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Ulverstone

FULL REPORT

ANTICIPATORY CARE PROJECT

ACTION LEARNING TO IMPROVE HEALTH IN TASMANIAN COMMUNITIES

The Anticipatory Care Action Learning Project research team acknowledges the palawa people of lutruwita upon whose lands we have conducted our research.

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The research reported here was produced by a collaboration between the Patrick Street Clinic and the Ulverstone and 7315 postcode area communities, the Tasmanian Government Department of Health, the University of Tasmania, and the Australian Prevention Partnership Centre. The Report was prepared by the University of Tasmania Anticipatory Care research team: Dr Susan Banks, Dr Robin Krabbe, Ms Miriam Vandenberg and Ms Thérèse Murray. We wish to thank Professor Richard Eccleston, Dr Therese Riley, Ms Flora Dean and Ms Sarah Hyslop for their insights and support throughout the project.

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Glossary

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

AC	Anticipatory care (see definition on p. 4)
CC	Connecting Care (the Ulverstone and 7315 postcode area: the project site)
CRG	Community Reference Group (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. 4)
PPH	Potentially preventable hospitalisations (see p. 14)
CLD	Causal loop diagram
PHT	Primary Health Tasmania

In Brief

Anticipatory care can 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. The system is shaped by policy at all levels of government and within organisations but must reflect local ways of working and resources.

The AC project in the 7315 postcode area 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 a little more equitable. Work by the Connecting Care (CC) team has fostered collaboration across several sectors, 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 to build on the changes.

Executive summary

This executive summary is formatted in four parts.

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Key points

Context

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 use of 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 Connecting Care (CC) site in the 7315 postcode area.

What was already known

People living in some parts of the CC area have higher rates of chronic illness, and potentially preventable hospitalisations than Tasmanians overall. They also have higher rates of risk factors for chronic illness, including smoking, overweight or obesity. Some of these factors are linked with being older (the 7315 area's median age is 47), but many are the product of the negative social determinants of health.

What our research has added

The Connecting Care project trialled 'proof of concept' actions to increase access to locally relevant health information, as well as developing a governance model for a sustainable network to support health and wellbeing in the Central Coast municipality. It also allowed us to explore the role of a GP clinic in anticipatory care.

Medical services (GPs) have historically been seen as central to AC, and it was valuable to have a GP clinic (the Patrick Street Clinic, PSC) as the lead organisation here. The project, led by PSC, has supported the development of new collaborations, increased the provision of locally relevant health information, and expanded our understanding of who is part of the AC system. The project has shown that the Patrick St Clinic's (PSC) medical expertise and leadership are essential components of the AC system, but that there are policy, business model and attitudinal barriers—among GPs, but also among other providers and the community more generally—to their full effectiveness.

Some AC project statistics for the CC site

CC and research activities:

Data gathering and sharing activities	250+ people
Health literacy training	25 people
Engagement with information hubs	6 sessions (e.g., 'Pit Stop', 101 participants, Step-up Program, 8 participants)
The CRG and lead group	22 members, meeting six-weekly

There are also many participants through public information sharing activities and social media.

The CC projects were:

- the 'Sustainable Governance' working group, and the development of a prospectus and Terms of Reference for a Roundtable to support anticipatory care
- a series of delivered and planned health and social care information hubs

- local resource information: through an online information portal, social media and printed resources
- health literacy training for staff and volunteers (based somewhat on The Right Place model operating in the Clarence Help to Health project site, and in the Huon Valley).

Actions taken in the CC AC Action Learning Project increased:

- connections and networks between service providers and with the community
- effective communication through these connections/networks to share AC knowledge
- awareness of AC services/programs among service providers
- service provider awareness of need to create supportive environments for health
- AC beliefs and attitudes about the need for collaboration across the system
- the likelihood of sustaining AC project gains through the proposed Central Coast Community Wellbeing Governance Model (for the Roundtable).

These gains from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project, but they are important short to intermediate markers that indicate a more enabling environment. The Roundtable proposal has the potential to sustain some of the new ways of working and of collaborating that have developed during the AC project. 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. These include:

- the uneven distribution of personal resources for health (i.e. access to the beneficial social determinants of health (SDoH), compounded by lack of confidence and motivation), and service and information provision that requires service users rather than providers to change
- policy settings (e.g., for bulk-billing, welfare supports, distribution of services, and funding) that reduce options for taking a social determinants of health—including mental health—preventive approach
- an individual responsibility for health approach, which risks blaming people who are at risk of, or diagnosed with a chronic illness for their condition
- general practice and other parts of the AC system based on for-profit, competitive business models reduce access, prevent outreach, impede information sharing and collaboration, as these services are rarely billable.

The full report can be read alongside the local report prepared by the CC team, and reports on the other three AC project sites: the Clarence municipality (Help to Health), Launceston's northern suburbs (Our Community Our Care), and Flinders Island (Our Health Our Future). A final report, incorporating external evaluation, will be delivered in December 2020.

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
- 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 Connecting Care (CC) project in the 7315 postcode area 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 Connecting Care site is the north-western postcode area 7315, including and surrounding the town of Ulverstone. The site's lead agency is the Patrick Street Clinic, represented in the project by GPs in the practice and a practice principal. The Patrick Street Clinic employed a project lead, Professor Judi Walker to manage the project. Five project support officers (PSOs) were also employed to work with the community and the UTAS team. Two PSOs worked with the UTAS team; others had data analysis or assistant roles (and little contact with the project researchers at UTAS). There was also a Connecting Care executive group, and a Community Reference Group (CRG) of local residents and representatives from services working in the area. The leads, PSOs, and CRG members are the CC 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 in the Connecting Care area. We wanted to know how they understood health, about their experience of the health system, and what supports or gets in the way of health for people of Ulverstone and surrounds.

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 CC 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.

We identified that the major opportunities for change were through:

Beliefs and attitudes (quotes are from local participants):

> *Individual and organisational beliefs and attitudes about health and the health and social care system [...] highlighting our reluctance to take responsibility for our own health and to truly put individuals, rather than organisations and systems at the centre of health and social care.*

Access to health and social care information:

> *There is poor quality and wrong information being shared in the community ...*

Collaboration and communication:

> *In the system you can fall through the cracks ... and I know that for sure.*

These three themes reflect that resources and relationships are very important for the effective functioning of the anticipatory care system. Relationships (between services and between community members and services) can make the system easier to navigate for better

prevention or management of chronic illness. Relationships can support learning about information needs and improve what and how information is provided. Weak (or absent) relationships result in a lack of collaboration and coordination across services. Some constraints are driven by competition, and by funding models that reduce transparency and information sharing. The effectiveness of the AC system is also constrained by the prevalent valorisation in the Connecting Care area of a 'personal responsibility for health' belief. When the SDoH are not considered, and poor health is constructed by health services or the community more generally as a product of personal decisions and actions, too many at-risk people feel unwelcome or marginalised from health supports. Stigmatising affects how likely people are to attempt to use a service or visit a place. The three most reported barriers to using health supports in the Connecting Care AC community survey were cost, confidence and motivation.

> **What does stigma look like?**
>
> Attitudes about a community or a person shape how they are treated and their expectations. These attitudes can be external (e.g., held by people outside the community), or internal (an expectation that you will be judged and found wanting). Stigma plays out in the lack of provision of services and supports to particular communities or people, in the demands that some communities or people do more for themselves (including 'victim blaming'), in judgmental responses to individuals, and in a person's unwillingness to approach particular services or places for fear of being treated poorly.

Trial actions to enhance the system

Each site developed action plans based on our shared understanding of where to intervene to build a more effective system. The Connecting Care team explored:

- information sharing through health and social care information hubs (the CC portal, social media, and printed resources, as well as pop up hubs)
- health literacy training for staff and volunteers (based somewhat on The Right Place model operating in the Clarence Help to Health project site, and in the Huon Valley)
- the effectiveness of (and potential improvements to) responses to chronic conditions by GPs (practice audit)
- developing a framework and governance model to sustain enhancements of the AC system in this site (the Roundtable).

During the project, we have continued to gather data and to reflect on what we are learning with the CC team (more than 250 people have contributed to our data). 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. The researchers and local team have a better understanding of what makes up the AC system, and have shown the importance particularly of information, of place, and of policy and processes on the anticipatory care system.

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 to support safer access to health for community members. This was evident in the data and demonstrated at our final CLD session, in 2020, where participants included people with education, and 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 CC site, the Patrick Street Clinic, has an accepted role in preventive health. It does this through its provision of medical health services to the community, and through advocacy for health services on the north west coast, and training of medical students. PSC also shares premises with other health and allied health services (e.g., PhysioTas, Hearing Australia). These factors give PSC a unique capacity to influence attitudes, practices, and policy.

The CC team conducted an audit in two GP practices of the characteristics of the patient population, prevalence of chronic conditions, numbers of medications prescribed, health assessments, hospital discharge correspondence and Medicare items not claimed. The audit has informed the two practices about their current ways of working but has not yet been made available to benefit anticipatory care more widely.

PSC's strengths include its existing trusted role and expertise in health care. Further, skills built through CC project activities increased PSC's capacity to respond when the COVID-19 pandemic hit. However, as a part of the anticipatory care system PSC's strengths are undermined by:

- uncertainty and reluctance across several parts of the AC system, including among GPs, about the significant role played by the social determinants of health and how these impact on people's capacity or motivation to act to improve their health. This may also reflect varying levels of understanding, or a sense of powerlessness to shift these larger structural forces. Consequently, effort remains focused on changing individual behaviours without parallel effort to change the broader structural forces affecting health and wellbeing (see Box)
- a dominant narrative that people need to take more personal responsibility for their health

- a need to pay greater attention to the soft infrastructure (relationships, knowledge, collaboration) elements of health services provision.

Box: How do the social determinants shape health and encounters with the health system?

The SDoH can be evident not only in a person's risks for developing disease, but also in whether or how they will use health services or respond to health advice. Across the project sites, we heard health service providers comment on the 'did not attend' statistics, and on people not acting on advice to reduce health-harming behaviours like smoking. While some understood that there were other factors involved, in several interviews, the provider blamed 'non-compliance':

> *Well yeah, it's abstaining from responsibility. I've noticed it's, "I've just got this, I can't help it, it's just the way I am." […] "Oh well, you can't enjoy life if you can't have a drink," or, "I'd love to give up smoking, but it's only six a day." That sort of thing. It's easy to come up with throwaway lines. […] It's got to be challenged, and if you don't visit your [health provider] very often, then you're not going to get challenged. And then, "Oh, that [provider], […] he was real rude to me. Told me I was overweight."*

There is evidence that stressors related to disadvantage make it hard to manage appointments (Campbell et al., 2015), be ready and confident to discuss a health matter, or take action like giving up smoking (Lawlor et al., 2003). Stressors include poverty, poor transport or literacy, mental ill-health or other chronic condition, or the need to juggle the demands of seeking work, getting children to school, or working several poorly-paid jobs (C. Martin et al., 2005).

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?

The CC team's focus was on trialling proof of concept activities, as a precursor to test what works or has potential. With that proviso, we learnt that some business models are preventing equality of access to the AC system. This includes models operating for GP and other health services. Business models and KPIs need to include the externalities of service provision. For example, an accessible, affordable local GP clinic not only supports acute and long-term health, but also has economic and social benefits for small communities—contributing to local identity, safety, and sense of place. GP services remain hard to access for too many residents in the CC area. We also learnt that:

- AC is best viewed through a social determinants of health (SDoH) lens. This approach is not yet fully embraced by some GPs and people in the broader community, and there are policy and attitudinal barriers that constrain how GPs respond to the SDoH
- Project gains were supported by:
  - the provision of dedicated, AC focused resources within the lead organisations: the PSOs
  - listening to community members, and acting on what has been heard (e.g., through the research and through information hubs)

    - active engagement and ongoing communication about the project with services and residents, through the project lead (Judi Walker) and the PSOs
    - an engaged Community Reference Group, who had or built connections with important players in the anticipatory care system, supporting sustainable change.
- Barriers to improvement of the system are at local, State, and national levels:
    - key performance indicators and business models that do not factor in externalities, soft infrastructure measures, and experiential data and therefore cannot effectively support equitable access to health
    - local historical stigmatising attitudes to some parts of the community reduce external and internal opportunities to change
    - some local, state and national policy settings reduce options for 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 continuing poor distribution of necessary services (e.g., the continuing lack of adequate, local and financially accessible mental health services).

Summary

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

- very early and careful engagement by GPs with other parts of community that they may not previously have recognised as being part of the AC system
- connections and networks with other service providers and with the community
- effective communication through these connections/networks to share AC knowledge
- a more widespread understanding of the nature and makeup of the anticipatory care system, and embracing of the role of elements not traditionally associated with medical models of health
- adaptability of lead organisation to new circumstances.

Recommendations

The AC project has demonstrated that enhancing the anticipatory care system is possible at the local level, through Connecting Care 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.

For local action

There are opportunities to maintain and build on what has been gained.

The Connecting Care initiatives

- Build on the individual, service, community, and AC system benefits from the CC proof-of-concept projects through the Roundtable initiative
    - This includes bolstering collective responsibility for AC

- Increase the focus on mental health and young people
- Invest in building volunteer numbers, capacity (including access to accurate information, and soft infrastructure skills) and reach to socially isolated people will enhance the AC system in the 7315 area
- Continue the Right Place model of building health literacy, communication, and relationship skills among providers to support early intervention and appropriate referrals (e.g., pharmacists, community health connectors, carers)
- Maintain the CRG working groups as needed and find means to support them to include a greater diversity of community members

Business models and key performance indicators (KPIs) have historically ignored qualitative measures of 'soft infrastructure' and change in favour of quantitative 'number of service' measures. These cannot adequately reveal how services in the AC (or broader health and wellbeing) system are performing.

- Review KPIs for the Roundtable to reflect externalities, soft infrastructure and experiential dimensions of performance

The Tasmanian AC project overall has demonstrated that there needs to be dedicated effort and resourcing to effect change in local AC systems:

- Establish a role, roles or approaches to support and enhance the AC system including through:
    - physical activity, social connection and information sharing initiatives (e.g., Information Hubs, maintenance of the Resource Directory, supporting Roundtable actions, and outreach)
    - relationships with existing and new service providers and researchers to strengthen coordinated approaches to improve health and wellbeing across the Connecting Care area
    - innovation to address AC needs.

