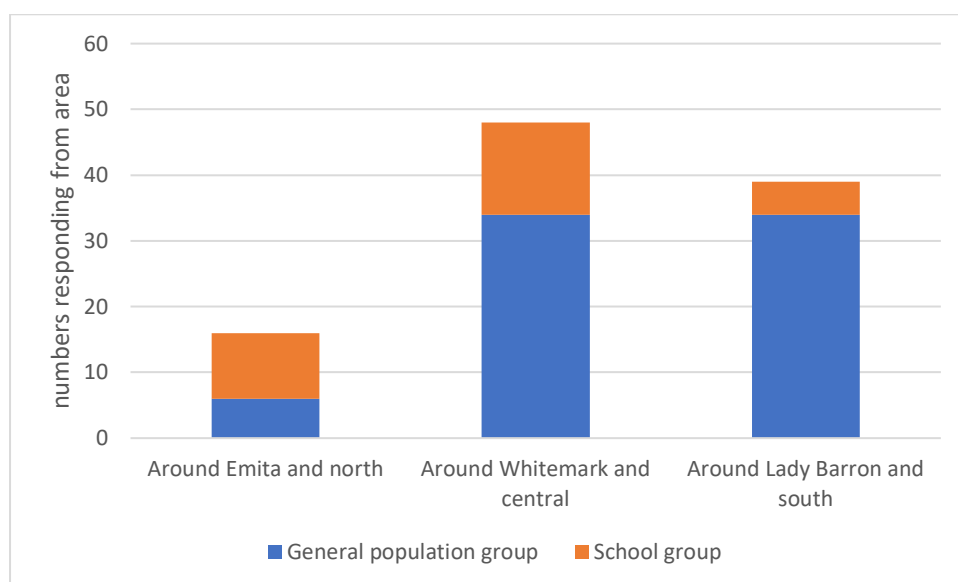


Figure A6a: Home location of survey respondents

Sex/gender

The sex ratio in the statistical area is area is 54.3% men and 45.7% women; in the general population survey, only 20.5 per cent of respondents were men. In the school group, 11 respondents were girls (34.4%).

Overview of quantitative results

Table A6a sets out some analysis results from the quantitative sections of the surveys conducted on Flinders Island.

Table A6a: Initial quantitative analysis results: Our Health Our Future

Participants	15 men (20.5%)	57 women (78.1%)	1 data entry error (1.37%)	Total = 73	
Age	Mean = 57	Oldest = 85	Youngest = 14	Median = 61	The median age for the Flinders and Cape Barren Islands (Census 2016) was 53.
Self-reported health	Excellent = 8 (10.96%)	Good = 46 (63.01%)	Fair = 18 (24.66%)	Poor = 1 (1.37%)	Total responding = 73
Mean age of self-reported health status respondents in each category	Mean age for 'excellent' — 53.88	Mean age for 'good' = 57.50	Mean age for 'fair' = 56.06	Mean age for 'poor' = 62 (one person)	
Sex/gender and self-reported health	8 people overall reported 'excellent' health. 3 were men (37.5%) and 5 were women (62.5%)	46 people overall reported 'good' health. 9 were men (19.57%) and 37 were women (80.43%)	18 people overall reported 'fair' health. 3 were men (16.67%) and 15 were women (83.3%)	1 person overall reported 'poor' health. 0 were men (0%) and 1 was a woman (100%)	Of the 73 people who responded to these questions, 15 (20.5%) were men. Men were well and truly over-represented in the self-reported 'excellent' health status. Numbers are small, however. Similarly, the representation of women in the 'good' and 'fair' categories is close to what might be expected, but fewer women are in the 'excellent' category than expected.

Self-reported health

All general community survey respondent (n = 73) answered the self-reported health question. Results are shown in Table A6b and Figure A6b. Excellent health was reported by 8 people (11%), good by 46 people (63%), fair by 18 people (24.7%) and poor by 1 person

(1.4%). Grouped into two broad categories, 74 per cent rated their health as excellent or good, and 26 per cent as fair or poor. These results mirror the results for the north of Tasmania more generally; in 2019, 78 per cent of Tasmanians, and 75 per cent of people in the State’s north, self-reported their health as ‘excellent’ or ‘good’ (Department of Health and Human Services (DHHS), 2020). People in the school sample were much more likely to report excellent or good health.

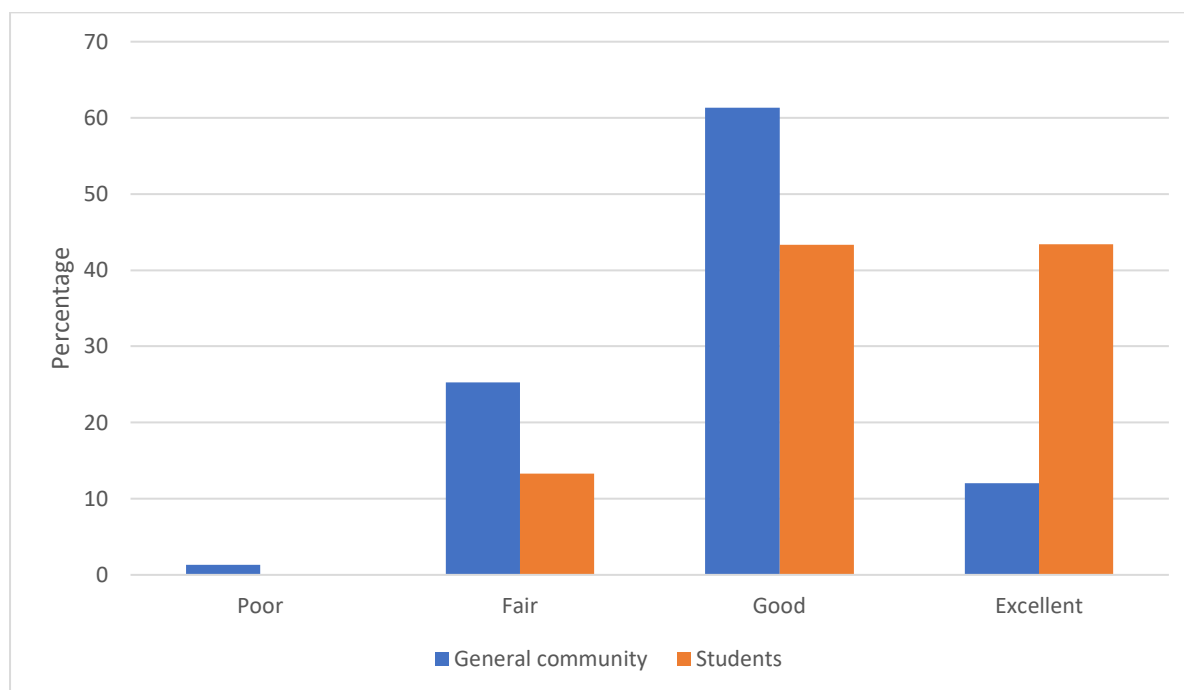


Figure A6b: Self-reported health for general community and school samples

We looked to see whether there were patterns of correlation in the data about self-reported health. Table A6b sets out the breakdown of self-reported health by age clusters (starting from the oldest and moving towards the youngest). Because we asked people for their exact age (rather than the ABS 5-year groupings), we sorted the data by age, and then grouped those respondents in tens (so the first group had a mean age of 81, the second, a mean age of 71.7, and so on). Interestingly, there is no real difference in the ‘shape’ of the data, with most holding to the pattern of the largest proportion of respondents reporting ‘good’, a smaller proportion reporting ‘fair’, then ‘excellent’ and then ‘poor’. The data give basically no evidence for an association between age and self-reported health (the sparklines illustrate this neatly). The variation shown in the last line (for people with an average age of 16) is for three people, and so is not reliable.

It is interesting that the mean self-reported health for Flinders Island survey participants (general community) is better (at 2.82) than for the other AC project sites (Clarence = 2.72; Ulverstone = 2.67; Launceston = 2.21).

Table A6b: Breakdown of self-reported health by age clusters (oldest to youngest, general community sample)²²

Self-reported health				no. in category	Mean age	Mean self report	Sparkline
Excellent	Good	Fair	Poor				
8	46	18	1	73	0	2.81625	
1	7	2	0	10	81	2.9	
1	5	4	0	10	71.7	2.7	
0	7	3	0	10	65.9	2.7	
1	7	1	1	10	60.7	2.95	
1	7	2	0	10	53.9	2.9	
2	6	2	0	10	45.1	3.05	
2	6	2	0	10	31.6	3	
0	1	2	0	3	16	2.33	

Some people wrote on the survey about things they wanted to change about their health (only 12 of the sample). Getting fitter or more active was a common comment, a couple of people wanted to stop smoking, and dietary changes (for weight loss or to reduce risk) were also mentioned.

Sources of support

We asked respondents “Who do you talk to about your health? (your ‘go to’ person)”, in the categories of family, friends, people who are not family or friends, and health care professionals.²³ One hundred and thirty-seven people answered these questions (93.8%).

Social supports

Family members

About three-quarters of participants spoke to family members (sometimes more than one) about their health (75.3%; n = 55). Spouses (wives, partners, husbands) were the most relied-upon family support, making up 38 per cent (see Figure A6c). That a quarter of respondents did not speak to family members is a potentially troubling statistic, especially when the results for other questions about social supports are taken into account.

²² A higher mean for self-reported health indicates better health.

²³ In some instances, responses to questions appeared in the ‘wrong’ place; i.e., people included friends or medical professionals in their response to the question about family. These ‘misplaced’ responses have been included in the ‘correct’ group of responses.