For PSC processes

Partnerships and collaboration across the system are essential. The PSC is a leader in health in the local and regional community, and has a central role in building and sustaining collaboration across this community and shifting attitudes to support AC. PSC can:

- Review KPIs in PSC to reflect externalities, soft infrastructure, and experiential dimensions of performance
- Review bulk billing policies and make public its bulk-billing policy and guidelines
- Mentor medical students on placement to investigate ways to enhance the anticipatory care system and chronic illness prevention
- Share evidence and local GP knowledge to support anticipatory care, including the findings of the GP audit to support better clinical management of chronic illness across Tasmania

- GPs continue to use the CC portal for health promotion messages
- Model outreach and collaboration to other local service providers as key tasks for all service providers working across the municipality
- Lobby for policy-level recognition of the SDoH factors affecting the community and continue to advocate for better provision of GP and other health services locally.

For local, State and national policy action

All levels of government have roles to play in efforts to alleviate chronic illness.[1] 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:

- Recognise that GPs play a central role in local AC systems, but that their capacity is significantly impacted upon by current business models and policies governing the ways in which GPs operate. Policy makers (in government and in GP and health provider peak bodies) need to:
    - Review and rewrite policy to remove barriers to health providers playing a more beneficial part in anticipatory care
- Local, State, and federal health initiatives need to develop KPIs that reflect externalities, local context and soft infrastructure, including relationships and experiential dimensions of performance
- KPIs need to factor in the need for specific service provision to address the problem of equity; resources and actions need to target resources to those most in need
- KPIs should specifically target the issue of equity; resources and actions need to be targeted to those most in need
- Factor the importance of place and belonging into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision, town planning, and social housing

Current, competitive 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 consider the adoption of the adoption of relational approaches to contract management and community-level or place-based budgets where resources are pooled and invested to promote long term health and wellbeing
- Funders to work as partners, providing guidance and monitoring of process (e.g., community engagement, how resources being utilised/targeted, without being prescriptive)

[1] These roles will be explored more fully in the final report.

- To trust local communities to identify their own priorities and strategies to address those priorities

GPs' role in the AC system can be better supported if they adopt clear, transparent information and easily understandable guidelines explaining their bulk-billing policy and practices:

- Continue bulk billed telehealth services, subject to evidence that this is improving access to GPs for members of marginalised communities who may also have poor internet and telephone resources
- Review national and state regulation of GP services to counter supply shortages
- Review national and state regulation of GP services to increase equity of access to bulk-billed telehealth (e.g., the recent guideline that only people who have a regular GP can use bulk billed telehealth reduces access to this service for many who do not have a 'regular' GP)[2]
- Review subsidies for rural and remote GPs to do outreach and education, with the aim of better supporting and evaluating effectiveness and reach
- Review subsidies for GPs servicing rural and remote areas to include outlying and disadvantaged communities.

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 co-design community specific responses. Assessing the longer-term health dividends is beyond the scope of the study:

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

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 team and community, and to adapt processes and tools for maximising participation
- 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 like researchers or members of the local site team), and thus support both genuine participation and local solutions.

[2] Many people in areas with poor supply of GPs are not on a GP's 'books' and so may be excluded from bulk billed telehealth.

Working together, the members of a community can enhance the anticipatory care system, but there are clear benefits from the direct research experience and evidence from the involvement of UTAS and the Department of Health. Building more effective and inclusive AC systems requires:

- Independent research support for evidence-based planning and action learning, systems thinking, ongoing reflection and review (i.e., university support)
- Policy and contracting support and management, and access to resources and information (i.e., DoH support)
- Community-based support for the identification and driving of change based on local needs and ways of working.

The contributions made by each group are particular and cannot be 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.

Partnering for health: The Anticipatory Care Action Learning Project Final site report, Ulverstone's Connecting Care

> 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). These rates are increasing. In 2017–18, there were 15,848 potentially preventable hospitalisations (PPHs) for chronic conditions in Tasmania (49.8%0 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)

Anticipatory care involves health services and individuals (C. M. Martin, Sturmberg, Stockman, Hinkley, & Campbell, 2019), but the risk of developing a chronic illness is also

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)

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 care[3] (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 Tasmanian 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. 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?

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

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. In the 7315 postcode area, the lead organisation is the Patrick Street (medical) Clinic, , and the local research question is:

Help to Health RQ	What role can a GP clinic play 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 there is a spread of selected 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 supports 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 Connecting Care site

The Connecting Care site takes in the town of Ulverstone and the surrounding 7315 postcode area (see Appendix 1). The project's lead organisation is the Patrick Street Clinic (PSC).

The table below (Table 1) sets out some characteristics of the site. It shows overall statistics for the 7315 postcode area, and for Tasmania. People here are experiencing the social determinants of health very differently: the median income across the 7315 postcode area is

lower than for Tasmanians overall, and about twice as many people are Aboriginal, though both these characteristics are unevenly spread. You can read a more detailed community profile in the 2019 report (Appendix 4).

Table 1: Who lives in the 7315 postcode area

	7315 postcode area	Ulverstone only	Tasmania
People	14,658	6,465	509,965
Age	47	47	42
Aboriginal	7.55%	7.5%	4.60%
LOTE*	92.9%	92.2%	88.3%
Income**	$956	$878	$1,100
Living in rented accommodation	25.7%	28.2%	27.3%
Highest level of education, Bachelor degree or above	10.8%	10.2%	16.2%
Highest level of education, Yr 10	21.1%	20.4%	17.4%
Home internet	72.9%	69.1%	78.0%
No car	6.3%	8.5%	6.90%
In full-time work	51.3%	50.1%	52.3%
Not in paid work***	7.3%	7.8%	6.9%
Voluntary work	23.1%	23.5%	21.30%

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

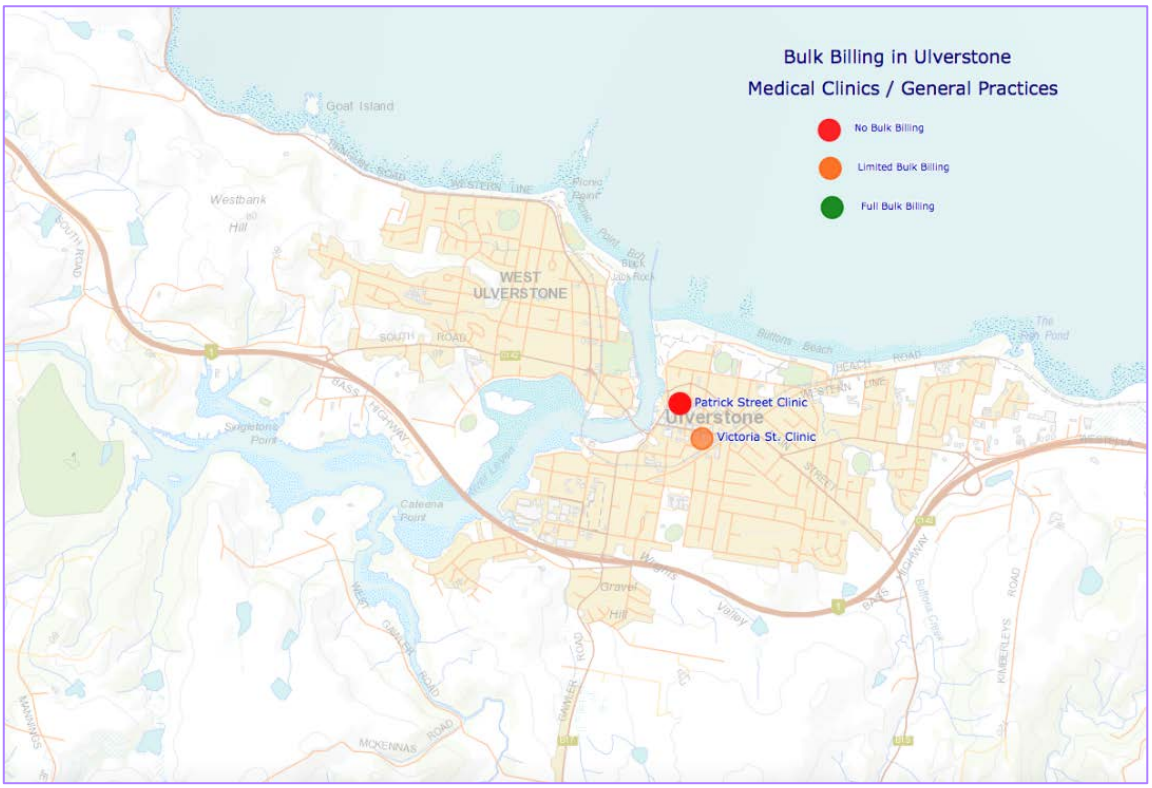


Figure 1: GP clinics and bulk billing, 7315 postcode area, January 2019

Maps generated 08012019 https://maps.thelist.tas.gov.au/listmap/app/list/map?bookmarkId=342082
LandTasmania

We gathered information about the location of GPs in the Connecting Care site (Figure 1). The maps show that GP clinics are located in the central business area of Ulverstone (though there are also clinics at Penguin, 12.8 kilometres from Ulverstone). This hub is distant from some parts of the 7315 area. No GP clinic offers full bulk billing and one offers 'limited' bulk billing.[4] The COVID-19 pandemic has affected bulk billing and promoted telemedicine consultations; this makes assessing the current situation complex. We do not yet know whether bulk-billed telehealth consultations are being used by the most disadvantaged people in the community.

Access to several of the social determinants of health vary across the 7315 area; these include income, education, secure housing, employment, and access to health services (including bulk-billing health services).[5] We do know that people in this area drink less alcohol and smoke less than Tasmanians overall, and that they are more likely to be overweight (PHT data). Ulverstone has high (about twice as many) potentially preventable hospitalisations as the state overall. For instance, the Burnie–Ulverstone area is one of four parts of Tasmania with the highest rate of anxiolytic prescription, signalling that mental illness is prevalent, and there is a slightly higher proportion of people with three or more chronic conditions (Ahmed et al., 2017b) (and see Figure 2).

Box: How do the social determinants shape health and encounters with the health system?

The SDoH can be evident not only in a person's risks for developing disease, but also in whether or how they will use health services or respond to health advice. Across the project sites, we heard health service providers comment on the 'did not attend' statistics, and on people not acting on advice to reduce health-harming behaviours like smoking. While some understood that there were other factors involved, in several interviews, the provider blamed 'non-compliance':

> *Well yeah, it's abstaining from responsibility. I've noticed it's, "I've just got this, I can't help it, it's just the way I am." […] "Oh well, you can't enjoy life if you can't have a drink," or, "I'd love to give up smoking, but it's only six a day." That sort of thing. It's easy to come up with throwaway lines. […] It's got to be challenged, and if you don't visit your [health provider] very often, then you're not going to get challenged. And then, "Oh, that [provider], […] he was real rude to me. Told me I was overweight."*

There is evidence that stressors related to disadvantage make it hard to manage appointments (Campbell, Millard, McCartney, & McCullough, 2015), be ready and confident to discuss a health matter, or take action like giving up smoking (Lawlor, Frankel, Shaw, Ebrahim, & Davey Smith, 2003). Stressors include poverty, poor transport or literacy, mental ill-health or other chronic condition, or the need to juggle the demands of seeking work, getting children to school, or working several poorly-paid jobs (C. Martin, Perfect, &

[4] Bulk billing information for the map was gathered as if by a potential patient, using clinic internet sites, and phone calls, in early 2019. The AC project has evidence that being unsure about whether one will be bulk billed is a barrier to access.

[5] Data for the 7315 area overall was not available.

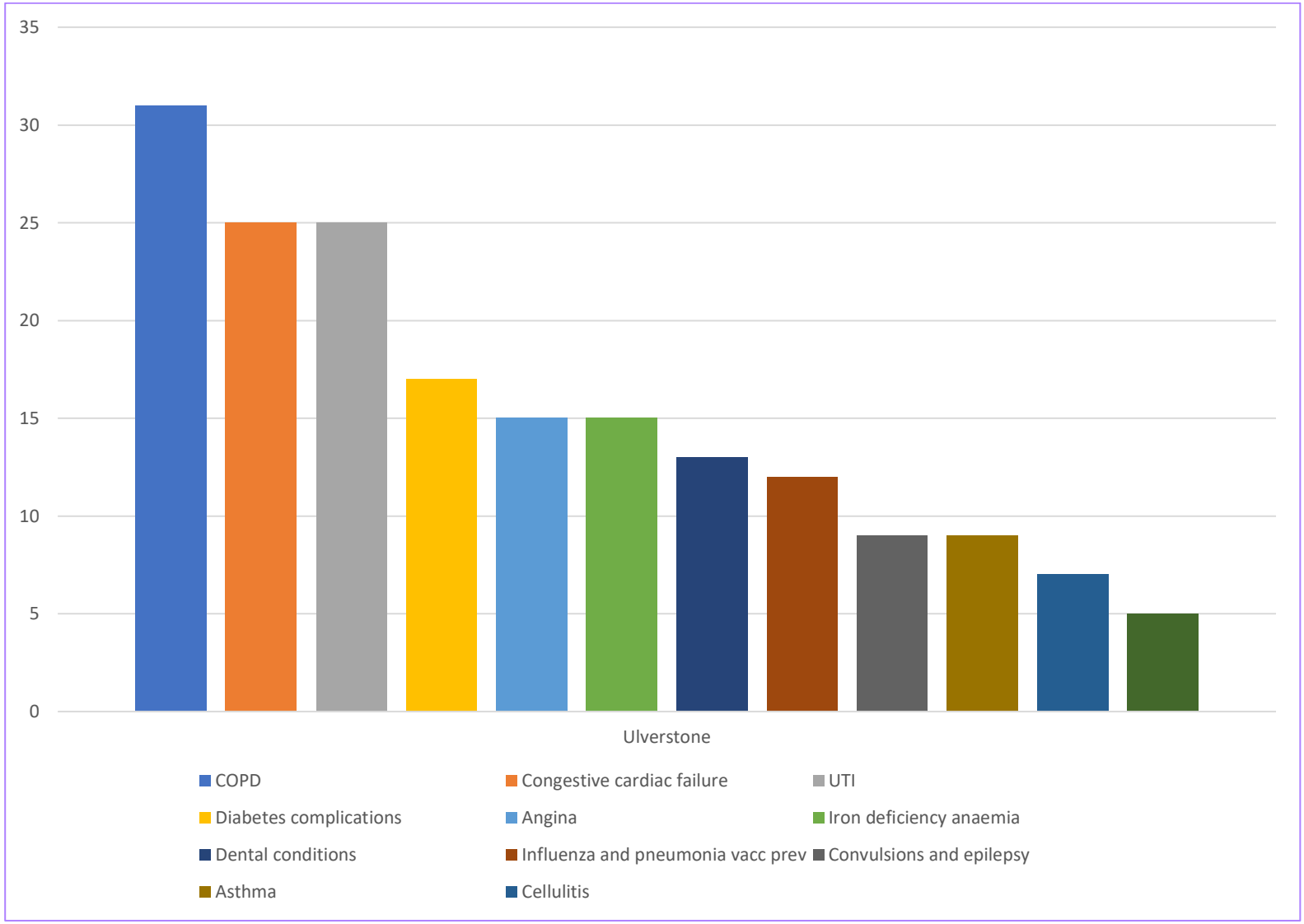


Figure 2: Potentially Preventable Hospitalisations 2017-18, Ulverstone

People in the 7315 postcode area are almost twice as likely to be admitted to hospital for things that could have been prevented (PPHs) (Table 2) than are Tasmanians overall. The three most common reasons for these PPH were chronic obstructive pulmonary disease, congestive cardiac failure and urinary tract infections. These conditions are at least partly associated with increasing age.