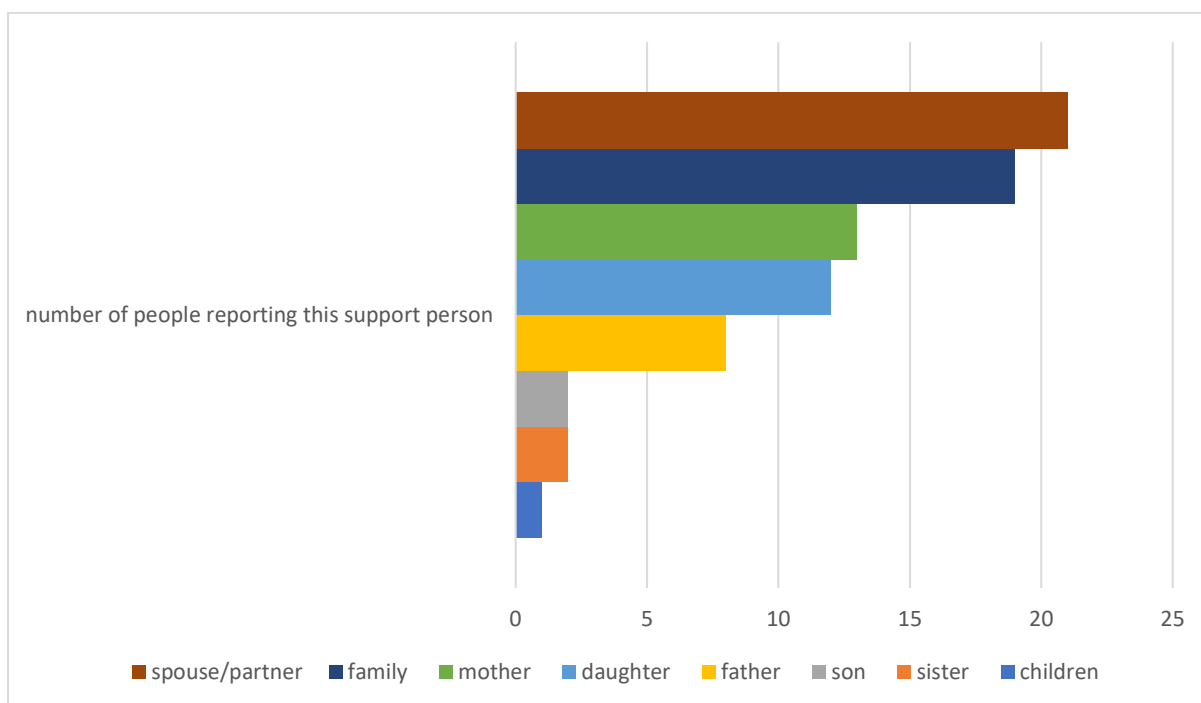


Figure A6c: Support from family members

Friends

Sixty-seven people responded to this question, of whom forty-three people (64%) talked to friends about their health. Mostly, these people were simply described as friends (33 people), or ‘mates’ and ‘workmates’ (5 people); there were also four people who listed exercise companions and two who specified craft groups.

Health-specific supports

All but eleven people responded to this question, and 62 (84.9%) said they spoke to a health professional about their health. Most respondents listed ‘doctor’ or ‘GP’ (44 people; 70.9%), with a further 11 people reporting that they talk to allied health professionals (e.g., diabetes educators, social workers). The next two largest groups of health professionals people reported seeking health support from is physiotherapists and nurses (10 people each; 16%), followed by dentists (7 people), FIAAI (6 people), specialists (3 people), and the MPC and psychologists (2 people each). Twenty-nine people reported seeing only one sort of health professional, eleven were seeing two, five were seeing three health supports and eight were seeing four or more. Quite a large proportion of people said they had a family member or friend who was a health professional (58 people; 87.0% of people responding to this question).

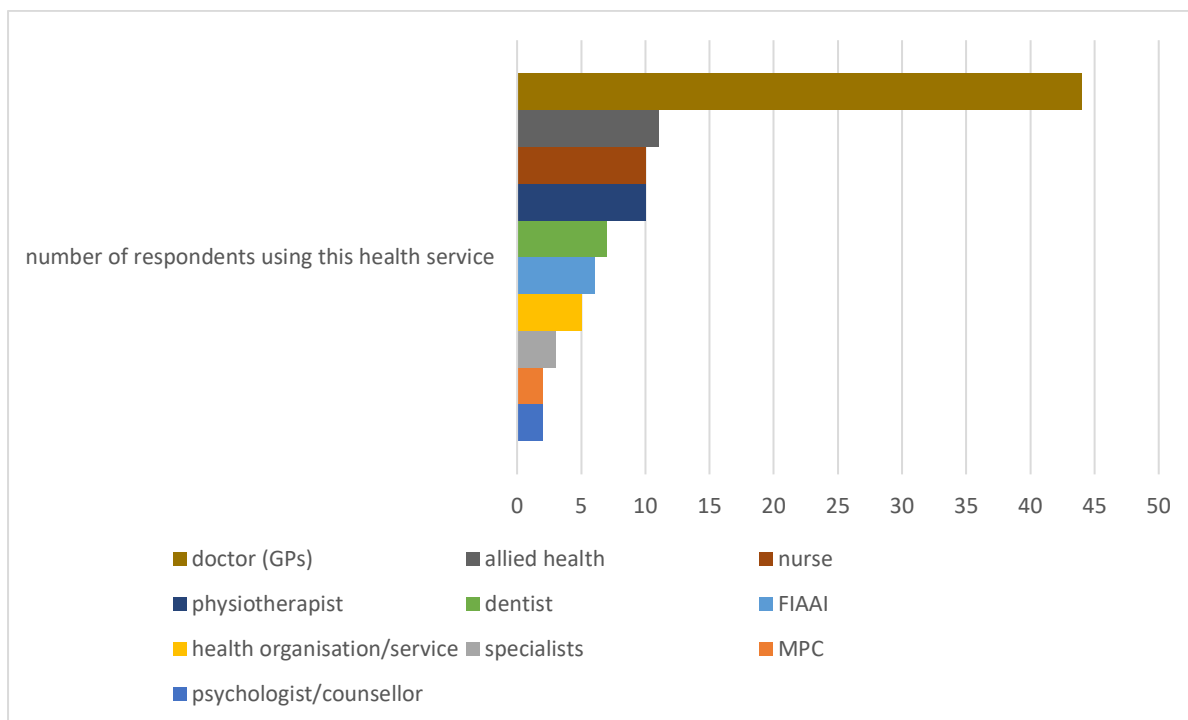


Figure A6d: Support from health care professionals

Social activities

Respondents were asked about the social activities they are involved in, and 72 people responded; only one person said they “*Stay mostly at home*”. People here reported higher numbers of social activities than has been reported in the other AC project sites. The average number reported by the general community respondents was 3.8; in other sites this average was 1.5 (Clarence: Help to Health), 1.9 (Launceston: Our Community Our Care), 1.7 (Ulverstone: Connecting Care). This result is interesting, but it could simply reflect more time taken by the PSOs to gather the information. Five people recognised that work is an important social activity. The largest single group was people who were doing five or more social activities (29.2% of respondents) (Figure A6e).

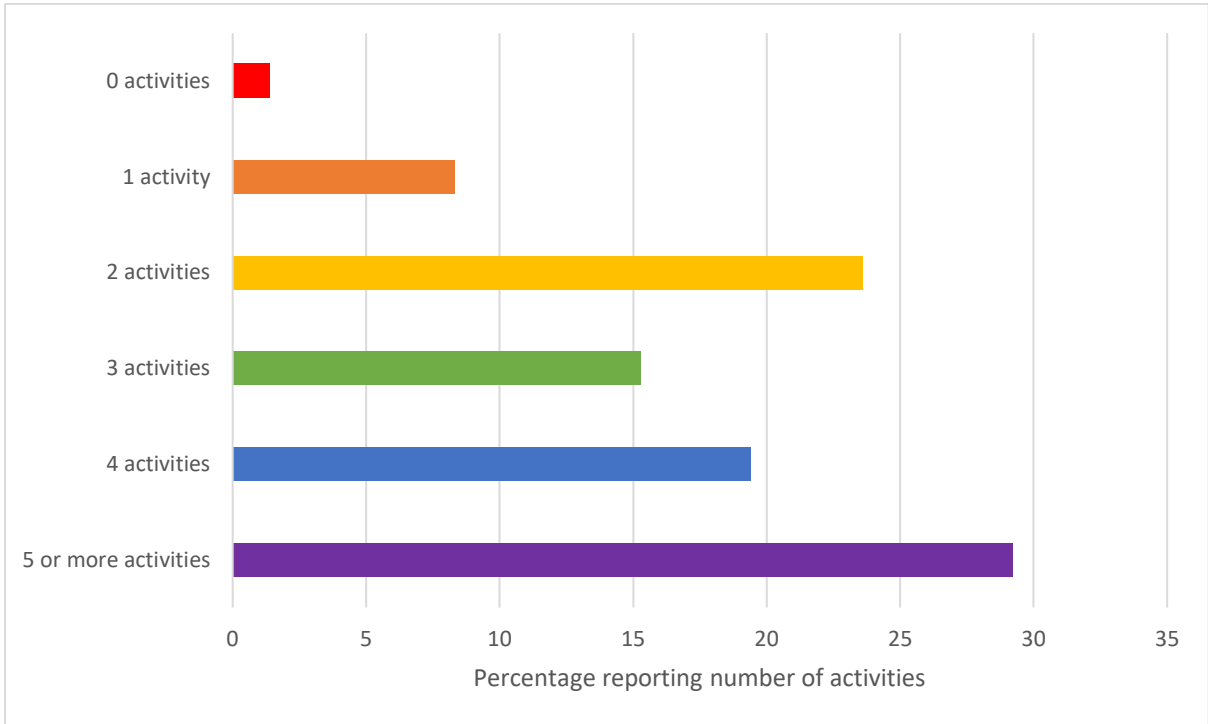


Figure A6e: Number of activities (social) reported by people in the community sample

Most children completing the survey reported multiple activities in several sites across the Island (and surrounding waters) (Figure A6f).

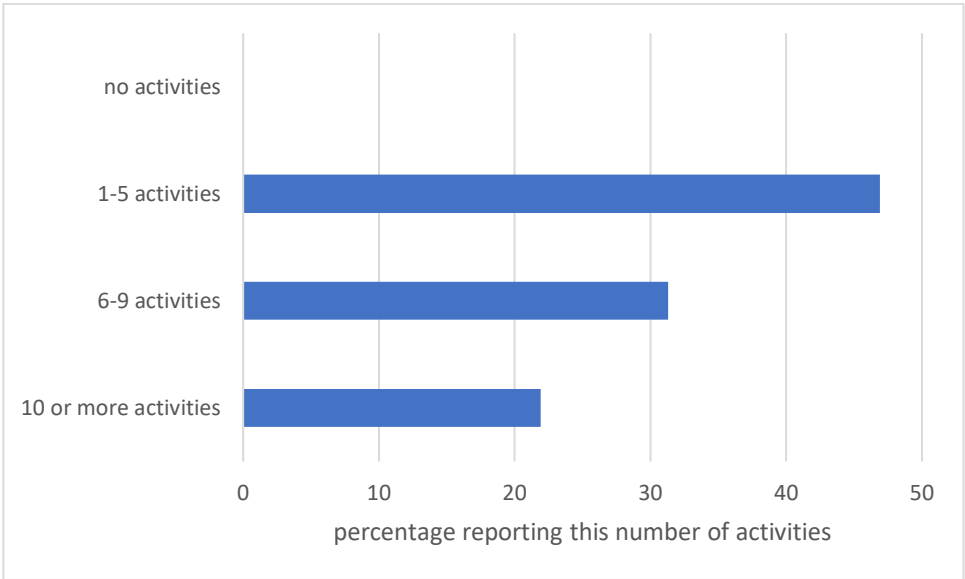


Figure A6f: Number of activities (social or physical) reported by people in the school sample

We looked at the relationship between self-reported health (general community sample only) and number of social activities (Figure A6g). People doing more social activities reported better health, a statistic that could reflect that better health makes social engagement easier.

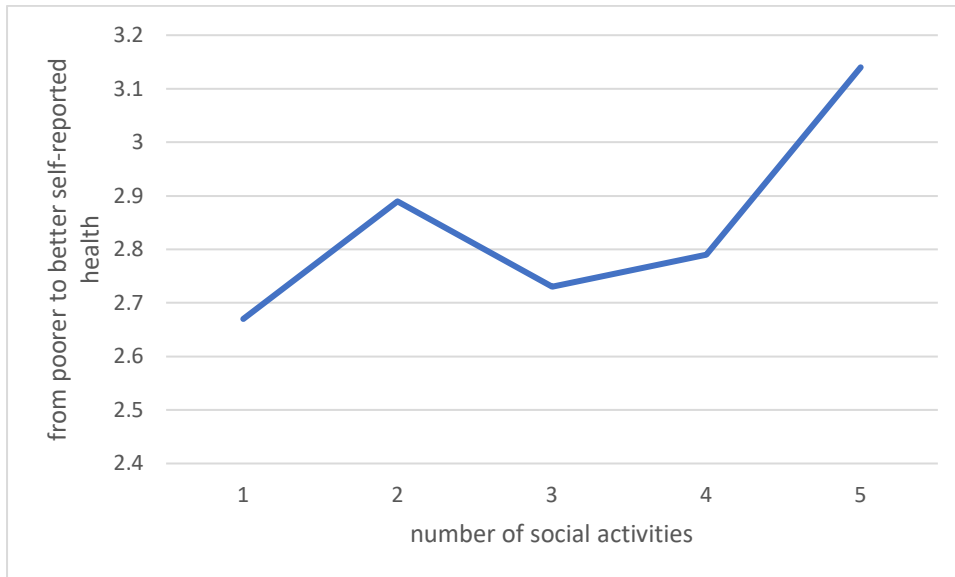


Figure A6g: Number of social activities and self-reported health

Physical activities

Physical activities were undertaken by 71 people (1 person did not report any physical activities, and one person did not answer this question). Fifty-five people reported doing a physical exercise (walking, bike riding, gym), and nineteen people were growing, catching or hunting for some of their food. The most commonly mentioned activity was walking (including bushwalking), which 21 people listed (29.6% of respondents), followed by going to the gym or a formal exercise class (19 people), and bike riding (9 people). Figure A6h shows the main categories of activity reported.

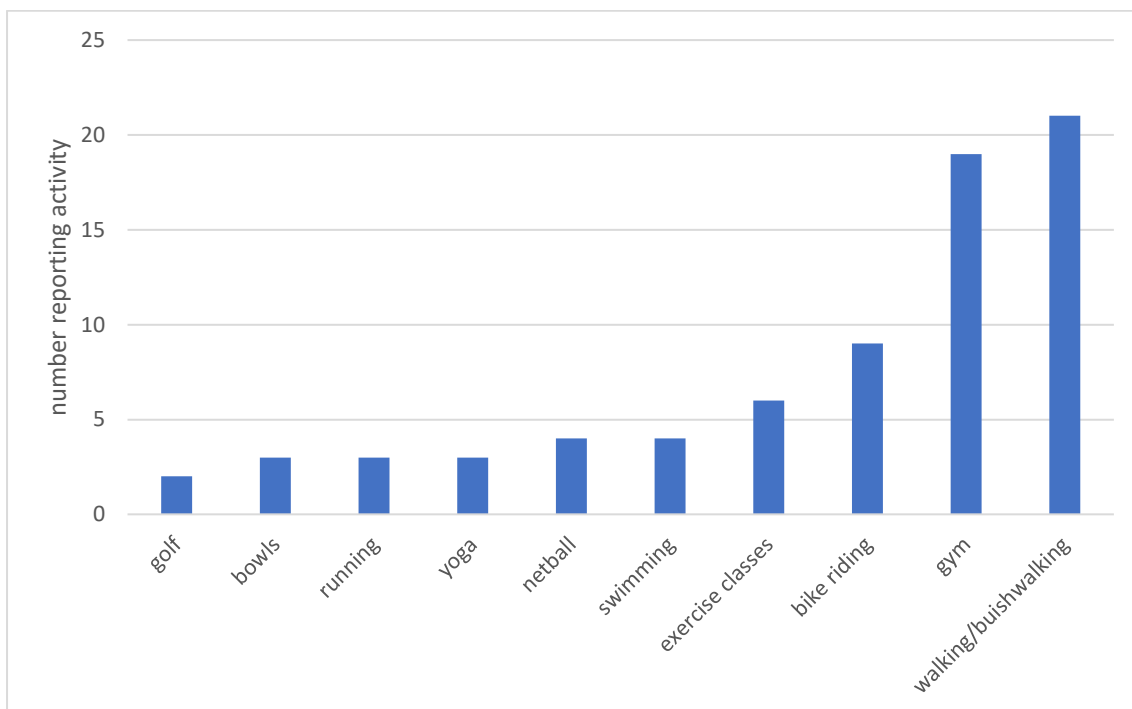


Figure A6h: Number of social activities and self-reported health

Eighteen people were doing no physical activity, fifteen people (20.5%) did one activity, twenty-six (35.6%) were doing two activities, and 14 were doing three or more (19.2%) (Figure A6i).

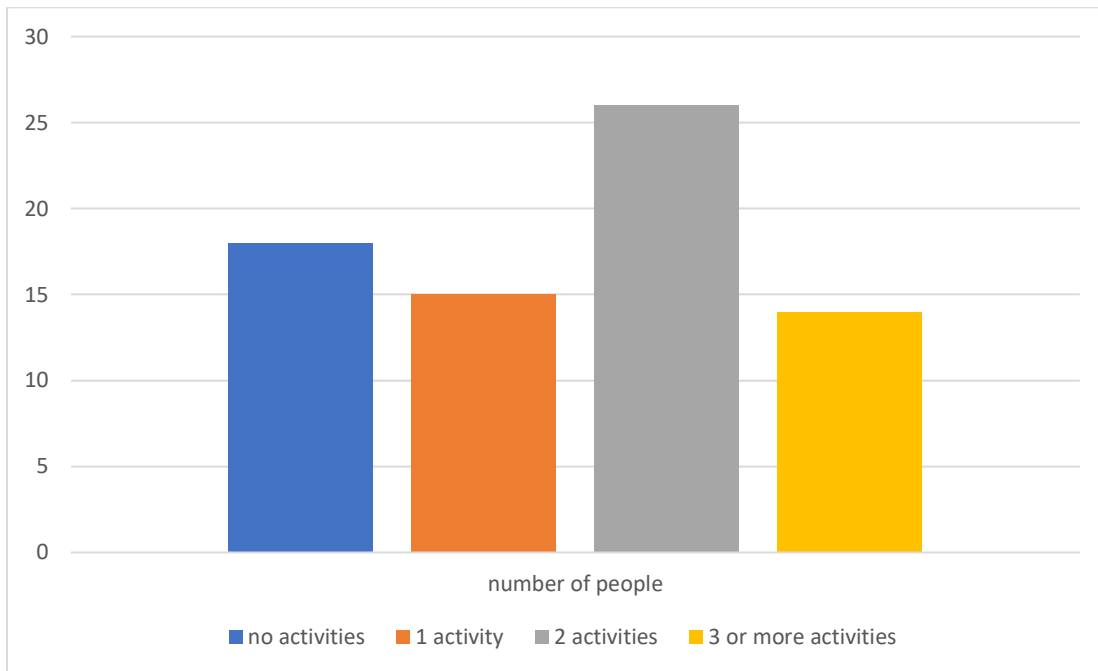


Figure A6i: Number of physical activities reported per person in the community sample

People reporting better health were also doing more physical activities (Figure A6j) and were more likely to be growing, catching or hunting some of their food. Correlation is not causation, however; better health is likely to make activity more possible.