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 west report slightly poorer health than Tasmanians overall (Table 2).

Table 2: Self-reported health in 2019. Southern Tasmania and Tasmania overall

	North West, overall	*Tasmanians (aged 18 and over)*
Excellent/very good	36.2%	37%
Good	40.8%	41.1%
Fair/poor	22.9%	21.7%

Source: Department of Health and Human Services (2020)

Methodology—why we did what we did

Action learning + Systems thinking (and tools)

Figure 3: The preliminary system parts

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.

The CCWG developed a preliminary Anticipatory Care Framework (see Appendix 4, page 21) (Healthy Tasmania Chronic Conditions Working Group, 2018). Working with TAPPC and Dr Riley, and informed by the WHO building blocks of health systems (World Health Organization (WHO), 2010), UTAS used this framework to identify six likely system parts (Figure 3). The parts are 'people and health', 'infrastructure', 'local health and service data and information', 'attitudes and actions', 'local leadership for health', and 'relationships, networks and partnerships'.

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 4) 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 or affect one another, and to learn about and adjust actions.

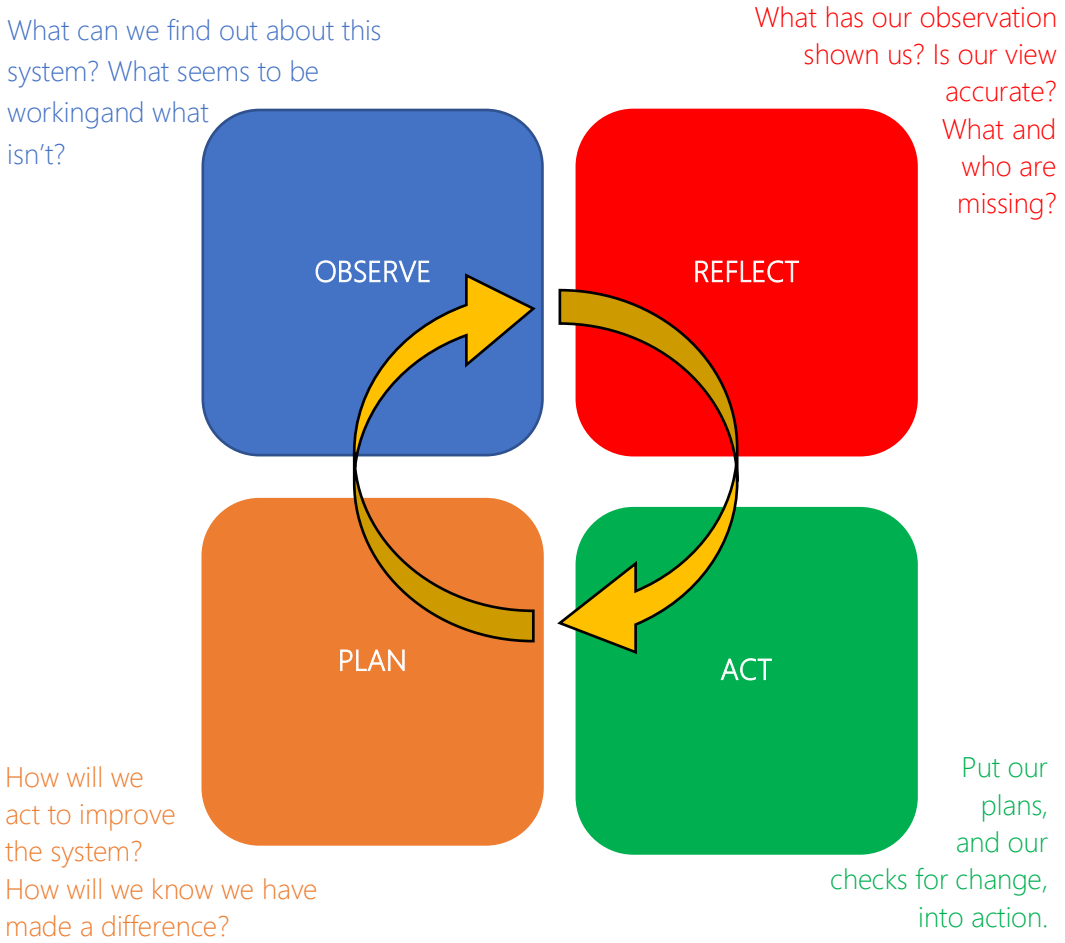


Figure 4: The action learning cycle

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. Williams & R. 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 in or out of 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 considered more or less important in determining the nature and extent of anticipatory care (see B. T. Williams & R. Hummelbunner, 2010). These ideas remind us that complex systems are dynamic, changing 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, re-flective 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 answers

The site's lead agency is Patrick Street Clinic (PSC). PSC employed Professor Judi Walker to lead the project. Each site was contracted to employ project support officers, whose role was to work with UTAS in the research, and to support local project activities. In the Connecting Care site, this role was somewhat distributed: the lead organisation initially gave some PSO work to an existing PSC employee and to two UTAS researchers, separate from the AC

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

research team. Towards the end of 2019, the initial PSO moved to another role, and a medical student (on leave from his studies) came into the team. Unlike the other sites, the CC team also employed two UTAS Rural Clinical School researchers to do particular tasks: data project management, and auditing. These researchers had no direct engagement with the UTAS AC team.

Connecting Care created Community Reference Group (CRG), made up of local residents and representatives from services working in the area; for the AC project, they were joined by the UTAS lead, a UTAS researcher, and the DoH Principal Project Officer. The CRG has met regularly over the life of the project. There are also working groups focused on specific activities in the CC project. The lead, PSOs, and CRG members are the CC 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.

O 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 'observe' stage, we looked for a wide range of information, so as to include different perspectives. We used census data (Australian Bureau of Statistics, 2016), 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 a series of narrated videos, and shared at a community workshop (CC held a workshop on 1st April 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 refection 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, 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 the LG). The LG 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 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?
- 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 the Leadership Group. 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 5). The 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 5: Linking the system parts

The Connecting Care lead, guided by the CRG and causal loop work, made an action plan (see Appendix 7). The action plan[7] 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 impact upon), 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?

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

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.

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

Planned actions were agreed to by CRG 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, it was intended that PSOs, the CRG and leads reviewed progress, using the observe, reflect, plan and act process. Regular meetings between the leads, PSOs, UTAS researchers, DoH Principal Project Officer and CRG 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.

Project structure and roles

The project structure, roles and relationships are given in Appendix 4 (page 18).

Local activities

Some AC project statistics for the CC site

CC and research activities:

Data gathering and sharing activities	250+ people
Health literacy training	25 people
Engagement with information hubs	6 sessions (e.g., 'Pit Stop', 101 participants, Step-up Program, 8 participants)
The CRG	22 members, meeting regularly

There are also many participants through public information sharing activities and social media.

All sites took many actions. In Connecting Care, these were formally planned. Activities are discussed in the Results section below and in the report prepared by the Connecting Care team (2020).

R 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 on 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 have also reviewed and revised our thinking in conversations throughout the project with the project lead, the DoH Principal Project Officer, Sax Institute and The Australian Prevention Partnership Centre (TAPPC) researchers and Dr Riley, the CRG 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 the CRG. We also delivered short presentations about the data and about the processes to the CRG across the project period.

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

[8] There are also arguments that researchers should trust "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.

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:

- GP audit of chronic illness management in PSC and VSC
- Survey data
- Thematic analysis: Interviews, fieldnotes, focus groups, reflections, and observations
- Systems work and causal loop analysis
- Project processes

A description of the data gathered is provided at Appendix 3. We reported on our use of health statistics and previous research (secondary data) in 2019 (Appendix 4). That material showed that people living in some parts of the Connecting Care area have higher rates of chronic illness, and potentially preventable hospitalisations than Tasmanians overall.

Context: GPs in anticipatory care

GP clinics have historically been understood as central to anticipatory care. The UK anticipatory care model is built on 'routine encounters' characterised by trust and established relationship, a non-fragmented health and social care system, and equitable access to a range of services (Watt et al., 2011). This model, while showing benefits (Kennedy, Harbison, Mahoney, Jarvis, & Veitch, 2011; Newbould et al., 2012; Watt, 2011, 2012) is not without problems, including that patients might not like care planning and might treat the GP as a site only for acute care. Other barriers identified in the literature include misunderstandings and ambiguity about boundaries around particular roles in the AC system; these make developing effective relationships across the system challenging. These difficulties are exacerbated by the complexity of some people's healthcare needs and by the time demands of planning and management (Kennedy et al., 2011; Robbins, Gordon, Dyas, Logan, & Gladman, 2013). Importantly, "Successful programmes require joint working and shared leadership to provide the necessary combination of coverage, continuity, flexibility and co-ordination" (Watt et al., 2011, p. 9).

The principle of the UK's National Health Service is that health care is provided based on need, and not on the ability to pay. That means that as well as GP services being provided without cost to the patient, so are mental health services, some dentistry, physiotherapy and

other allied health, and some tests and scans. And in some places, social prescribing (doctors prescribing gardening or some other social and physical activity: Brandling & House, 2009; Drinkwater, Wildman, & Moffatt, 2019) is developing, although the evidence remains slight (Bickerdike, Booth, Wilson, Farley, & Wright, 2017). Social prescribing relies on a willingness to embrace the role of the social determinants of health, and to resource and support general practice to do that.

Comprehensive audit of anticipatory care at Patrick Street and Victoria Street GP Clinics

The CC team conducted an audit in the Patrick Street and Victoria Street clinics. The audit investigated the two clinics' management of chronic diseases, including using national benchmarks for comparison. The audit has been reported as finding that "both clinics are demonstrating high levels of care for patients with chronic conditions" (Connecting Care, 2020, Phase 3 outcomes). Detailed results have been shared with the participating clinics, but the data and findings, have yet to be made to the UTAS team or the DoH.

Survey results

Survey responses told us about how participants think about health, what elements in the system they use, and what gets in the way.

We designed the survey to learn about other perspectives of the system and what boundaries and interrelationships may be shaping it. 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. The revised form was interviewer-administered in each AC project site by the local PSOs and a member of the research team.

One hundred and forty-six people completed the survey in the Connecting Care site 2019. This is a good-sized sample, though it is not representative: participants were older and more likely to be female than is true for the whole 7315 postcode area. It is also likely to reflect that at least some of the surveying was done in a GP clinic. The PSO also went out into the community to recruit possible participants, and this had other benefits. The PSOs and researcher were able to meet people in many settings, get a sense of what is available in various parts of the 7315 area, and of how people use their community. This outreach has been valuable for building an understanding of the community and the health system across this diverse site and for connecting with a wider range of community members. The results of the Connecting Care survey are reported in full at Appendix 6. Although the survey

sample is not representative, the themes present in the responses are supported by other data gathered.

Main findings from the Connecting Care survey

We asked people general questions about health and how they understood it. We needed to include all sorts of perspectives—what language people use, who thinks in what ways—so we could understand the AC system. We wanted to be as inclusive as possible of the ways people think about health, rather than asking only about medical or clinical health. People mostly defined 'being healthy' in non-medical terms. The overwhelming theme here was 'being able— able to move freely, live a normal life, do the things the person wants to do, and so on. Almost half the respondents included mental health in their response, for example, "*Being balanced in my mind, my body, my mental health and my spirituality*". This is a higher proportion than for the other sites in the project and was much more likely to be mentioned by women than men.

Three-quarters of respondents wanted to change something about their health, with getting fitter or building strength being the largest single focus. A smaller proportion wanted to be free of an existing condition, and/or lose weight.

We also asked people how they would rate their health. Self-reported health has been found to be a reliable measure, including predicting a person's likelihood of becoming ill (Miilunpalo et al., 1997). Slightly more than 63 per cent of the participants rated their health as 'excellent' or 'good'. This is a poorer result than has been reported by Tasmanians overall. In 2019, 78 per cent of Tasmanians, and 77 per cent of people in the State's north west, self-reported their health as 'excellent' or 'good' (Department of Health and Human Services (DHHS), 2020). There appears to be no relationship in the data between age and self-reported health.

Talking about health

We asked participants "Who do you talk to about your health? (your 'go to' person)", Most people said they spoke to family members (usually spouse/partner or children), and to health professionals (most frequently GPs/doctors, pharmacists, physiotherapists, and mental health professionals). Many people also spoke to friends, including about a third of people who had friends with health roles.