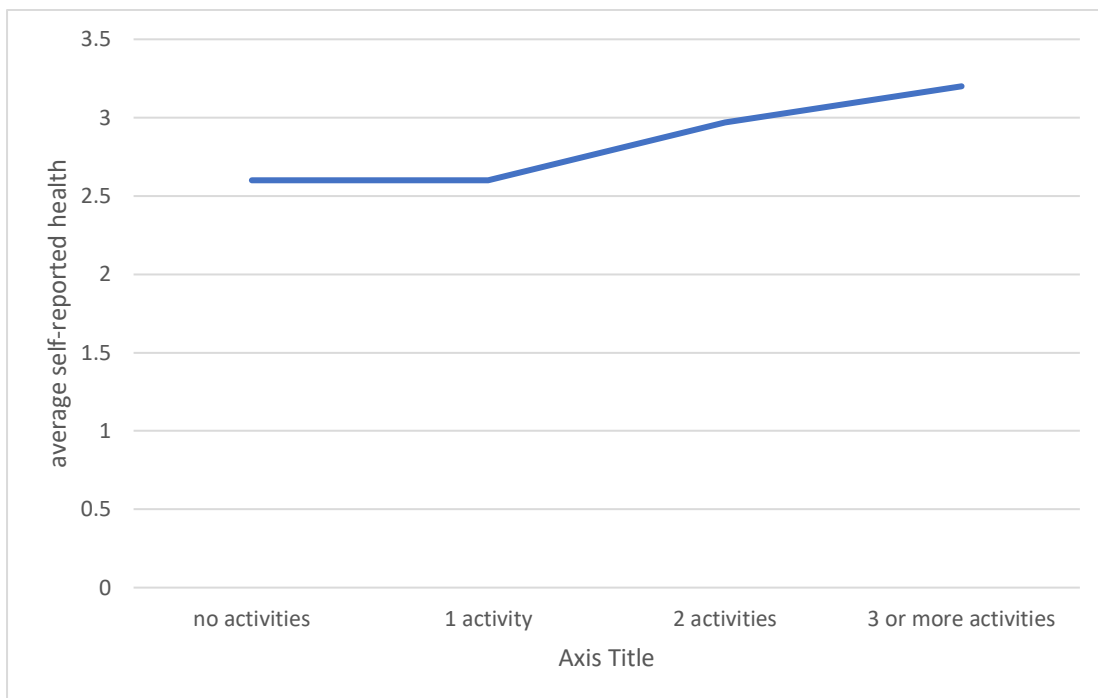


Figure A6j: Number of physical activities and self-reported health in the community sample

Barriers to maintaining your health

Survey participants were asked what prevented them from accessing people, places or services for their health. While scale varies, the patterns of response are remarkably similar for all four project sites (Figure A6k). For the Flinders Island sample, time was the greatest barrier—time of day an activity was available, or conflicts with shift work. Cost also prevented people from being involved in health-benefitting activities.

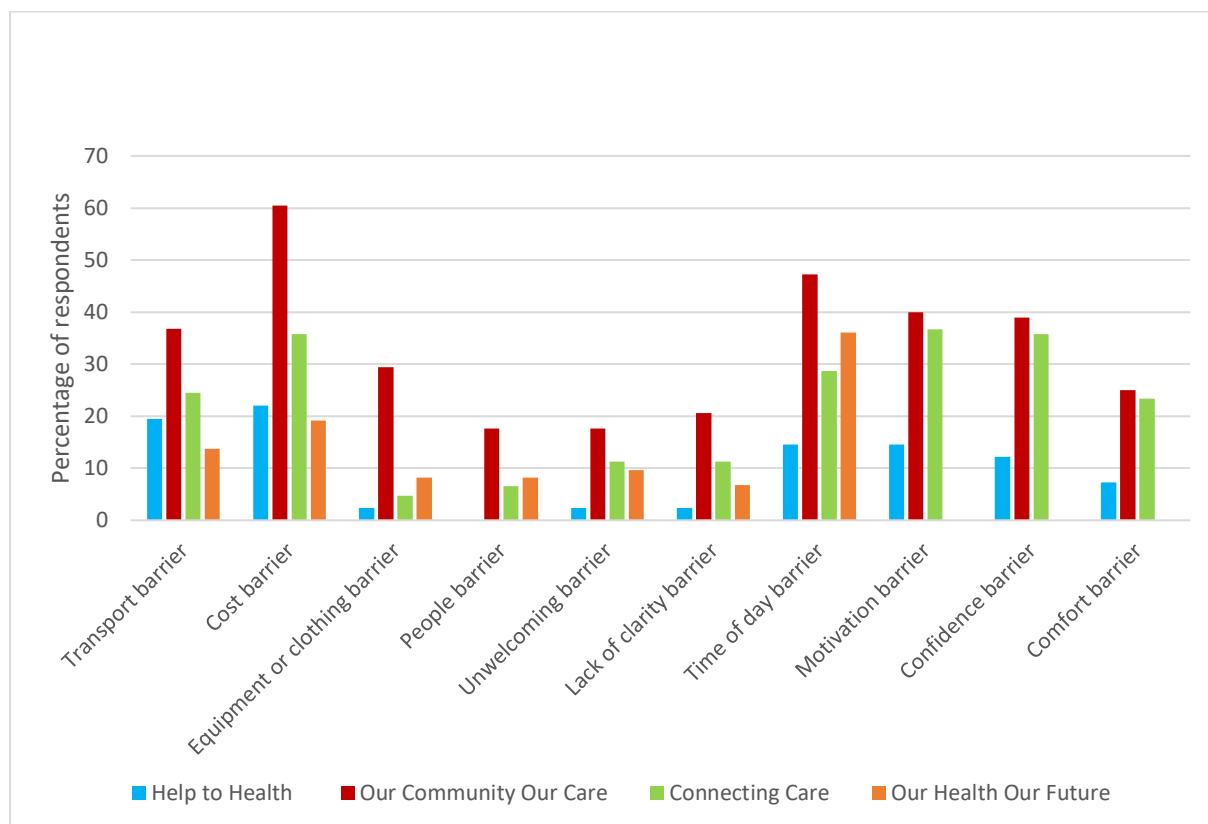


Figure A6k: Survey data, all communities—barriers to accessing AC (%)

People were invited to write in any other comments about barriers, or activities. These are presented below.

(unsure if can attend): community shed/ surfing as an adult

[Injured]

[participant] comments that [participant] doesn't walk bush tracks as has a fear of falling

[participant] fairly new to island and hasn't got to know a lot of things as busy working full time

[participant] is so busy, it's hard to fit everything in. Volunteers a lot at the museum, but enjoys it. She feels welcome everywhere she goes. Doesn't like driving at night, with all the animals out, so prefers day activities.

[participant] wasn't aware of some groups

Busy organising things around kids and work—they are the main priorities. The Community Gym is a great option to go exercise at any time—'really appreciate having it available'

Busy with kids and work—hard to find the balance

Car travel—Sickness. Would like to do more voluntary work when retired

Caring for unwell [partner]

Cost of Emta Hall, would like to use pool for exercise (school?), don't have time due to full time work and family commitments

Costs

Didn't know about [several activities] available

Didn't know about lots of things—fairly new to island and hasn't got to know a lot of things as busy working full time

Didn't know about specific FIAAI services. Didn't know about Nordic walking—sounds fun!

Didn't know about volunteer weeding

Didn't know motocross was once a month, walking group

Don't like groups

Financial reasons unable for me to attend any more than I do

Fuel costs and misses events because otherwise occupied

Gym requires you to have a buddy, so if you can't find someone you miss out; working full time + having to do household chores on the weekends leaves little spare time; went to community shed once—[felt unwelcome] never been back...!; Exercise classes are not always on if not enough participants; weather can limit outside activities.

Having no gym partner sometimes

I don't join groups because too much obligation to volunteer

I don't have one other than I work full time

I don't have time and I am looking after [injured body part]

know about a lot of the groups but didn't know who to contact

Lack of company

Lack of desire!

Lack of public transport is a major issue for people who can't drive. 'I want to be able to get on a school bus to Whitemark, but won't let me s it's not allowed—ridiculous waste of resources.'

Limited due to work commitments, financial cost of getting on/off Island, would do more if possible

No bike, Running group—feel too unfit & intimidated, gym—need someone to go with / haven't orientated

Nothing stops me unless I am sick

Recent health issues have slowed [participant] down, but getting back into things now.

Scottish dancing—didn't realise it was still on, Tai Chi classes, Nordic walking group

Secret men's business, the cost

Shift work and driving at night prevents activities.

Shift work, weather—windy

Sometimes it is the wrong time and not in line with work or child care, I also find there to be a lack of things happening in the community at appropriate times, usually at night OR late afternoons

Spends most of time at work, so accessing health care is hard—nothing is available after hours. Has depression/anxiety—makes it hard to go out. Hearing issues limit action as hearing aids make things too loud in a crowd. [participant] also lacks confidence in groups due to mental health issues

The cost of getting a family on and off the island can be very prohibitive, but that's the price of living somewhere so remote and isolated

The cost of petrol/travel, not wanting to travel at night, prefer to put my feet up, ...

There are a lot of groups on the Island

Time, travel time, people not making a real commitment to or (?) group functions

Time, work, too tired after work, gym equipment breaking down, not working

Transport issues—totally reliant on others to transport and support to activities/events

With [some activities] for example, don't get any updates and they are quite often at beaches etc, so never know where to go.

Work commitment. Shift work

work during the week

Work, anxiety, over worked, I like my own company, my job is very interactive with the island so on my days off I like to kick back and relax

Work, needing home down time, too tired after work, lack of motivation

Work, too tired after work, ...

Working 4 days a week, have Monday' off

*Works during the day and would prefer to go to gym in arvevening rather than mornings.
Katie's exercise classes have finished as she's moved away—[participant] will miss them; not
confident to try yoga on own, but might try.*

Would do more voluntary work when retired

Appendix 7: Our Health Our Future Action Plans, 2019 and during COVID-19

Original action plan, 2019

Category	Function	Form	Ripples	Resources	How will we know it is working?	Sustainability?
Direct health impact and service collaboration	Increased alcohol awareness among population—including FASD, and increased screening (with follow-up) + consistent messaging across the island	Promotion of alcohol screening among health providers + knowledge of next steps (staff education) Community campaign—Could the posters use quotes from our data (including the police) + images of locals? Plus the meme that Flinders Islanders care about each other, look out for each other	Increased service collaboration (starting from links with KB) Builds coherent bureaucratic processes Reduce DV, better relationships, safer roads, less shame for police	People: AI and Fiona; [name]; ... Budget?	Measurables:	
Social and physical health impact	GAME On Flinders: increase physical activity and maybe socialising:	Plan to trial in a couple of places: <ul style="list-style-type: none"> • Ball bin • Dog throwing stick • Frisbee • Cricket gear • Bucket and spade and kicking ball/tennis balls • Racquets and balls at the Lady Barron tennis court 	Community connection, family and social engagement, increased physical activity Whole of community	People: Fiona; will liaise with Sammi at Council Tools: the gear (bins +) Initial purchase, with ongoing opportunities to	Three angles: Photo gallery, Observation, Conversations Instagram or FI Community Noticeboard photo gallery and on a dedicated OHOF noticeboard in Walker's and Lady Barron Store	

	<p>Yellow beach; nr The Wharf; Lady Barron; Killiecrankie and Whitemark BBQ areas + Cape Barron Parks and Wildlife control two beaches (Allports and Trousers Pt) and they are not prepared to host the GAME On stuff there. September kick-off date. Lady Barron tennis courts work ... Health promotion group (Hipsters) (FIAAI, FT, [name and name] meeting and will manage the GAME On) Council workers will also check in on the sites. Killiecrankie—local pride.</p>	<p>(preventive health) Sense of pride in place</p>	<p>donate or sponsor Metal garbage bins (can be secured and sealed) Branding with the project logo and some guide re what they're there for Advertising (Promotion in Sharp magazine and Island News (The Examiner ...), videos on social media) Budget?</p>	<p>Follow-up conversations with people who post (we are seeking stories) Observations by Exec and Fi and AI of people at the sites (keep notes) Island News—prize for best photo each month? Get people to take photos, upload, community noticeboards, Walkers [SMB said to ask Walkers for a noticeboard] + conversations ... JL re a 'say thanks' opportunity. FT said [name] is really keen to use the dog throwing ball thing, and to have the stuff at the tennis courts at Lady Barron ...</p>
<p>Referral pathways: increase clarity and reliability of referrals</p>	<p>Steps:</p> <ul style="list-style-type: none"> • Audit current visiting services/specialists [who, when/frequency and for how long? Ochre, FIAAI, MPC, community nurses, allied health professionals, visiting services or specialists, ACAT/MyAgedCare/NDIS/NDSS, RFDS, Anglicare AOD, Integrated Living, Northside, etc.]—end of July • Audit referrals sent in last 12 months [? Sent by Ochre, by FIAAI, by MPC, by community nurses, by allied health professionals, by visiting services 		<p>People: Duane and Robyn Budget? RMcK time ...</p>	<p>Repeat mapping? Repeat audit? Repeat survey?</p>

	<p>or specialists Formal and informal referring? (e.g., a resident referring their mother for an ACAT assessment). Include asking services (e.g., RFDS, Integrated Living, ACAT, + the formal services that we more frequently think of)]—end of July</p> <ul style="list-style-type: none"> • Map referrals process—existing—end of July • Develop and promulgate questionnaire to specialists and service providers re: processes/ referral requirements—end of July • Develop future referrals process—mid September • Develop future monitoring processes and ongoing management—end September 			
Community directory	<p>Steps:</p> <ul style="list-style-type: none"> • Find previous booklet design—complete • Collate Community Groups—running smoothly • Check all contact information • Design Booklet • Send out to group to triple check all inclusive • Print Booklet • Update info on Council website • Info for OHOF website • Distribute / Promotion of Booklet 	?	<p>People: [name] and AI Budget?</p>	<p>Count of distribution? Increased knowledge of groups? How can this be measured? Survey visiting services Are there more people attending the group? Could new attenders at a group be asked how they found out about it? Measure hits on it on the Council site</p>
Cultural competency	<p>1. Design a cultural competency protocol or workshop [a collaborative process where the discomforts are laid out by all in a safe environment]</p>		<p>People: FIAAI to lead Budget?</p>	

- for service providers in this community with follow-up or sustainability
2. Design a 'design a cultural competency protocol or workshop' training (this could be sold in other communities)—that is, a training on how to develop a cultural competency workshop/protocol for a particular community

Revised action plan, COVID-19 period

<i>Category</i>	<i>Function</i>	<i>Form</i>	<i>Ripples</i>	<i>Resources</i>	<i>How will we know it is working?</i>	<i>Sustainability?</i>
<i>Direct health impact and service collaboration</i>	Increased alcohol awareness among population—including FASD, and increased screening (with follow-up) + consistent messaging across the island	<p>Promotion of alcohol screening among health providers + knowledge of next steps (staff education)</p> <p>Community campaign—Could the posters use quotes from our data (including the police) + images of locals? Plus that meme that Flinders Islanders care about each other, look out for each other</p>	<p>Increased service collaboration (starting from links with KB)</p> <p>Builds coherent bureaucratic processes</p> <p>Reduce DV, better relationships, safer roads,</p>	<p>People: AI and Fiona; [name]; ...</p> <p>Budget?</p>	Measurables:	

		less shame for police		
<p>GAME On Flinders: increase physical activity and maybe socialising:</p>	<p>Plan to trial in a couple of places:</p> <ul style="list-style-type: none"> • Ball bin • Dog throwing stick • Frisbee • Cricket gear • Bucket and spade and kicking ball/tennis balls • Racquets and balls at the Lady Barron tennis court <p>Yellow beach; nr The Wharf; Lady Barron; Killiecrankie and Whitemark BBQ areas + Cape Barron</p> <p>Parks and Wildlife control two beaches (Allports and Trousers Pt) and they are not prepared to host the GAME On stuff there. September kick-off date.</p> <p>Lady Barron tennis courts work ...</p> <p>Health promotion group (Hipsters) (FIAAI, FT, [name and name] meeting and will manage the GAME On) Council workers will also check in on the sites.</p> <p>Killiecrankie—local pride.</p>	<p>Community connection, family and social engagement, increased physical activity</p> <p>Whole of community (preventive health)</p> <p>Sense of pride in place</p>	<p>People: Fiona; will liaise with Sammi at Council</p> <p>Tools: the gear (bins +) Initial purchase, with ongoing opportunities to donate or sponsor</p> <p>Metal garbage bins (can be secured and sealed)</p> <p>Branding with the project logo and some guide re what they're there for</p> <p>Advertising (Promotion in Sharp magazine and Island News (The Examiner ...), videos on social media)</p> <p>Budget?</p>	<p>Three angles: Photo gallery, Observation, Conversations</p> <p>Instagram or FI Community Noticeboard photo gallery and on a dedicated OHOF noticeboard in Walker's and Lady Barron Store</p> <p>Follow-up conversations with people who post (we are seeking stories)</p> <p>Observations by Exec and Fi and AI of people at the sites (keep notes)</p> <p>Island News—prize for best photo each month?</p> <p>Get people to take photos, upload, community noticeboards, Walkers [SMB said to ask Walkers for a noticeboard] + conversations ... JL re a 'say thanks' opportunity. FT said [name] is really keen to use the dog throwing ball thing, and to have the stuff at the tennis courts at Lady Barron ...</p>

<p>Referral pathways: increase clarity and reliability of referrals</p>	<p>Steps:</p> <ul style="list-style-type: none"> • Audit current visiting services/specialists—end of July • Audit referrals sent in last 12 months [? Sent by Ochre, by FIAAI, by MPC, by community nurses, by allied health professionals, by visiting services or specialists Formal and informal referring? (e.g., a resident referring their mother for an ACAT assessment). Include asking services (e.g., RFDS, Integrated Living, ACAT, + the formal services that we more frequently think of)]—end of July • Map referrals process—existing—end of July • Develop and promulgate questionnaire to specialists and service providers re: processes/referral requirements—end of July • Develop future referrals process—mid September • Develop future monitoring processes and ongoing management—end September 	<p>People: Duane and Robyn Budget? RMcK time ...</p>	<p>Repeat mapping? Repeat audit? Repeat survey?</p>
<p>Community directory</p>	<p>Steps:</p> <ul style="list-style-type: none"> • Find previous booklet design—complete • Collate Community Groups—running smoothly • Check all contact information • Design Booklet • Send out to group to triple check all inclusive 	<p>People: Sammi and Al Budget?</p>	<p>Count of distribution? Increased knowledge of groups? How can this be measured? Survey visiting services Are there more people attending the group?</p>

- Print Booklet
- Update info on Council website
- Info for OHOF website
- Distribute / Promotion of Booklet

Could new attenders at a group be asked how they found out about it?
Measure hits on it on the Council site

Cultural competency

3. Design a cultural competency protocol or workshop [a collaborative process where the discomforts are laid out by all in a safe environment] for service providers in this community with follow-up or sustainability
4. Design a 'design a cultural competency protocol or workshop' training (this could be sold in other communities)—that is, a training on how to develop a cultural competency workshop/protocol for a particular community

People: FIAAI to lead
Budget?