Health supports

We asked people about their social, physical, and 'medical' or clinical supports for health. Nineteen people (13%) did not report doing anything for their social health, twenty did no physical activity (13.7%), and twenty-six (17.8%) did not seek medical support for their health. The most common social activities involved food: visiting cafes or eating out with friends. Walking (including dog walking and bushwalking) was the most common physical activity. More than a quarter said they were doing three or more regular physical activities (Figure 6).

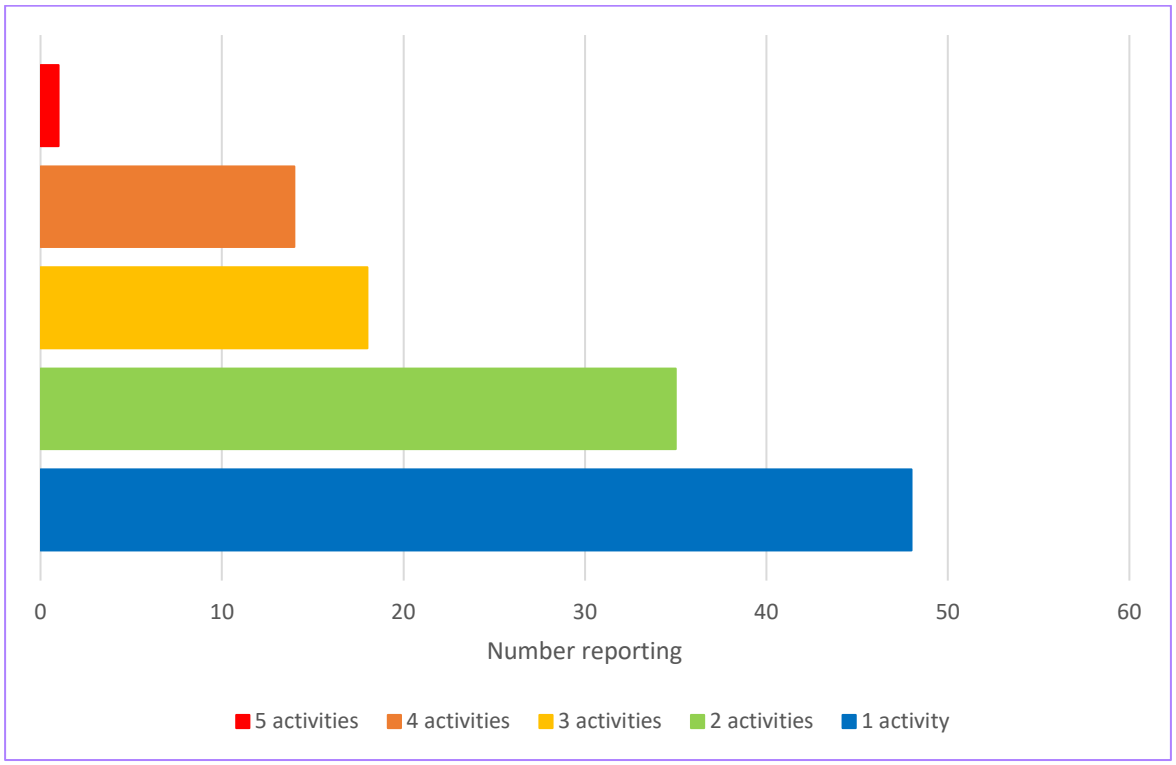


Figure 6: Number of physical activities reported by respondents

Most of those who sought medical support went to a GP. Figure 7 shows where people sought clinical health support. About a third of respondents visited two or more health professionals, and the remainder listed only one.

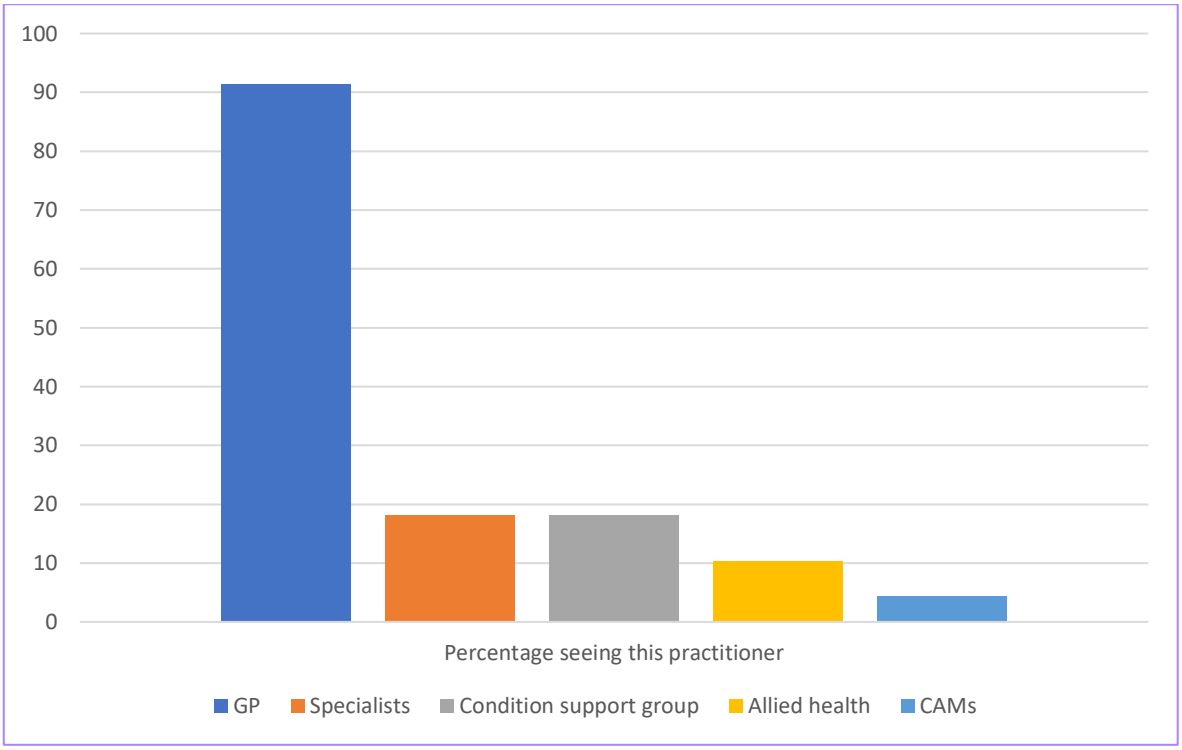


Figure 7: Where respondents go for clinical support

Barriers to maintaining your health

Participants were asked about things that get in the way of them maintaining their health. While cost was a significant barrier (in all sites), lacking motivation was slightly more important here. A lack of confidence was also prominent, and the written comments underlined that for some people who were socially isolated, trying something new, alone, was daunting. We compared the barriers reported by people across the four project sites (Figure 8).

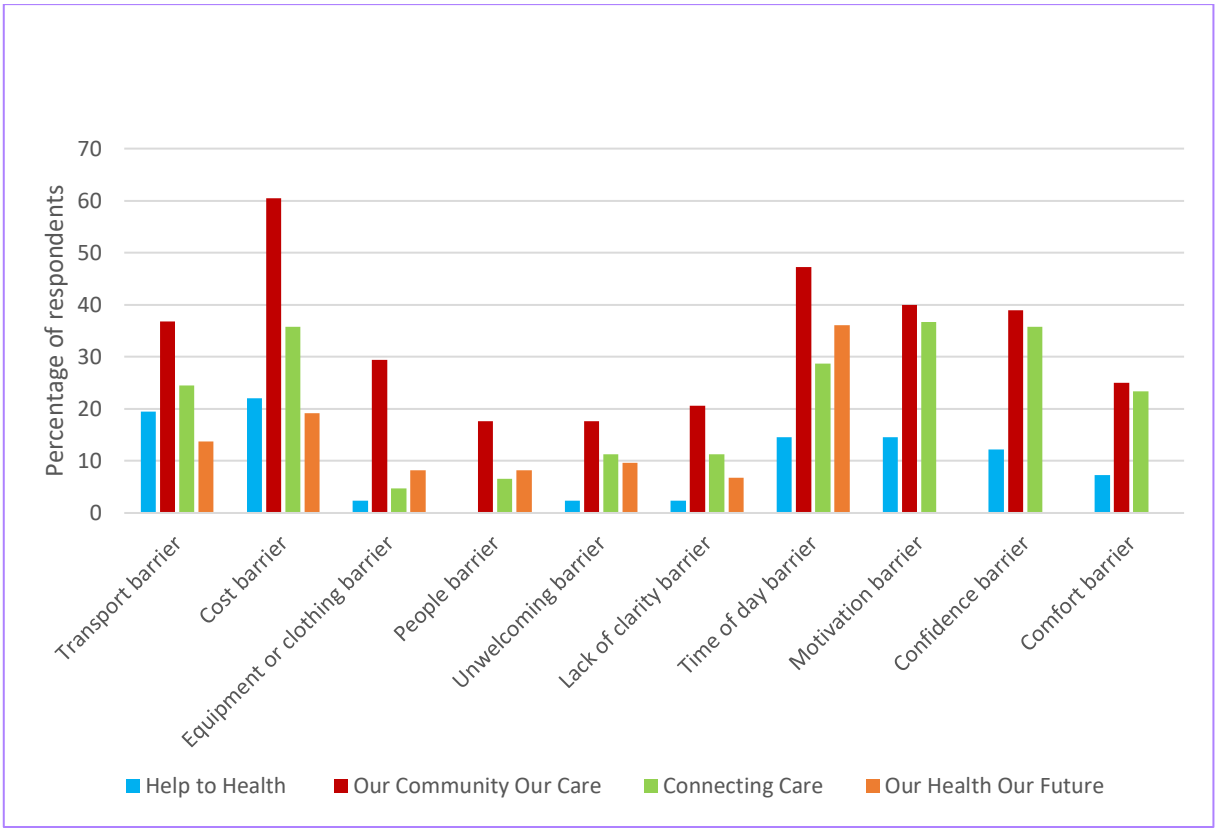


Figure 8: Barriers to using health supports across the four Tasmanian AC sites

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

The data gathered information on Ulverstone and surrounds residents' experience with the health care system, and their reflections on barriers and enablers to an Anticipatory Care (AC) system to improve health outcomes. Five themes were identified from this process: beliefs and attitudes, silos, resources, leadership and mental illness.

Some of the main findings are:

- Good relationships are perhaps the most vital ingredient for almost all the elements of the AC system. One prominent example is that disadvantaged people who often have problematic experiences with the health and other interconnected systems. They tend to experience ongoing unequal access to resources which contribute to poorer health outcomes. Stigma can increase social isolation and prevent people from seeking help.
- Participants report that they experience challenges in accessing medical health services. General Practitioners (GPs) are generally well respected and are the first point of contact for many people when they have health issues but are commonly time poor. The expense of specialist care, for example via hospital and specialist consultations, is compounded by reduced local options. These barriers could be significantly reduced if we built capacity for at home care and community care.
- There are many, somewhat disparate, community projects, which appear to be particularly effective in, for example, reducing isolation, but in general they lack sufficient resources to achieve greater scale and reach more people who need assistance.
- Mental ill health was identified as a particular problem in this community, for which social isolation can be both a contributor and a result. Many people do not seek help for mental health issues, particularly when they are not able to identify they have problems in this area.

Beliefs and attitudes

Beliefs and attitudes are arguably central to the effectiveness (or failing) of the Anticipatory Care system. Beliefs and attitudes shape how policy is formed (including within organisations), how services are delivered, and how community members respond to services. That individuals should take responsibility for their health is a strong theme in the Connecting Care data:

> *… there's this view amongst the local population that the doctor is God, and is responsible for finding a miracle cure that will be taken once a day with breakfast. And if the doctor can't do that, and they don't have a good enough bedside manner, then they'll change doctor. […]*
>
> ***Q:** So just a basic lack of responsibility for people's own health?*
>
> *Well yeah, it's abstaining from responsibility.*

One participant told us about several unsatisfactory interactions with the health system that had been resolved when they took the initiative:

> *… the system's assuming that we were poor, and we'd wait for a government-supplied [treatment]. […] And that was a lesson to me that look, just find a way. But our group thinking here is, "Oh well, it's on the government to give us the tablet or the thing." Well, actually take responsibility for yourself. Find it. So, we do have attitudinal failures.*

This understanding, of 'attitudinal failures', relies on the presumption that people have the individual capacities needed to act. But, as the survey data also showed, several barriers are structural; systems and services that are hard to navigate or understand, and a lack of transport or financial resources are compounded by complex lives, and a lack of confidence

or motivation, resulting in some people being unable to get help or use health resources. These challenges mean that people's focus may not be on advice received, something that we hear affects both use of prescription medications, and social prescribing:

> *I think with social prescribing the risk is that I see them ...[to] talk to them about the cardiovascular risk... maybe I tell them you need to join a walking group ... then they joined the walking group and then something else happens and their daughter gets sick and another crisis takes over and they forget the crisis that happen in the doctors... surgery.*

Further, service providers' attitudes are very important to the effectiveness of the AC system; they can support engagement or make it difficult:

> *it's a lot of body language too, yes. I mean, we are all... different. Some nurses ... even if they're not interested in what they're doing to me, they should at least pretend to show compassion ... calm the patient down ... because you're frightened. And you want somebody to be just standing there talking to you in plain English and you feel that you can talk to them. ... the whole kit and caboodle to me comes down to the human race. How we handle ourselves and how we handle other people ... communication [is] top of the tree.*

Beliefs and attitudes contribute to (and are shaped by) the impacts of other themes in the data—resources, fragmentation, leadership and mental illness.

Resources

People spoke about several sorts of resources that were shaping the AC system and their role in it or access to it. For example, having a positive belief in one's own self-efficacy, and that of others and the system in general might underpin the ability to mobilise an array of resources. We have categorised resources as personal, inter-personal, information and infrastructure.

Personal resources

People and their characteristics (including beliefs and attitudes) tend to be the most important resource for the Anticipatory Care system, since this system is all about people—what people can do for themselves, what people can do for each other, and what resources can be generated by the actions of people (in both formal and informal roles). Particularly where institutional resources are limited, mobilising resources from the community is important.