Appendix 8: Examples of CLDs for OHOF

Causal loop analysis tries to identify how parts of a system are linked and then how changing one part might affect the others. Doing causal loop analysis involves:

1. Identifying what the parts of a system are
2. Deciding how they are connected
3. Seeing if there are feedback loops
4. Testing these loops using 'real-life' examples

In this appendix, we work through this process for some of the Our Health Our Future projects. The first diagram (Diagram 1) shows all the themes the UTAS team found in the data. It was prepared before the CLD session in 2019. Many of these themes came up when we did the CLD workshop (but not all) or came up in a different guise.

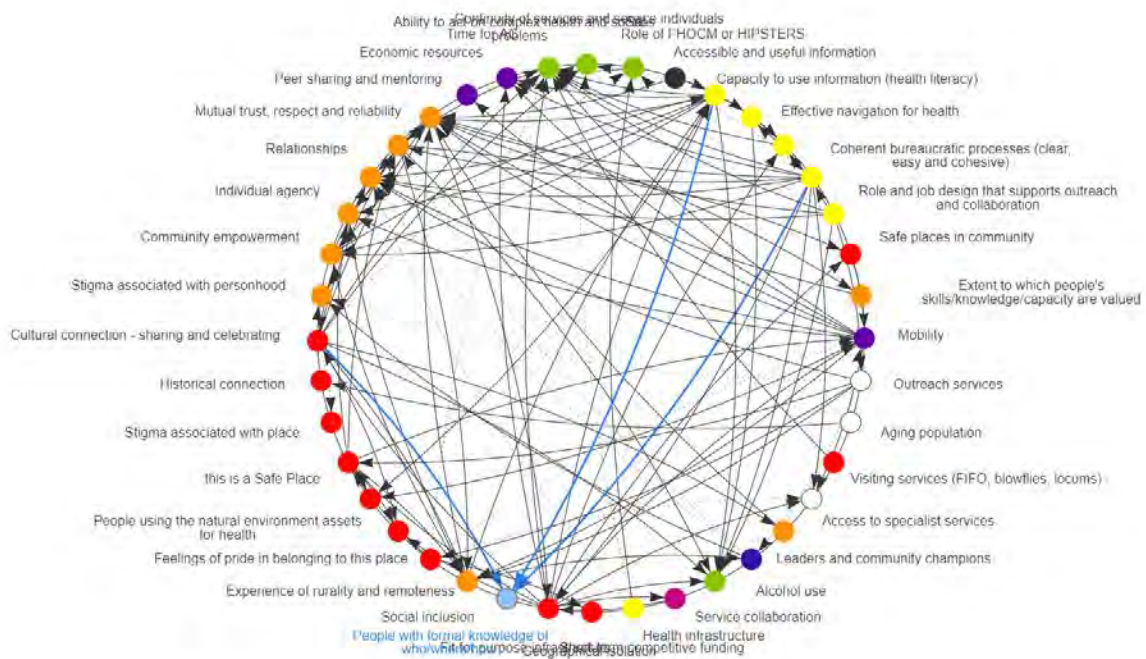


Diagram 1: Whole of AC system in OHOF

Note: the variables at the top are (clockwise, starting with Economic resources): Time for AC; Ability to act on complex social and health problems; Continuity of services and service individuals; Silos; Role of FHOCM and HIPSTERS. At the bottom the variables are (clockwise from Health infrastructure): Short-term competitive funding; Geographic isolation; Fit for purpose infrastructure; People with formal knowledge of who/where/how.

Next, working from the butchers' paper diagram we created in the 2019 FHOCM workshop, the UTAS team focused only on the variables that are relevant to service collaboration (identified as a major opportunity for change in the system), and mapped the causal links (Diagram 2 shows two ways of illustrating the system).

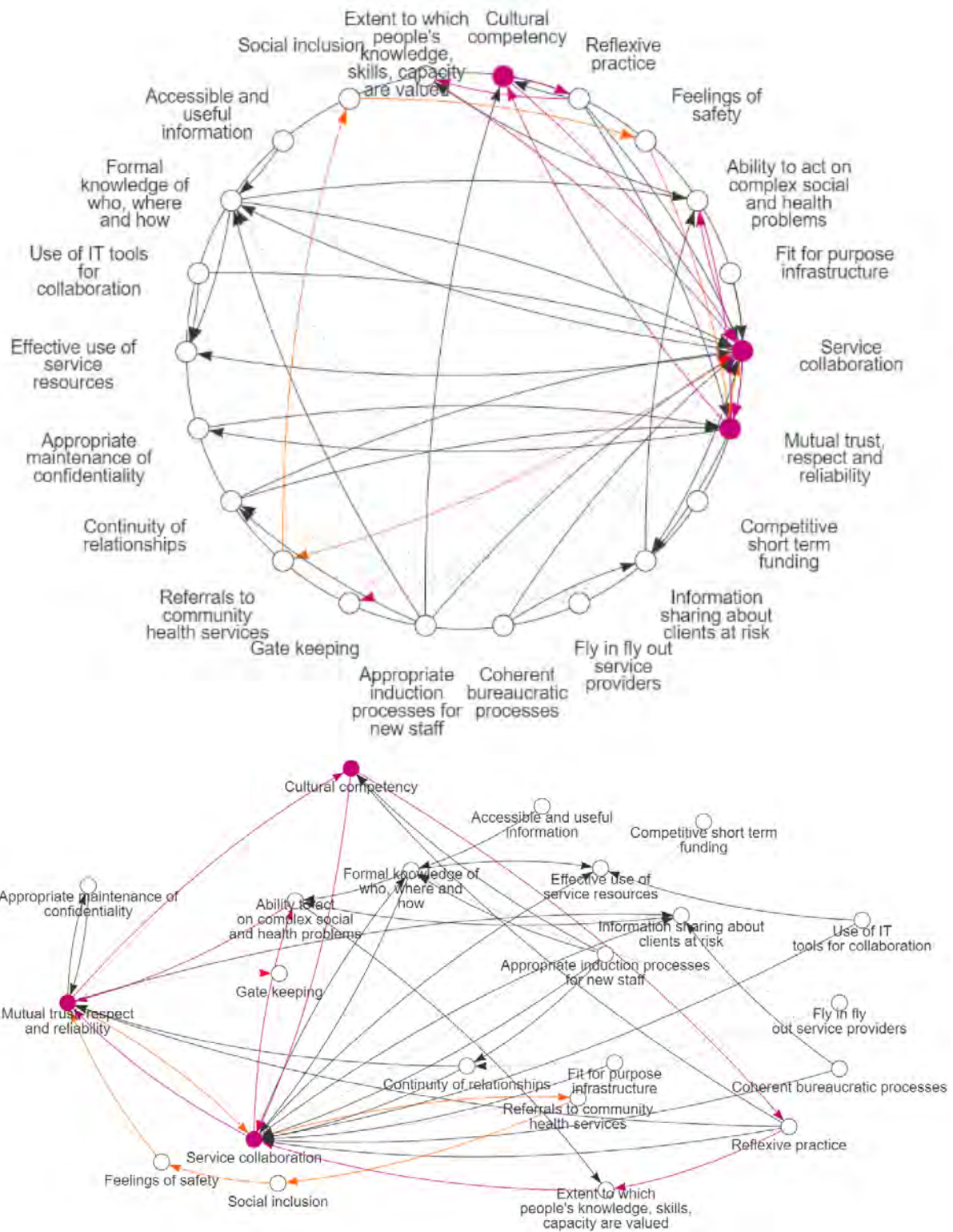


Diagram 2: CLD for “service collaboration”, 2019

We then looked for reinforcing relationships between the variables. Reinforcing loops suggest that any action that builds the strength of one of the included variables will support and strengthen each of the others in turn. The simplest loop here (orange arrows) is one that links Referrals to community health services, Social inclusion, Feelings of safety, Mutual

trust, respect and reliability, Service collaboration, and back to Referrals to community health services. One reinforcing loop (orange) links Service collaboration and Mutual trust, respect and reliability. The second distinct loop (in purple) shows *that you cannot have service collaboration without cultural competency and reflexive practice*, at least theoretically. (And that also means that when you build cultural competency you build reflexive practice and respect for people’s capacity knowledge and skills, in turn.)

There are several loops in Diagram 2. The major loop suggests that when an intervention supports Cultural competency, this will in turn build Reflexive practice, then Extent to which people’s knowledge, skills, capacity are valued, then Service collaboration, then Mutual trust, respect and reliability, and thence back to Cultural competency (Diagram 3). A second loop involves: Cultural competency supporting Service collaboration, which supports the Ability to act of complex social and health problems, which supports Mutual trust, respect and reliability, which supports Cultural competency. Another loop shows that Cultural competency supports Service collaboration, which supports Ability to act, which supports Mutual trust, which supports Cultural competency. And finally, Diagram 4 shows the mini-reinforcing loop: Service collaboration, Ability to act on complex social and health problems, and Mutual trust, respect and reliability.

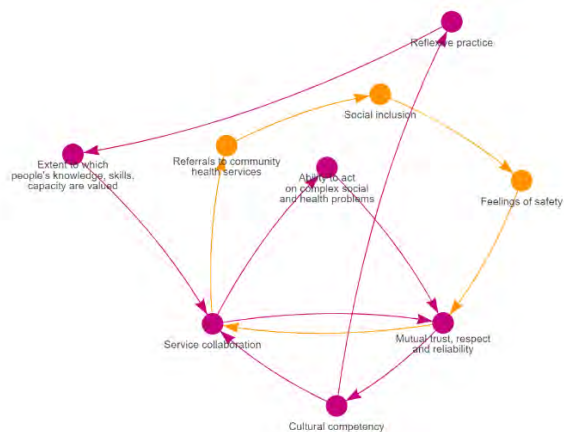


Diagram 3: The role of cultural competency

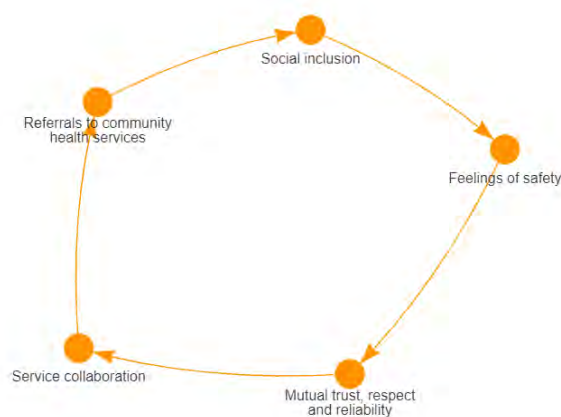


Diagram 4: Mini reinforcing loop

Table A8a: Some definitions of variables

Accessible and useful information	
Ability to act on complex health and social problems	People need to be able to act—alone or with others—on health problems. In this community people are falling through the gaps, and they shouldn't be. They should be able to get the help they need
Coherent bureaucratic processes	Because if processes are not coherent it makes it difficult for people to navigate the system and access resources, supports

	and services. Coherent bureaucratic processes need to be a common goal across the system that processes align with
Community empowerment	Because people who feel empowered are more likely to exercise agency and will have greater capacity to navigate the system
Community engagement and collaboration knowledge and skills among staff	People will feel welcome and included and ask questions and go places and become less socially isolated
Extent to which people's skill/knowledge/capacity are valued	Agency. Recognises individual's role in the system and their strengths/that they have something to offer. Includes volunteering
Feelings of pride to belong to this place	Innate empowerment. People will look after each other. We are in it together. Collegiality. Mutuality. Unity
Fit for purpose infrastructure	Supports healthy living. Enables access to AC services, places and programs
Formal knowledge of who/where/how	
Mutual trust, respect and reliability	Fosters relationships, maximises capacity. Includes continuity of staff. Acknowledges history
Peer sharing	People have knowledge (of many sorts) and it's valuable. Benefits from peer education
Quality of relationships	Because people and services need to work together to achieve outcomes. Relationships are pivotal in action
Safe places in community	To connect. To be present. To be valued. To have a break. To feel cared for. To have coffee. To be culturally safe and inclusive
Social inclusion	Gives people the capacity to engage in society and have a quality life. Social inclusion is the process of improving the terms on which individuals and groups take part in society, improving the ability, opportunity, and dignity of those disadvantaged on the basis of their identity



Design Briefs: Systems Parts Posters

Overview of project

Flinders Island

The data and required illustrations:

We have done some research on health issues (both qualitative and quantitative) and have grouped this information into a systems part which has a theme. Each theme will become a poster, which illustrates the research we have gathered regarding that systems part. The purpose of the illustration of individual system parts is to support the participants in making sense of the data in a more meaningful way than just charts and text (on the individual part). But so that they can also make inferences about how the information in one part—might influence or affect information in another part. Later in the workshop we will seek to identify relationships between these parts, and then describe the dynamic of this relationship.

The individual parts have a theme (infrastructure, culture), and the data we have included below relates to a couple of key points we want to highlight about that theme in terms of what is happening in their community. Metaphor, story, etc are welcome, but overall the illustration needs to speak to the key points we have provided you, but you can consider how to weave or thread these together.

The framing for the illustrations does not need to have a shared narrative across the parts. In fact, part of the issues is that they are often perceived as isolated and separate. While they do in fact exist as part of a 'system' they are not typically understood or considered as such.

The Data:

Below are details for one set of posters.

Each poster is identified by the Theme, both sets have the same set of themes. In each system poster theme are two key types of information to be illustrated: 'what we are learning' and 'what is emerging'. On a few posters there will be an additional type of information which is 'what we are exploring'.

The title of each set should be located at the top of the poster, below which should be the name of the theme for that poster.

The definition for each theme should be at the bottom of the poster in a reasonable font size to be read while standing a few feet back from the poster

Flinders Island

Flinders Island is part of the Furneaux group of islands. Flinders Island has two main townships—Whitemark and Lady Barron, both located in the southern third of the island—and several other small settlements. It is mountainous, fringed with beaches and rocky foreshores; the remainder is farmland, bush and National Parks. The Island has two wind generators. Cape Barren Island, to the south of Flinders, is the other main populated island, and has a mainly Aboriginal population.

We also need to represent the depth of connection to the Furneaux for all Tasmanian Aborigines, not just those who live here now.

Access to the Island is by light aircraft or boat.

Theme –people and health

Definition—This refers to the demographics and health status of the community.

Some Islanders' self-descriptions: “resourceful”, “talented”, “generous”, “people want to help”, and “punching above our weight”

What we are learning

- diverse population (strong Aboriginal community with ties to country, along with a mix of Anglo Island-born people and (maybe) sea-changers); Flinders Islanders are older than the State median (53 for European Islanders and 49 for Aboriginal Islanders, compared with 42 and 24 for the State)
- access to economic resources is very mixed—the Island has a high median weekly income, but there is also a higher than State average proportion of people with very low weekly incomes
- very high involvement in volunteering (38% compared with State rate of 21.3%)
- the Island has a lot of activities that support health: e.g., running, walking and cycling groups, Pony Club, the gym at Lady Barron, and there are also many less formal/organized opportunities to be involved in things that keep people well—bushwalking, swimming, active jobs (farming, fishing, ...) etc.
- farming, working for local government and running accommodation services are the top industries of employment
- there are high rates of potentially preventable hospitalisations (50.4 per 1,000 compared with Tasmania's 21.2 per 1,000); top reasons for potentially preventable hospitalisations are for chronic obstructive pulmonary disease, congestive heart disease and infections—this is linked with an older population, lots of older people living alone (somewhat more single person households than for the State (35.4% compared with 29.6%)); and limited after hours services
- Flinders Island has the highest rates of hospitalisation for cardiovascular disease and dementia. Overall Flinders has the highest crude rate of hospital separation for the selected combined chronic conditions out of all the LGAs (ranking as either number one or two for six out of the ten chronic conditions). The Island also has a much

higher rate of prostate cancer and lung cancer than the other 11 top-placed local government areas, and of mental and behavioural problems (chronic illness)

What is emerging/still being explored

- Multi-tasking is an important aspect of Island life—very high rates of volunteering, and people taking on multiple roles
- Some people are reporting very active social connectivity; how widespread is this?
- Some local concern about meeting the mental health needs of the community
- Identity as Aboriginal is an important aspect of health since it affects the services accessed; for example there are specific MBS items for Aboriginal health checks

Questions: To what extent are the Island's poor health statistics the product of an ageing population, distance and timely and ready access to health services, or are some of the measures used not appropriate for very remote communities (for example, length of hospital stay may not be appropriate for remote communities)?

Is it more important to keep Islanders healthy because of the distance and difficulties of accessing services: do we need more up-front investment in anticipatory care—managing risks—for Islanders? When Islanders get unwell, they get very unwell.

Theme—Local infrastructure

Definition This refers to the services, professionals, centres, businesses, environments and programs that support health

Quote: Islanders come up with innovative and practical solutions to challenges. As one person put it, “Tie it up with wire, hold it together”

What we are learning

- geography is challenging—getting to and from the Island is (usually) by light plane (service very dependent on the weather); supplies (medical, postal and other) come in by plane or cargo vessel; delays can be costly (for getting to appointments, treatment, etc.), and many tests, treatments or consultations off the island are expensive and time-consuming [flights, accommodation, lost work time]
- GPs –2 weeks on, 2 weeks off plus interns (short term); difficulty of building relationships with and knowledge of community. This is also true for other specialists who fly in and out (at various frequencies). Some of this is caused by ‘choppy’ funding systems that result in frequent change of clinicians/service providers, who may have low investment in Islanders; in turn, Islanders may have reduced trust in services
- supports for mental health insufficient (consistently reported to UTAS)
- there are no weekend or afterhours health services. This means that the Multi-Purpose Centre (the hospital and aged care facility) becomes a ‘safe place’ for some at weekends [although not everyone has transport to get there]; it also means that people discharged from hospital on the mainland may have no supports
- multi-tasking is a feature [very flexible practitioners] to compensate for lack of people on the ground with the qualifications and scope of practice to deliver some services ...

- physical health supports include varied natural environment, sporting and recreation clubs and groups, gyms and classes; growing your own vegetables, and farming, fishing or hunting your own meat are aspects of Island life ... some problems with imported food supply, including reliability, quantity at peak tourist season.

What is emerging?

- Flinders Island Aboriginal Association Inc Health Service (FIAAI) and the Multi-Purpose Centre (MPC) serve different populations—opportunity for more resource sharing? MPC is a state government service, with aged care facility attached; it is located at Whitemark. FIAAI is a community run Aboriginal organisation located at Lady Barron.
- Fly in fly out [providers who fly in to the Island and fly out again] and short term funding of some services makes it hard for residents and health workers to know what services exist and when/how to access them
- Whether Islanders feel a service is trustworthy and safe affects whether they seek help and where [this is about confidentiality, and the risks associated with revealing illness or incapacity (e.g., older people concerned with potential loss of independence), as well as cultural safety for Aboriginal Islanders]
- Availability of visiting health services is inconsistent

Theme Local health service data and information

Definition This refers to data collected by organisations about the health of the community and to information about health and community services. What exists and how is it shared.

What we are learning

- Reporting on programs and services somewhat internal [often seen only by funding organisations; often just participation numbers or dollars spent] and some health data is hard to access—the idea of a closed shop, or data that sits untouched. Access to this data could help us to have a better understanding of the community’s health
- Residents and health workers do not always know what services and supports there are, how to access them, or who they are for; is information sharing a problem?
- Follow ups from referrals and discharge planning from mainland hospitals are sometimes inadequate (this is about health services not sharing information and communicating with each other effectively)
- Health information sharing (brochures, notices) happens in Ochre General Practice waiting room, community notice boards, Flinders Island Aboriginal Association Inc Health Service (FIAAI) and the Multi-Purpose Centre (MPC), and through schools and clubs and activities; [great example of effective information sharing is the No Smokes campaign using local people on posters (see below)]

What is emerging?