The lack of confidence or motivation (two personal resources), mentioned above, are exacerbated by a lack of resources and by poverty. Many people living in poverty are also affected by the other social determinants of health (poor quality housing and food, lack of education, un- or under-employment, etc., Marmot, 2005; Marmot & Allen, 2014; World Health Organization (WHO), n.d.). These factors effectively marginalise people from the systems that keep other people well, placing them at greater risk of illness and making them 'hard to reach'.

> *we've got some patients we've identified who are just little isolated pockets in the community and don't have the capacity to reach out and ask for things themselves*

Poverty was shaping people's health behaviours:

> *I mean I need constant painkillers. I need constant—like with diabetes medication, insulin and stuff. And they're talking about, we're going to have to start paying for all our—like top price for our medications. It does put an impact on us because we're only pensioners. And we're trying to help our grandkids as well, and we just can't do it all.*

> *The system as it is now, if you go and see your GP, generally, if you've got a healthcare card or a pension card you get bulkbilled, and that's good, at a lot of clinics. At some clinics they don't, you have to go and pay and claim the gap back afterwards anyway, which also makes the process more traumatic for people, because they really will be waiting on that rebate, for when it goes into the bank.*

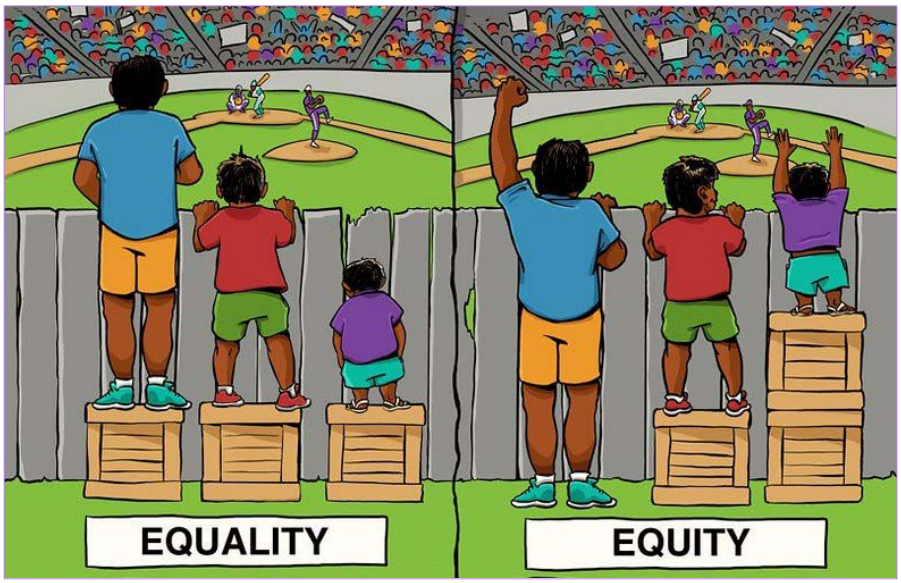


Illustration 1: The difference between equality and equity (creative commons image)

The system was seen as inequitable (Illustration 1):

> *I think a good health system shouldn't ensure that everybody pays the same amount of money, but that the service equally accessible to everybody. The example picture would be three kids looking over a fence watching a sporting match. They're all different heights and they all have different sized boxes to see over the fence. That then is equity, not equality.*

Making access to preventive health very difficult for already marginalised and at-risk groups:

> *... if you can afford to go and visit a dentist or you've got private health insurance, you will have better teeth than somebody that doesn't. I mean, that's just a fact. The same*

> *with a lot of the preventative health things, somebody might have identified they've got high cholesterol, they might have been to the GP and attended as a bulk-billed patient, had a test to say their cholesterol's seven. Get a script, go to the pharmacy, they might take that for a couple of months, it doesn't make them feel better, in fact, in some cases it can make them feel worse. They decide they don't want to continue with the therapy because there's nothing really in it for them. If you weren't on some sort of benefit, that would cost you between $20 and $40 a month. For some people, that's not as affordable as it sounds.*

When poverty is combined with low literacy, shame becomes an important factor, and people's confidence to seek help is reduced:

> *…the patient's embarrassed, they haven't got the money, they're not going to buy. For them, it's not a good experience, they're not going to associate that with a good experience and they may not come back and seek more information or what they can do about it…*

Low literacy was repeatedly identified as a particular problem:

> *I suppose maybe people with low literacy, or lack of technical knowhow, I could see definitely not being reached …*

And a source of some confusion:

> *I don't like popping pills. So if I go home, I read the side effects, I don't take them. They said, "Well not everyone has the side effects that what's on the piece of paper". So you stop reading the side effects and take the medication.*

The barriers put up by poverty and low literacy may be exacerbated by processes in which information sharing does not take account of individual capacity to take in the information, such as dealing with pain or complex needs:

> *I really can't comprehend what they were trying to tell me.*
>
> *Q: Is it the way that they—is it too complicated?*
>
> *A: Oh no, I think they were good, it's just me. I've always got so many other things on my mind that I can't concentrate. But it wasn't me, because I was talking to another chap that was in the program too, and I said, "Did you understand what was spoken to or about the program?" He said, "nope".*

Some service providers were aware of this barrier:

> *It's not just—you try and be approachable and non-judgemental. I think that's a fine line sometimes between alienating somebody. But once people get defensive about something, they tend not to listen. Even if it's technically the correct thing to say, there's ways of delivering things to people in a form that they'll listen and understand, and perhaps make that useful for them.*

Inter-personal resources and social capital: Relationships

"Social capital" (Hunter, Neiger, & West, 2011), or relationships of goodwill and trust between people is a very important resource for health. Health is more than physical, as the interview, focus group and survey responses underline:

> *I really think that a healthy community shares social events and builds that sense of connectedness. And I think that's what's missing a lot in our communities nowadays. I think there used to be a real sense of neighbourhood, but I don't know that we have that anymore... I think people feel a bit more isolated ...*

> *Like, having a healthy family, something like that. And community, like that can be part of staying healthy and yeah, different sporting ...Socially as well...Yeah, social, yeah.*

> *I think if you stay home and you don't go out anywhere, and you don't have any visitors, you become worse and you've got mental health problems as well, involved there.*

> *I guess I didn't really know much about the support with community members, but coming to the project it was kind of like a hidden a world was open to me, like all these passionate people willing to help out ... not just ... care. But yeah, I guess I couldn't really see that until I was also involved with it, so it surprised me a bit.*

Volunteering is a form of—and boost to—social capital, and the Connecting Care area has fairly high rates of volunteering (23.1%). This was severely affected by restrictions imposed in response to COVID-19, as many volunteers are over the age of 65, an age group at greater risk from the virus. This change, which may be long-term, is likely to have significant consequences in the Central Coast community. Nonetheless, volunteers with caring attitudes and beliefs are a significant resource to support health (both for volunteers and those being supported). Where volunteers are part of service provision, they can help people feel greater trust, increasing the accessibility of a service:

> *I think in some ways, because it's done by volunteers, I think people are a bit more trusting, because they're not being paid to come. They're not doing it because they're going to get money out of it. They're doing it because they're actually interested, and so I think that's one thing. The Ulverstone Neighbourhood House, the team that are there at the moment, have done really well at engaging with the local community.*

But volunteers need to have, or develop, certain qualities; in addition, time is needed to manage this resource:

> *Volunteers are great and come in various capacities ... volunteers take a lot of managing as well. [...] You need quite appropriate volunteers and for something like that can be hard to find. Yeah, you can get quite a few volunteers that are suitable for all sorts of roles, but it's almost harder than hiring an employee to do it.*

Effective health care also relies on trusting relationships between services and community members; this supports both more beneficial interaction, and the important tracking of health over time:

> *all the GPS have access to all the patient notes. So if you can't get in to see your doctor, then you'll see another doctor in the practice who doesn't have to go through and ask you all the same questions again, and I think ... that's really the only way you can anticipate how people are whether or not they're going to ...have a chronic illness ... you've got to look at that the patient history over time.*

Again, time is needed, but is in short supply, to build and sustain this resource:

> *it's just as a GP you have to process so much information in such a short amount of time*

Young people were identified as a group lacking important social and other supports for preventive health; this is significant given that the earlier individuals are supported to adopt healthy habits the more likely they are to maintain them into adulthood:

> *I wouldn't say there's any organised [things to do for youth] ... I can't think of any sort of things in the community that are sort of just our age group. Or even if there was I don't think there would be any that would actually be popular for young people.*

One participant suggested possible means to build this resource:

> *...I think that's part of the engagement process. I think it's connecting with parents who you can connect with first, and then I suppose on the basis of those relationships, engaging with some of the others... there are key people who are ... sort of influencers, ... and being able to connect with those people, and then on the back of those relationships, accessing others. ... it's all about building relationships. Looking at what potential connections there are and latching on to those.*

Infrastructure

Some participants noted that the relationships that underpin anticipatory care at all levels needed to be supported:

> *I don't think there are any robust systems that support anticipatory care. 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.*

In the absence of capacity "to reach out and ask for things", such system-level change could support people to improve their health. This includes changes to the AC system part 'infrastructure'. Infrastructure includes so-called 'hard' infrastructure like buildings and services, the 'soft' infrastructure. of relationships and networks, as well as funding to support the system. Urban and community design is fundamental to good health. Generally, participants think Ulverstone is well serviced in terms of parks, walking and open spaces, but highlighted the need to continue to improve and further develop some networks that would socially support people to participate:

> *we know from other projects that have happened in the world that Community projects that encourage exercise and a good diet work really, really well and so ... designing cities and designing towns that are you know friendly to riding a bike or friendly to pedestrians friendly for public transport. So people aren't needing to use their car to drive from point A to point B, and you know designing spaces where people want to go out and walk and Use the legs it's all just about nudges, isn't it? It's not about telling people you have to do this because we know that that doesn't work but I think if we can design a community and design a lifestyle where we nudge people to do the things that we know is good for them like a healthy plant-based diet and regular physical activity that would do the trick*

Several other system changes to support and improve anticipatory care were identified (e.g., better training for staff, support to expand beneficial programs, care coordination, and more home care but require very different funding arrangements to current models:

> *All of our funding structures are linked to individual service(s)… in this room we've got a huge amount of capacity… for influencing groups in different ways, but to do that it would have to be voluntary activity, like getting into schools, getting into the aged care citizens' club for the afternoon to talk about things, to reach those unreached people. … our system is not modelled [for that].*

> *We have several [staff] who are busting to do group education, but just at the moment there is no way for us to reimburse their time for that.*

> *there were care coordination nurses at a few of the local GP's …and I think that they worked really … some of the GPS really got on board with it … They would be able to go and do home visits and do assessments …then refer to the OTS or whoever needed to have those referrals to make sure people are getting those services that they need at home … that works really well … then the nurses can feed back to the doctors about …what they saw.*

> *…we're trying to get people to live at home for longer so they don't enter aged care, or they don't need hospital admissions. That would be the most pragmatic way of doing that, I would have thought. Whether or not it's them managing that through compliance aids, dosage administration aids from the pharmacy, they get things delivered, they have support services in terms of … shopping and help them cook and that sort of thing. That's certainly a better way than having them admitted to hospital twice a month for the last six months of their life … because you see that so much.*

Information

Information—in the language and places where people can access it—is an essential part of anticipatory care, and a resource that was prominent in the data. Several people spoke of not feeling they had the information they needed:

> *Also, make sure the client understands the condition that he or she has, and what the medications are for. They could also—by coming to the home, they could see these and follow up also about hospital visits that the person might have come from hospital—I know with certain operations, you can get a six-week package or a three-month package, depending. But if you've been to hospital and you need to have tests following, there isn't a quick follow up on how you are.*

Information was missing or was provided in ways that did not meet needs, including because people may be distracted by their condition, or by shame, for instance:

> *From a patient point of view, but how you educate them; I do not have the answer. Except telling them point blank—like if they're leaving, being discharged—tell them this, this, this and this. I am definitely a believer in the old-fashioned way of eyeball to eyeball.*

> *the patient's embarrassed, they haven't got the money, they're not going to buy. For them, it's not a good experience, they're not going to associate that with a good experience, and they may not come back and seek more information or what they can do about it.*

Box: Finding new ways to share information: Festival in the Park

Pop-Up hub at Festival in the Park as part of Pitstop Project
Connecting Care had a stall at Festival in the Park on Sunday 23rd February 2020. This hub shared information about the Directory and about local health services. Three CC health-related videos (Staying Social, Life Lessons and Staying Active) were showing during the day and visitors could take home healthy snacks, branded postcards, and magnets from the stall.

Leaders

Leaders and leadership were prominent themes in the evaluation report (Gleeson, 2020) and local site report (Connecting Care, 2020); it was less prominent in the qualitative data and tended to focus on informal leaders (e.g., people whose own experience of the health system had driven them to create supports). Community organisations are a significant resource, presumably with good leadership:

> *The strengths I suppose are that we're community based. We're a predominantly volunteer organisation and so therefore we have people from within the community being trained up and supported to help other people in the community. So, that's probably one of our strengths. I think another strength is that whilst we're a predominantly volunteer organisation, we have a fairly professional approach. We certainly look at research that's available and plan our activities and interventions around those.*

Change is hard for many people, meaning that formal and informal leadership, and the having a shared vision to unite people is very important for addressing gaps and ineffectiveness in the system. Where financial resources are constrained for paid formal leadership positions, lower cost, often volunteer, and more informal community-based leadership can fill the gap. One version of leadership prominent in the Connecting Care data took the form of supporting people to navigate the system. In several instances, this navigation support did not come from people in formal roles, but from others who had 'found their way', and who were well enough connected in the community to share their knowledge. In the qualitative data, leadership relied heavily on existing relationships or on building new ones. This was described as "a web of connections", driven from the 'grass roots':

> *I know—particularly in health, if they want something to change, don't depend on the ones at the top. Come down to the people that work on the floor and do it that way!*

It was also characterised by an understanding of the need for behaviour change, a task for which effective communication is very important. Effective leaders were seen to adopt behaviours that make them:

> *approachable and non-judgemental. I think that's a fine line sometimes between alienating somebody. [...] once people get defensive about something, they tend not to listen.*

Silos—and a fragmented system

'Silo' is a term for organisational behaviour and cultures that restrict collaboration and maintain clear and sometimes impenetrable boundaries between parts of a system (in this case, the AC system). Beliefs and attitudes underpin such competitive and disjointed models, in which relationships are constrained. In these situations, individuals and organisations can both fail to acknowledge interconnectedness, particularly that goals are often better achieved by working together, and actively work to maintain their separateness:

> *[An improvement would be] probably somehow improving the technology …that is able to… move across both interfaces the private and the public so … re tele-health also the department doesn't have an electronic file yet. I don't know if I'll ever… see it in my lifetime of working with the Department. But… if there was an electronic file that was kept and that GPs can have access to … then they know that they're not waiting on a discharge summary or they're not waiting on things that just don't happen … because of the nature of bureaucracy.*

Many comments from participants identified problems caused by a lack of coordination and by fragmentation:

> *In terms of aged care, if a doctor attends a nursing home and changes the medication on the chart, usually they're very good at sending that through to a pharmacy because they know they won't get that medication change unless the pharmacy knows. Whereas there's not—for the information flow, there's not really anything in it for the hospital to send it to the GP, because they're not going to get a gold star. There's no—*

> *what's in it for me to send it to them, because from their point of view, it probably doesn't matter as much. I mean, there's nothing that's not going to happen if they don't send it to the GP, apart from the fact the doctor won't have a clue what the patient's taking when they attend subsequently.*

Such fragmentation means that "… the system gets really hard for them to navigate when they've got an illness burden", and people may struggle for weeks or months to get the support they need:

> *It's a bit distressing because I mean you want to know what your results are and you can't get in to get them. And on [day] when I went in, their computer system had broke down so they couldn't give me the results. So I went to the doctor, all the way from [outlying area] to the doctor for nothing. That's petrol, which when you're on a limited budget, you've got to be careful of.*

Lack of information sharing can be a symptom of siloing, and leaves people uncertain and frustrated:

> *… you get one doctor from the mainland that tells you a heap of bull crap, … Then you go back for another one and you've got a different doctor who then again doesn't fix the problem, just talks about general crap. Then when you go to specialists and stuff like that and you come to your GP to find out that they don't have any information because there's no sharing.*

Competitive funding promotes silos and discourages collaboration, but disconnection like that reported above can be prompted by legitimate concerns about privacy:

> *I think there's some of those things have potential and so it's about just each service are getting over those hurdles of the barriers that are created through confidentiality or service requirements*

Siloing also reflects a belief that some roles in the system are more important than others; for example, medical specialists generally are perceived as more important than pharmacists, who in turn may be considered more important than service users. There can also be tacit mistrust of the motives of other providers; this was evident in remarks made by GPs in most AC project sites, about the 'encroachment' of pharmacies on tasks traditionally restricted to doctors, resulting in what was described as further exacerbating fragmentation of care (e.g., pharmacies offering flu vaccines without access to patients' health records) and about the commercial imperatives operating in chemist shops. This glosses over the business imperatives that shape how GPs deliver services. Some people located this problem with local GPs, but health professionals, too, are experiencing the frustration of systems that do not work:

> *… sometimes trying to navigate the maze of someone's care where all the hospital people are just not doing their jobs, their appointments haven't been made correctly, and that can take an hour of time to sort out, and they all shut at 4 o'clock don't forget in hospitals, even outpatient. So, it's really, really difficult, because so many of those people we see at the end of the day …*

Fragmentation and lack of coordination mean that:

> *Now, I don't know whether that's a break down in the left hand not knowing what the right hand's doing—in other words they'll pass it on, or whether it's part of the system, I don't know! But end result; it was a hassle. So, in the meantime you can't start treatment until they get the result.*

People:

> *in the system you can fall through the cracks … and I know that for sure.*

Mental illness/distress

There is a spectrum of mental health and mental illness in the community, and mental distress is a prominent theme in the qualitative data. As well as prevalence, many people commented on the inadequacy of services to deal with the magnitude of the issue:

> *I think mental health is a huge issue. I think there is still stigma attached to people sharing mental health issues. It's definitely getting better. But I see so much of it in schools. […] so much of it affecting our young people but I also have had family members. I've had a couple of very close people in my life that have had severe depression and suicidal thoughts and I know that what we offer isn't good enough for that critical crisis care. I think there's got to be a much clearer message for anybody seeking that crisis assistance. And it's not go to ER and sit and wait there for two or three hours and a half.*

This finding is supported by the high anxiolytic prescription rates and by survey results (reported above and in Appendix 6). The data supported the social determinants of health view, which recognises the multiple factors that influence mental health:

> *Looking at those factors there, bullying, low school completion rate, smoking, alcohol, other drugs, youth unemployment, socio-economic disadvantage, mental illness, suicide and family violence. So, I guess they're the kind of things that contribute to the group of people that we work with*

> *… looking at a fairly direct link between the number of adverse childhood events and likelihood of things like cancer, diabetes, mental illness, suicide. Mental health is a big issue especially a lot of violence, family violence, and obesity's a major, major problem. Alcohol abuse is a major problem. … Diabetes is big…. Isolation… depressions' big…. We do lots of mental health care plans, especially with psychologists. Marijuana use is almost a normality in this area, which is not always helpful.*

Although many people (particularly younger people) included mental wellbeing in their definition of health in the survey (Appendix 6) which suggests a level of comfort with the topic, mental distress still attracts stigma:

> *I think the stigma attached to depression, psychological issues is less now than it was 10 or 20 years ago, but it's still got a way to go. It is seen as more normal to take things, for whatever length of time, to help mood, depression, psychological health. So that's certainly positive.*

People reported that feeling safe is foundational for mental health and help seeking:

> *I think in high school, there's lots of drama and stuff and there's lots of different things that happen. But since I have got into Grade 11 it's been completely different because there's less people and it's a bit more friendlier I think and not as much people to start drama. That's just my opinion, I feel much more better and safer this year than last year.*

Services need to 'create' safety:

> *... we've got a lot of programs around the place—services. But actually wanting people to engage in those services is—they don't want that—they fail to feel like they belong. I think that's a real barrier [...] But as soon as that belong[ing]—you know, that [...] making a place where you feel safe, express your opinions and all that sort of stuff*

Even in the absence of a diagnosed mental illness, a lack of confidence, in for example social interaction, can reduce people's capacity to optimise looking after their health:

> *Because if you talk about employment, or even going to the doctors, you feel not empowered and not confident and you're very—your belief in yourself is quite low and that sort of stuff.*

In the following example, and in several comment in the survey responses, participants referred to the confidence needed to go alone to a health-related activity:

> *It just depends on the person you are. [...] I'd say with me personally that it's—I'm not very confident or comfortable with that kind of thing, like alone, I would go with somebody. I'd really want to go but I just wouldn't be able to do it mentally, so. You'd feel too anxious about it? Yeah. the anxiety and stressed out beforehand but if you want to do it you'll do it. That's just how I am, if I want to do something I'll go and do it. And you meet new people there anyway.*

The importance of mental health as underpinning health generally and underlying many of the comments during the interviews was a highlight. This again points to communities being an important resource as they are most able to provide (often indirect) mental health support—particularly in a timely manner.[9] Again, here, the problem of disconnected or 'hard to reach' groups came to the fore. The following quote particularly identifies gaps in mental health supports for youth:

> *I think there's a whole group of young mums, dads, young adults undertaking probably a lot of risk-taking behaviours, which is part of being young. But I don't know who is addressing their health needs. I'm not saying they're not being addressed. But we often see the pointy end of it, and it's quite hard to access psychological support for people who might be struggling with depression or alcohol and drug related issues.*

[9] This underlines the need for training for community members to support mental health—for themselves and others.

> *The young ones are coming through, [...] Yeah, just that they really, really struggle to be in groups. They're very socially isolated, I would say, and struggling to break that anxiety, yeah. [...] So it's huge. So to answer your question, to go back to that, yeah, the younger ones are certainly coming through the system. The trauma is still there. The trauma-based stuff comes through. You know, like dysfunctional families, abuse, sexual abuse, all that sort of stuff stays with—stays with people.*

> *I don't know if you've seen here a lot, but the young ones now, they're so anxious. Their anxiety and their high need to achieve, or they're expect—acceptance in life. So that then they find—you find quite a few of the young ones over there are quite hard, because their anxiety—can't stay in supermarkets, can't stay in present—in certain situations unless they're doing alcohol or doing some drugs to be able to stay in that situation at a young age.*

Summary

The thematic analysis of qualitative data identified five factors affecting the anticipatory care system here.[10] These themes overlap and affect one another, as is shown in the causal loop diagrams. They can be understood as things that assist or get in the way of the system parts working together: opportunities for change.

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 impact upon 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.

[10] Analysis of the data is continuing and will be reported in December 2020, and in research papers.

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 'authorizing' roles.

We asked a graphic artist to create posters of each system part, for the Connecting Care community (Appendix 9 is the design brief for the graphic artist), and took these posters to the community forum at Ulverstone on 1st April 2019 (see Illustration 2 and Appendix 10).

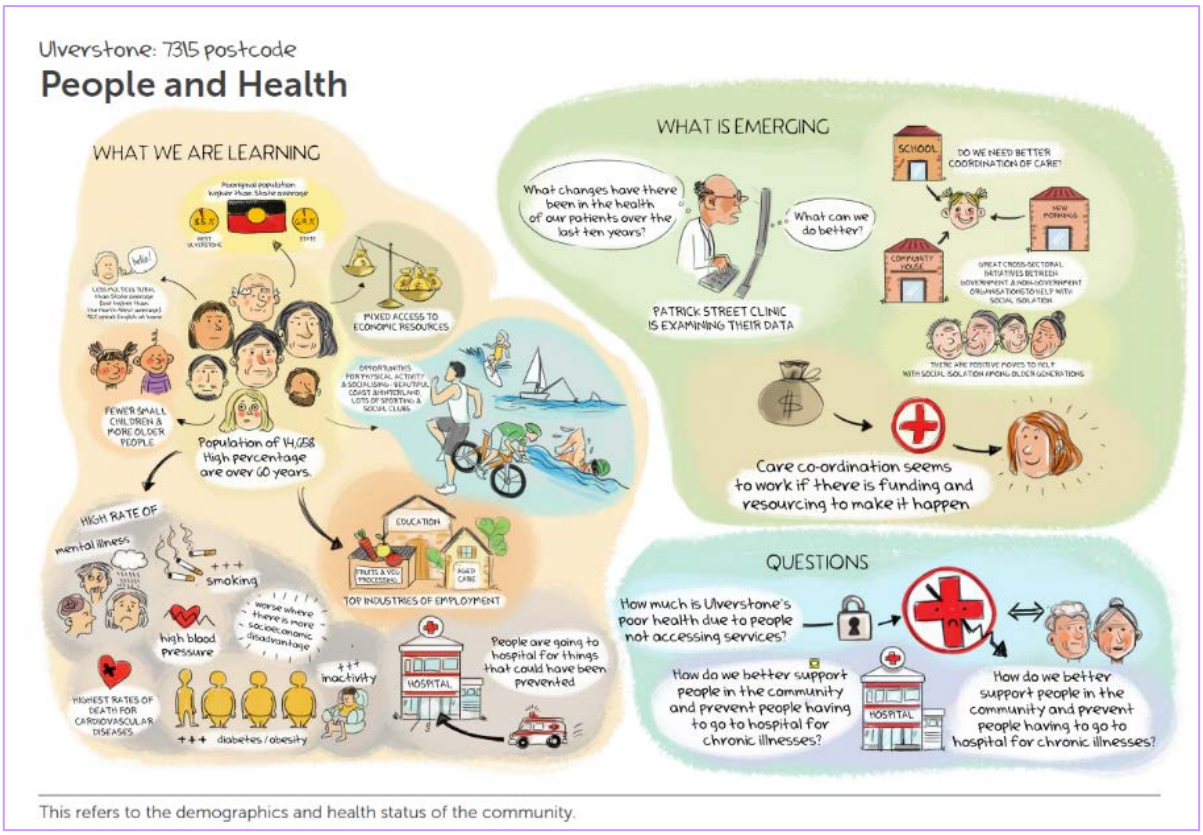


Illustration 2: Example poster of the preliminary system parts in CC

Forty-one invited people came to the 2019 community workshop. They were local residents and people providing services into the community. Analysis of the observations and notes made during workshops in each community (including summary documents and fieldnotes made by UTAS and Sax personnel, and byDoH project staff) 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.

Causal loop analysis sessions 1 and 2

Two causal loop sessions were held with members of the CRG and some additional participants. Participants created the diagram, and then the research team continued the analysis using data from the workshops along with interviews, fieldnotes, project documentation, observations and conversations.

CLD 1 (2019) summary

Data analysis to this point identified some over-arching themes across the AC project sites; these were Processes, Access, Connection and Safety. The themes guided our causal loop analysis in the communities. Connection was a particular focus in the Connecting Care session: how partnerships, people and information were linked in the system. Drawing the CLD (Figure 9) was informed by stories from participants, and other evidence from the data we had been gathering.

Key constraints within the system—including distance and isolation, poor communication, lack of service collaboration, fragmentation, damaging attitudes (e.g. stigma and blame), service relocation and political interference—were recognised as being legitimate barriers to AC access and connection in this site. However, there is a further barrier presented by a fundamental view in the CC site: that good health is achievable if people take responsibility for their own health, and that effort therefore needs to go into providing people with information and support to make good health choices.

Addressing some of these factors relies on adequate resourcing, whether at individual or service level. Inadequate resourcing prevents proactive system improvement and the development of contemporary initiatives such as call back and follow up support services, or, indeed, the relationship work that is needed to improve the functioning of the AC system. However, there are ways to enhance the system despite resource constraints.

The CLD session showed that opportunities exist in:

- volunteering (community health connectors), including extending engagement to those who are socially isolated
- support and early intervention models (e.g., pharmacists, community health connectors, carers)
- information provision and communication, and
- bolstering collective responsibility for AC through partnerships.

It was evident that there are 'well-connected' individuals in the community, whose potential in the AC system has perhaps not been fully recognised. The way health is valued in the

community, and the framing of health information were recognised as important for community engagement with AC messages, and in particular to prevent blaming individuals for their poor health. Action planning in Connecting Care was informed by the causal loop analysis.