- The role of social media and the internet in the provision of health information is unclear [project researchers only have a little anecdotal information about this—but we don’t have statistics or much information about people’s use]
- The health services on the Island are welcoming and flexible for some—but not everyone experiences this. Trust and safety concerns get in the way. We need to know who is not having positive experiences of the health system.
- Sharing of information among health services is patchy [one informant described this as seeing “silos everywhere including within organisations, with a plane flying over];

cooperation and coordination have been identified as things to work on—hence the development of the Flinders Organisations for Health Committee (FOCHM)

- How accessible (Easy English, culturally safe, etc.) is the information that is being shared?

Where we are trying to explore/looking:

- How is social media or the internet being used for health information and support, by community members and by clinicians?
- Is there a need for more (and more accessible) information about the roles of various specialists, tests and procedures?
- Does more need to be done to improve safety and trust in other services?

Theme Attitudes and actions that affect health

Definition This refers to beliefs and attitudes about health and the health system. It also refers to how these attitudes inform practices and actions.

What are we learning?

- Flinders Island Aboriginal Association Inc Health Service (FIAAI) approach to health and wellbeing is holistic—social determinants of health (housing, education, safety, employment, health service access, etc.) coupled with a “How can we?”, rather than “Why we can’t” approach (self-report)
- People who work off Island (more likely to be men) are less engaged and time-poor; this reduces their access to health services, and responsiveness to symptoms
- Low use of illicit drugs, but risky levels of alcohol consumption a social norm? Is smoking also a social norm? [these behaviours are reflected in the health statistics]
- preliminary survey data suggests relatively low physical activity among participants—lack of time due to work pressures?

What is emerging

- Some people are reluctant to engage with the health services due to a need for safety and trust
- We are yet to understand how health providers understand and engage with health and the health system [idea that, like community members, some may not know what is out there, or what direction to point people in—especially if not residents or long-term visitors]
- Some Islanders may be reluctant (or not equipped) to take more control over their health
- Strong drive through Flinders Island Aboriginal Association Inc Health Service (FIAAI) and Ochre (private GP clinic) to increase uptake of annual health checks (for Aboriginal Islanders)

What we are trying to explore/looking at:

- Need to know more about how Islanders think about and act on health concerns ...
- Need to know more about how FIFO health providers think about anticipatory care on the Island

Theme Relationships, networks and partnerships

Definition This refers to formal and informal networks , partnerships and relationships that enhance or enable the health of the community. Here we are referring to community members and their networks as well as professional service providers and agencies

What are we learning?

- There is increasing cooperation between the health services and providers who are based on, or fly to, the Island (FOCHM)
- Small population means people multitasking and so engaging across different sectors and networks—relationships and networks are important for getting things done and supporting people's health
- ...

What is emerging

- How easy is it for FIFO practitioners to engage and be engaged with? [idea that they may not be in the loop—a broken communication line in the service network]

Where we are trying to explore/looking:

- What is the level of communication and trust between services?

Theme Local leadership for health

Definition—This refers to the people and organisations that are influential in supporting the health of the community

What are we learning?

- Formal leaders are evident and active (FOCHM's engagement in Anticipatory Care is an example; Flinders Island Aboriginal Association Inc Health Service (FIAAI) leader is another); but we need to know more about who else influences what community members and organisations do about health
- Some people initiate and drive health—running group, yoga classes, the gyms, men's health (Secret Men's Business) ...
- ...

What is emerging?

- Question—Who is influential in improving the health of the community? This poster could include a large question mark with a range of people represented—General Practitioner, Flinders Island Aboriginal Association Inc Health Service (FIAAI) health workers, community nurses, physiotherapist, youth worker, school teachers, etc. ... ,
- Are there other leaders, or key health information and support people, like the hairdresser, neighbours, publicans?...

Where we are trying to explore/looking:

- ...

Appendix 11: Presentations and papers

Policy reports and papers

2020

Final project report, Community 1: Help to Health, Clarence.

Final project report, Community 2: Our Community Our Care, Launceston.

Final project report, Community 3: Connecting Care, Ulverstone and the 7315 postcode area.

Final project report, Community 4: Our Health Our Future, Flinders Island.

Community workshop (reporting findings), Community 2: Our Community Our Care, Launceston, 17th June (via zoom).

Community workshop (reporting findings), Community 1: Help to Health, Clarence, 6th August (via zoom).

Community workshop (reporting findings), Community 3: Connecting Care, Ulverstone and the 7315 postcode area, 25th August (face-to-face).

Community workshop (reporting findings), Community 4: Our Health Our Future, Flinders Island, 27th August (via zoom).

2019

Interim project report, Community 1: Help to Health, Clarence, 2019.

Interim project report, Community 2: Our Community Our Care, Launceston, 2019.

Interim project report, Community 3: Connecting Care, Ulverstone and the 7315 postcode area, 2019.

Interim project report, Community 4: Our Health Our Future, Flinders Island, 2019.

Posters/findings briefs

2020

Access to affordable general practice care, FINDINGS BRIEF NO. 1

Action for prevention FINDINGS BRIEF NO. 2

2019

The Anticipatory Care Project (project overview)

Senior government briefings

2020

UTAS AC team (2020). Findings to date report (delivered with DoH Principal Project Officer, Flora Dean) to the Healthy Tasmania Chronic Conditions Working Group, Hobart, 20th February.

UTAS AC team (2020). Health Promotion & Public Health Sharing seminar, Public Health Services, DoH, 21st February.

UTAS AC team (2020). Discussion regarding reporting, with the Healthy Tasmania Chronic Conditions Working Group, Hobart, 25 June.

2019

Statewide Anticipatory Care forum 1, 16 May 2019.

UTAS team (2019). 'What do we now know about anticipatory care in our sites and overall'. Presentation to the Healthy Tasmania Chronic Conditions Working Group, Hobart, 8th August.

UTAS AC team (2019). Bulk-Billing and GP Access, discussion with the Healthy Tasmania Chronic Conditions Working Group, 12 September.

UTAS team (2019) Causal loop analysis session with the Healthy Tasmania Chronic Conditions Working Group, Hobart, 24 September.

Statewide Anticipatory Care forum 2, 18 November 2019.

External consultations and meetings

2019

Wynne Russell (TasCOSS)

Peter Barns, CEO HR+ (health workforce consultancy)

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Our Community Our Care Community Forum, Ravenswood, 13th February.

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Our Community Our Care Community Forum, Newnham, 14th February.

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Our Health Our Future Community Forum, Whitemark, 28th March.

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Connecting Care Community Forum, Ulverstone, 1st April.

UTAS AC team (2019). 'What systems affect our health?'. Presentation to Help to Health Community Forum, Clarence, 4th July.

Healthy Tasmania Community Forum, 13th August 2019, Hobart.

Pain Revolution, 10th September 2019.

TBRI training, SPNH, 8th November 2019.

2020

Tasmanian Wellness Framework—Situation Analysis Part 1, presentation and workshop, 27th February, 27th March, and 29th May (Strategic Purchasing and Funding, Planning, Purchasing and Performance, DoH).

Dean Cracknell (Town Teams/Neighbourhood Leadership, City of Launceston)—22nd May 2020

Internal policy engagement

2019

Dr Elspeth Stephenson and Dr Helen Yost (UTAS) (re trauma informed approaches in health and education)

Ms Sandra Murray (UTAS) (re food security)

2020

Mr Robert Alderson (UTAS) (re community engagement with UTAS)

Media engagement and public lectures

Media engagement

2019

Willard, J. (2019a). The State of Health: anticipating care needs in Launceston's Northern Suburbs, *The Examiner*, 26 March.

ABC Radio (Northern Tasmania), Interview with Piia Wursu, 20 November 2019.

Willard, J. (2019b). Supporting Better Health, *The Examiner*, 24 November, p. 6.

2019

Public lectures/presentations

Banks, S., Krabbe, R., Vandenberg, M., & Murray, T. (UTAS AC team)(2019). 'Anticipatory Care: An action learning project—Getting a sense of the system that supports our health'.

Presentation to the Tasmanian Health Service forum, *Accessible Services: It's in our hands*", Hobart, 30 October.

UTAS AC team (2019). 'Anticipatory Care: An action learning project—Getting a sense of the system that supports our health'. Presentation to the Tasmanian Health Service forum *Accessible Services: It's in our hands*", Devonport, 6 November.

UTAS AC team (2019). 'Anticipatory Care: An action learning project—Getting a sense of the system that supports our health'. Presentation to the Tasmanian Health Service forum *Accessible Services: It's in our hands*", Launceston, 14 November.

UTAS team (2019). Hosted and presented at the *Health Care Services Work-in-Progress Seminar* (presentations from UTAS researchers, Launceston City Council project staff, personnel from local health-related project), Rocherlea, 20 November.

Academic publications

Presentations

Banks, S., Krabbe, R., Vandenberg, M., & Murray, T. (2020). The 'Aha' experience: Using systems thinking to map and tweak anticipatory care. Presentation to the Preventive Health Australia conference (virtual), 13–15 May.

Banks, S., Murray, T., Vandenberg, M., Krabbe, R., Preston, E., & Eccleston, R. (2019). The Anticipatory Care Action Learning Project: Working with government and communities. Presentation to the School of Social Sciences 'Brown Bag' seminar series, Hobart, 30 August.

Peer-reviewed paper

Boland, J., Banks, S., Henning, T., Krabbe, R., Lawrence, S., Murray, T., & Vandenberg, M. (2020, revise and resubmit). A pragmatic covid-era literature review: Using zoom to engage in action learning work. *Public Health Research & Practice*.

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