The diagram shows that providing **useful health information** is a key aspect of the AC system in the Connecting Care site. This was understood as a factor that could help or hinder **services system navigation**. **Effective communication** between services, and with community members and service providers therefore presented an opportunity for intervention, as did **volunteerism**. Simply providing people with good information—particularly if it is disguised as 'enhancing health literacy'—will not necessarily enhance health outcomes, and frameworks such as the Ottawa Charter for Health Promotion (1986) provide useful guidance for building environments (e.g., infrastructure, policy and processes) that can support communities to use information to maximise health and wellbeing.

Accessible and useful information was identified as an important variable. Our focus is on how services meet the information and other needs of potential clients, rather than on the health literacy of citizens. This may include using Plain or Easy English in communication, providing information in locations that are accessible and familiar, or through trusted people. Accessible and useful information supports people to make decisions about their health needs and AC.

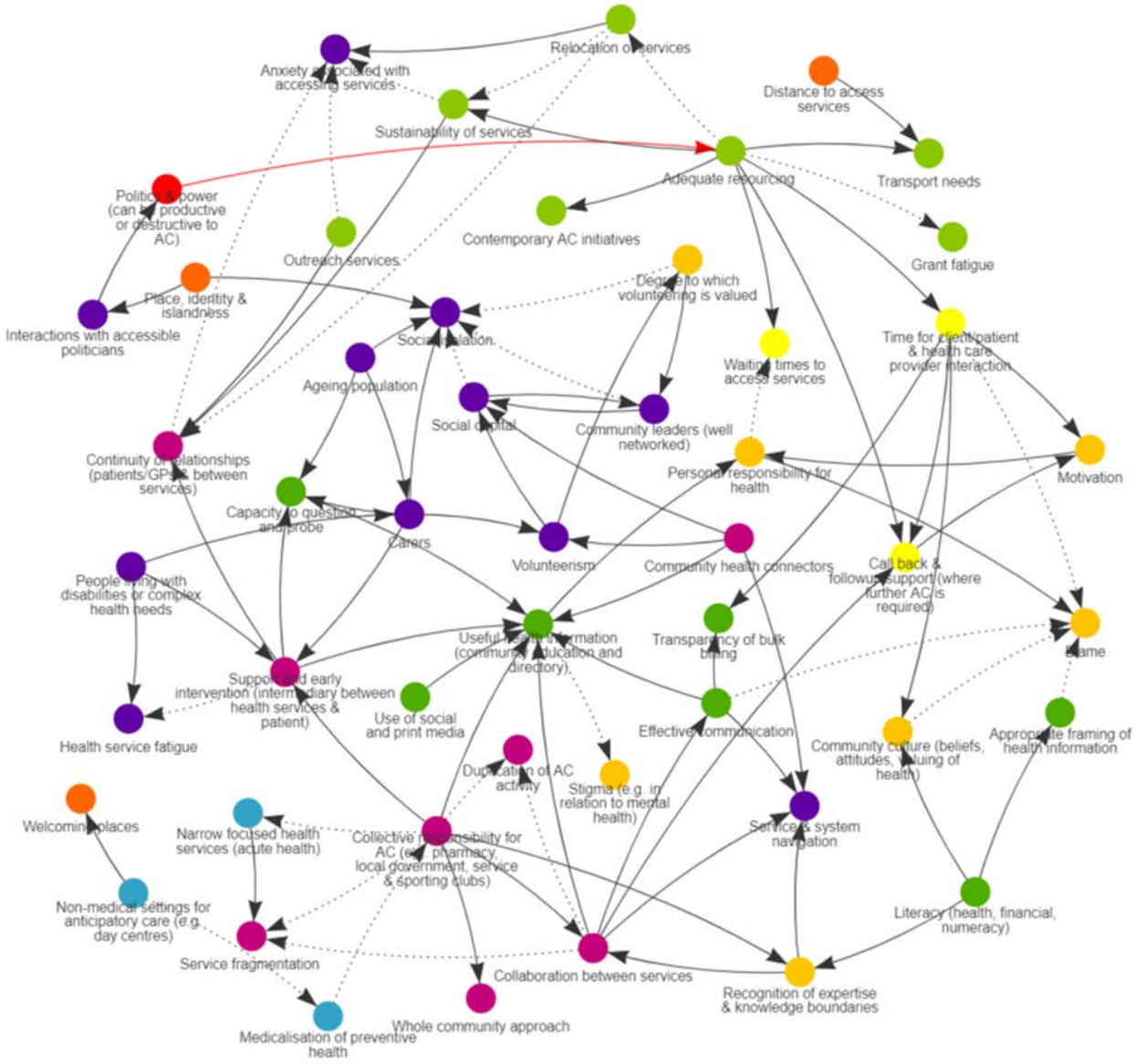


Figure 9: Causal loop diagram for AC in the Connecting Care site, 2019

Note: The colours in the model reflect key themes as follows:

People (purple), resources/infrastructure/funding (light green), place (dark orange), attitudes (light orange), partnerships (dark pink), communication & information (dark green), models of health service delivery (aqua), processes (yellow) and policies (red).

Results-driven action plans

The lead worked with the CRG 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 Connecting Care action plan set out two broad approaches (see Connecting Care Final Report, 2020):

- "An overarching **6 month project** to develop a strategic and sustainable framework for entities involved in anticipatory care activities in Ulverstone by January 2020.
- Concurrently, research into and roll out of Proof of Concept activities to trial and evaluate
  - different health and social care information hubs
  - anticipatory care resource information
  - a community health literacy initiative to train front-line staff and volunteers in existing local businesses, and
  - initiation of in-Practice improvements resulting from the GP Audit and three GP/community projects by medical students through the Rural Clinical School" (p. 20)

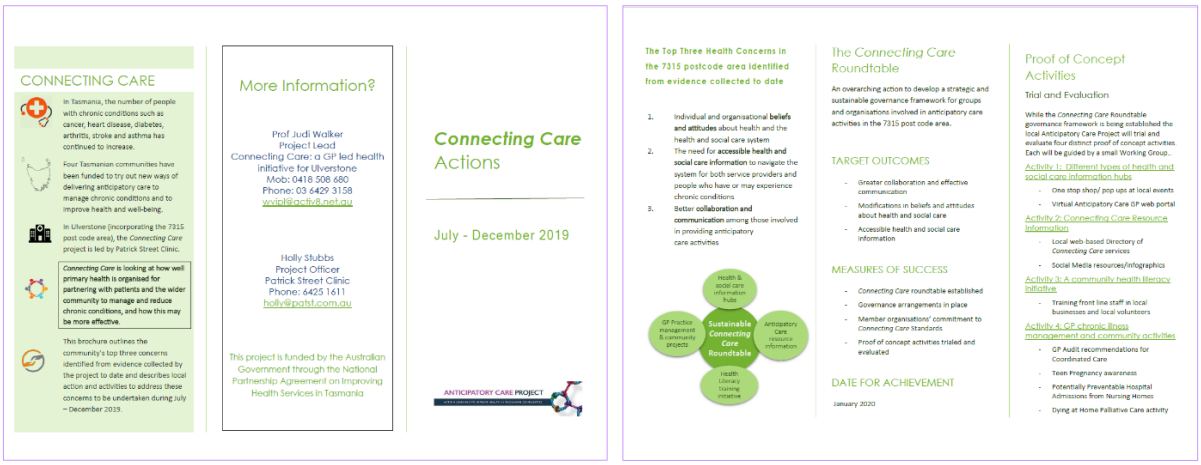


Illustration 3: Connecting Care brochure, listing activities, July 2019

In practice, these actions (see Illustration 3) translated into:

- a 'Sustainable Governance' working group, and the development of a prospectus and Terms of Reference for a Roundtable …
- a series of delivered and planned health and social care information hubs

- local resource information: through an online information portal, social media and printed resources
- health literacy training for staff and volunteers (based somewhat on the The Right Place model operating in the Clarence Help to Health project site, and in the Huon Valley).

The activities, including the project management, were evaluated by Maree Gleeson (2020).

CLD 2 (2020) 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. We also learned about the project's impacts through our observations of the CLD session itself. One significant observation was that several participants from non-medical services had not been involved in the early parts of the project but now understood their role in the AC system.

CLDs are an important tool for representing the feedback structure of systems. They are excellent for quickly capturing hypotheses about the causes of dynamics; eliciting and capturing the mental models of individuals and teams; and communicating the important feedback processes you believe are responsible for a problem.'[11] The CLD has boundaries and therefore will not capture everything that is going on but it does draw attention to the key focus areas of our work. The second CLD (2020) is shown in Figure 10. It represents what has taken place as a result of the Connecting Care project.

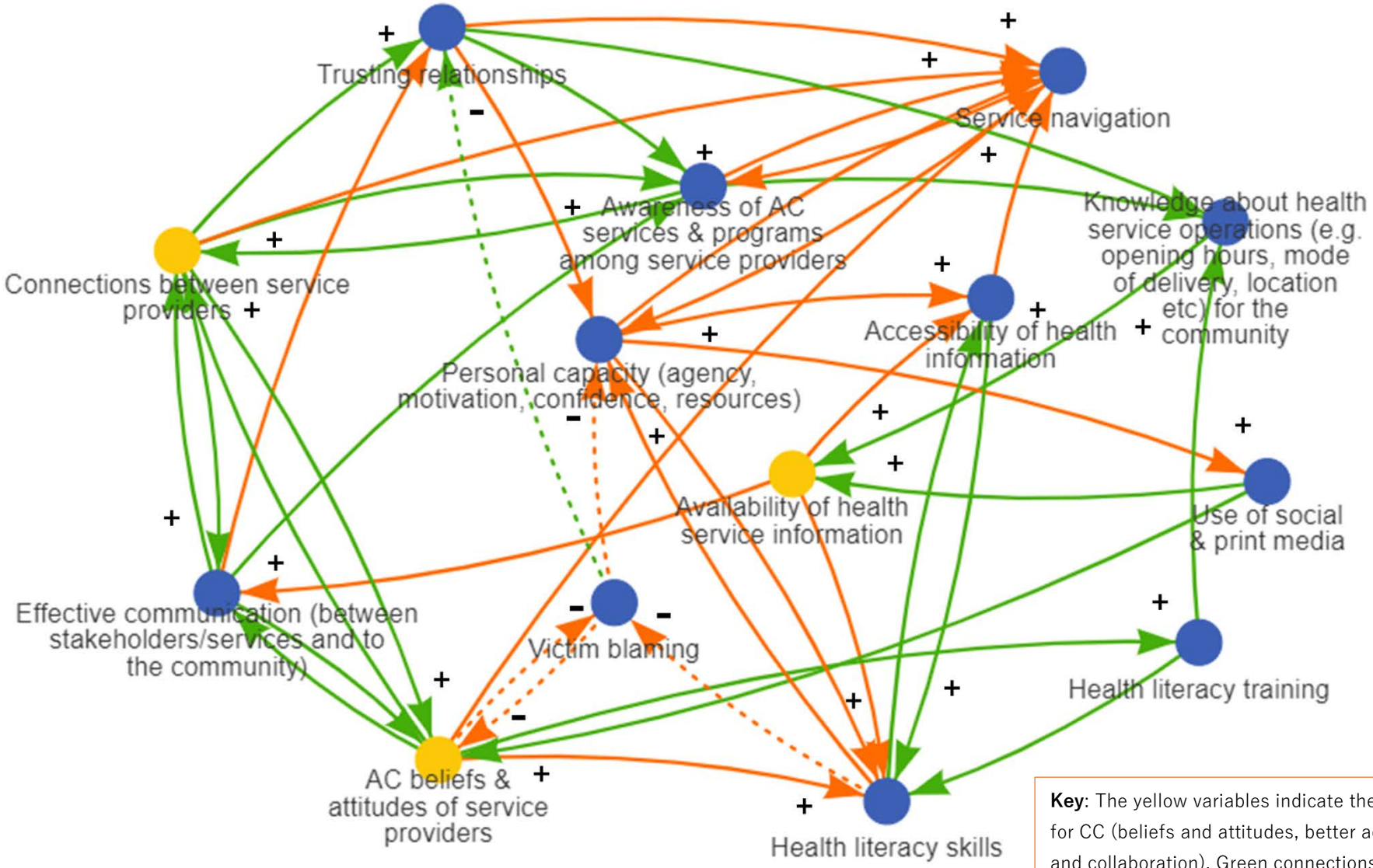
The CLD illustrates that the system is dynamic. During the session, links were made that created more than 600 loops in this model. Some of the loops are 'reinforcing' and some 'balancing'. Reinforcing loops are relationships in which increasing one variable (A) will result in increases in the other/s (B), which in turn will drive increases in the first (A). An example in Figure 10 is the loop between **Effective communication between services & with community** > **Connections between service providers** > **Effective communication between services & with community**. Balancing loops have the opposite effect: increasing variable A will decrease variable B and thence decrease variable A. An example in the diagram is the loop between **Victim blaming** > **AC beliefs and attitudes of service providers** > **Victim blaming**. Either form of loop can be beneficial, neutral or damaging, depending on the variables involved. For instance, there are some neutral reinforcing loops involving AC beliefs and attitudes involving service providers, victim blaming, personal capacity and trusting relationships that may reinforce the status quo

[11] The Systems Thinker, https://thesystemsthinker.com/

Box: What you don't know *can* hurt you

Through their work on the resource directory project, CC's CRG members contacted services and organisations to include. They asked the organisations for contact information, as well as about the way the service is delivered and about access for people with disability. In talking with BreastScreen about their mobile van, it became apparent that although the van is accessible, this was not apparent on the van. Women who use wheelchairs were missing this important screening. As a result of this contact with the CRG, BreastScreen has now added an access sticker to the van.

While session participants provided evidence for some of the loops, the orange lines in Figure 10 indicate that we are uncertain about whether we have the evidence to demonstrate that this relationship exists. For instance, while it is likely that increasing **health literacy skills** will increase **personal capacity**, we do not yet have evidence that this has happened. Similarly, greater **personal capacity** could increase **use of social and print media**, the **accessibility of health information** and improve **service navigation**, but we do not have evidence for those effects.



Key: The yellow variables indicate the three key focus areas for CC (beliefs and attitudes, better access to information, and collaboration). Green connections indicate causal links for which we have evidence; orange links represent potential shifts. There are mainly feedback and reinforcing loops i.e. increase in one variable, increases another and so forth, which reinforces an increase in the orginal variable (+).

Figure 10: Causal loop diagram for the main components of AC in the Connecting Care site, 2020

When we only look at the relationships between variables for which the session and our data provide support (the green lines), we can identify 10 feedback loops. Several of the reinforcing loops that show this are simple, and go between two variables:

- **Awareness of AC services & programs among service providers > Connections between service providers > Awareness of AC services & programs among service providers**
- **Effective communication between services & with community > Connections between service providers > Effective communication between services & with community**
- **AC beliefs & attitudes of service providers > Connections between service providers > AC beliefs & attitudes of service providers**
- **AC beliefs & attitudes of service providers > Effective communication between services & with community > AC beliefs & attitudes of service providers**
- **Accessibility of health information > Health literacy skills > Accessibility of health information.**

Box: More access to locally relevant information

One of the connecting care aims was to find ways to share accurate information to support people's health. Connecting Care trialled several ways to do this and one of the ways has been through social media—and videos. The first videos shared information about things like exercise and the value of social interaction. We knew from our research that a sense of place and of familiarity mattered to people's health, and that was factored into the videos: they used local landmarks, and recognised, respected local people—including a local expert, Emil.

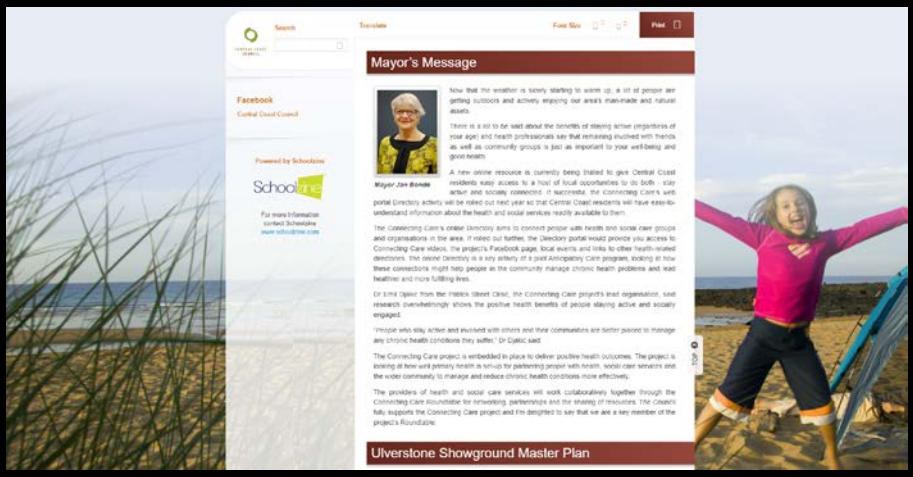
These new skills and ways of working meant that when COVID came along, Connecting Care could quickly provide accurate information, from trusted people—about the virus, about mental health during the pandemic, and about telehealth– to an established audience.

Others are more complex:

- **Awareness of AC services & programs among service providers > Connections between service providers > Trusting relationships > Awareness of AC services & programs among service providers**

- **Effective communication between services & with community > Awareness of AC services & programs among service providers > Connections between service providers > Effective communication between services & with community**
- **AC beliefs & attitudes of service providers > Effective communication between services & with community > Connections between service providers > AC beliefs & attitudes of service providers**
- **Effective communication between services & with community > AC beliefs & attitudes of service providers > Connections between service providers > Effective communication between services & with community**
- **AC beliefs & attitudes of service providers > Effective communication between services & with community > Awareness of AC services & programs among service providers > Connections between service providers > AC beliefs & attitudes of service providers**

Box: New, shared goals to support anticipatory care



There is evidence that attitudes and beliefs to support anticipatory care are shifting, bringing in consideration of the social determinants of health. The Mayor's message (shown here) is one example. The council has understood that it has an important role to play in the anticipatory care system, and is working with Connecting Care on the Roundtable. This shift is also evident in the link between Connecting Care and the Ulverstone Secondary College's clock tower shopfront, where lots of organisations started to come together (before the pandemic). And we also have evidence from the qualitative data; there is recognition of a common preventative model—a shared vision, an understanding of the importance of the social determinants of health.

> *"I think for people living with chronic conditions, they can so easily become isolated because their life is difficult, … psychologically difficult at times and emotionally. So other organisations within the community are really important. It might be, yeah, social groups, community houses. So, I guess all those other social connectedness people"*

> *"So talking about social determinants of health is a big part of what we do as well and you know, the [work we do] … maybe we have to take this program to the community rather than waiting for them to come and see us within business hours"*

In summary, we are confident that, on the basis of the information we have, the main impacts on the AC system, through Connecting Care initiatives, are:

- There has been **effective communication between services** and community (although there is limited evidence for the latter);
- As a result, there has been an **increase in awareness of AC services/programs among service providers**, and there have been c**onnections** formed between service providers

> *"In preparing the directory, we've asked people … to nominate if they have an accessible facility or not, … and it means people ask themselves the question and reflect about their own facility services, and access … it's hard to measure, but that self-reflection is important"*

- **AC beliefs and attitudes** such as the need for collaboration (by virtue of the funded project) have enabled this communication and connections, which have
- Reinforced beneficial **AC beliefs and attitudes**

Some questions remain about evidence. For instance, additional evidence needs to be gathered to show:

- whether active projects are affecting **service navigation**? (e.g. are trusting relationships being formed that will lead to enhanced service navigation; is awareness of services/programs among service providers improving service navigation; is access to information leading to service navigation—is it just among service providers or for the wider community?)
- that **trust** was enhanced through the project by, for example, **effective communication**?
- that this project has affected **personal capacity**—motivation, confidence, agency, resources? (e.g. did trusting relationships increase personal capacity; did health literacy skills increase personal capacity; did personal capacity increase so that people could access social media?)
- that the additional information created and made **available** through the project has also been **accessible** (and if so, to whom)?
- that the information that was **available** was **effectively** communicated?
- that those who participated in the **health literacy** training applied their skills; and whether it shifted their thinking in terms of AC beliefs and attitudes (a focus on SDOH, access for those most in need, prevention etc)?
- that participants are using reflexive thinking to ensure we didn't **blame people** for their lack of agency. What evidence is there that our messages moved in the direction of **AC beliefs and attitudes** (i.e. supporting those most in need via structural improvements) and not only pushing responsibility back to individuals (**victim blaming**)?

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, or reading minutes of, CRG and 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)
- Conversations with service providers linked with Connecting Care activities

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

Research activities and project processes

The following table (Table 3) lists the project processes, what worked about them and what did not. Note that in this site, there were two groups of Project Support Officers. The first group is Holly Stubbs and Tom Galpin; they appear in the table as PSOs (H & T). Their role mirrored how PSOs worked in the other AC sites: they worked with the lead in CC and with the UTAS AC research team to gather data, to reach out into the community, to support activity design and implementation and to engage (when possible) in the PSO Community of Practice. Other PSOs were employed in CC to provide analytical skills for the GP audit, and to do administrative tasks; they appear in the table as PSOs (G, P, V & H).

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

Activity	*Who lead?*	*What worked about it?*	*What didn't work about it?*
Timeline	DoH	Timeframes for the project were always a challenge but this was well understood by all parties involved from the outset. Both the scope of the research and the project at each site was tailored accordingly The time for the project was extended, this supported us to deepen some relationships and develop the activities further	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 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 The short time frame also created difficulties including people from marginalised groups in the interview and data collection process; trust is needed for this if we are to gather rich information and this takes time The COVID-19 pandemic has affected programs and activities in all AC project sites, reducing opportunities and time available for some trials
Contracting between parties	DoH, lead organisation/s, UTAS	Provided clarity about project goals and expectations	Some aspects of contracting were very time-consuming, misunderstood, or presented other challenges, and remained a source of difficulty in the Connecting Care site (e.g., how the PSO role was filled, sharing audit findings)
Ethics	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 (consent concerns for children, for example)

			Ethics processes also require amendments for adjustments to recruiting, staffing and processes; while necessary they are also time-consuming
History of AC	An approach from the British NHS	Takes an holistic and SDoH approach	Risk that too much effort is spent trying to reproduce a GP-centred model, which current Australian Medicare system and associated business models and processes impede
Interviews	UTAS researchers, PSOs	Some support from lead to identify potential interviewees Reached mostly 'usual suspects' very effectively; UTAS researcher in CC site was able to reach some 'unusual suspects' Interviewees were willing and thoughtful Produced very detailed and 'rich' information Could be conducted when the opportunity (e.g., an existing meeting or shared activity) arose	Format only works for people who are confident or where the interviewer could quickly establish a trusting relationship with interviewee High-quality transcription is costly
Focus groups	UTAS researchers	Allowed us to include people who were unwilling to be interviewed alone Group members prompted and encouraged one another Participants appeared to build new bonds over shared stories Could be conducted when the opportunity (e.g., an existing meeting or shared activity) arose	Method can result in one or two voices dominating the conversation (this was evident in some focus groups and workshops; a product of shyness but also of power dynamics) Can be hard to arrange
Observation	UTAS researchers, PSOs	Increased collaboration between researchers and PSO Found new ways to learn about AC system and people's interaction with it	Requires a lot of time, which was short PSO's in CC site did not have same role or connection with UTAS in relation to local research tasks, attending community of practice meetings, etc. This reduced how much we could learn about the site and projects as they were implemented, as well as reducing the outreach and engagement aspects of

			the role. An important aim of the PSO role was to build that person's capacity; this was severely limited
Surveys	PSOs	PSOs (H & T) working with UTAS AC team were able to reach and hear from more–and more hard to reach—people, only some of whom completed a survey Gave us data about understandings and experiences as well as barriers (in format directly comparable with other sites) Expanded PSOs' (H & T) knowledge of the CC area	Time was short Administering the survey was time consuming, making PSOs (H & T) wary of inviting people to complete There is general scepticism in communities about 'yet another pointless survey'
Community Consultation Workshops	Sax Institute and TAPPC	Brought together local residents and services Gave researchers an opportunity to become a little more familiar with and in the CC site Identified additional potential interviewees and focus group participants	CC workshops brought together residents and service providers but had fairly poor representation from the 'unusual suspects' the project wanted to include Risk that notes taken at group tables or added to posters were heavily influenced by 'noisiest', most powerful, or most literate people there One intention was to ask participants to comment on how different parts of the system were linked; lack of time prevented this being included in workshop 1
CLD sessions	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 real opportunity for shared learning and co-design; there were no "experts" Process brought stories to the surface that enabled us all to better understand the AC system Process allowed for genuinely participative action learning	We were all learning as we went along so process was at times difficult to navigate CLD is visually complicated and initially off-putting Several workshops are needed to make this a fully participative process 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 'Ownership' and perceptions of the usefulness of the CLDs varied The nature of what constitutes evidence varied; some clear evidence gathered was not taken seriously by some in the CC team

Systems traps session	UTAS researchers	We were all learning as we went along Brought members of the project community (including from CC) from across the four sites together Opportunity to learn how systems traps were appearing in sites and how participants understood and were responding to traps	We were all learning as we went along Session was probably of variable value to the participants other than UTAS
Community of Practice	UTAS researchers and PSOs	Brought members of the project community from across the four sites together Gave us all opportunities to reflect together on what was working and what was not Enabled UTAS participants to hear how work in general and on particular activities was going Built trusting relationships between the four AC project sites, and between PSOs (H & T) and UTAS team Shared problem solving Built capacity in Systems Thinking and reflection for all participants	Logistics sometimes difficult. Ulverstone's PSO attended only one session Unsure whether too hierarchical (as in, too much UTAS and not enough PSOs (H & T)) [analysis of session data is continuing] Disrupted by loss of some PSOs (H & T) Having more sessions would have been beneficial, but time and other pressures prevented this
PSO reflections	UTAS researchers and PSOs	Built relationship between PSOs (H & T) and lead researcher Enabled lead researcher to hear how work in general and on activities was going, and do some shared problem solving Provided opportunities for critical reflection on UTAS researchers' role and project processes Provided evidence of growing systems thinking by PSOs	Variable engagement and sometimes too many other commitments (on both sides) Took a little while to find best means for reflection for each person PSOs (G, P, V & H) were not linked with UTAS AC team and took no part in CoP or reflection
Project activities	Leads, PSOs	Some activities showed that local action can influence the AC system and address priorities for better function (see the AC Framework) Addressed some goals of AC system work	Heavy workload for PSOs (H & T) and leads COVID-19 affected opportunities to trial some activities, and made adjustments to others necessary

		Worked towards involving a wide range of community members and listening to them Built on some effective and trusting collaborations with services and institutions	
Project Support Officers' work	PSOs (supported by leads)	We were all learning as we went along; lack of a predetermined program of work provided space for responsiveness to local circumstances First PSO had existing good links with community, GPs and some services; Second PSO had some medical training and links with community PSOs (H & T) were eengaged, observant, reflective thinkers Training/ways of working that seek and build on strengths and relationships	We were all learning as we went along The site's contracting approach reduced opportunities for engagement between UTAS and PSOs (G, P, V & H) PSOs (H & T) had little time or support to engage with the Community of Practice PSOs (G, P, V & H) were not linked with UTAS AC team
Leadership Group (structure, makeup, how it worked)	CRG members	We were all learning as we went along (opportunity for some) 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 less reliably CRG meetings followed clear processes A core group of members remained committed and actively sought solutions Opportunity for UTAS to learn about community, services, and approaches	We were all learning as we went along (frustrating for some) More time and openness and less pressure needed to support relationship building between UTAS and CRG members Some resistance in CRG to new ways of thinking/working and to UTAS lead More work was probably needed to engage with CRG and with a wider diversity of community representatives; this required time which was in short supply
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

The impact of the COVID-19 pandemic on the project and this site

> *I think we're all agreed that the COVID-19 impacts are going to have a very big impact on anticipatory care into the future; we're not going to go back to what things were like.*

In early March 2020, the World Health Organisation declared that the outbreak of a novel virus, SARSCoV-2 (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 has increased.

Telehealth consultations

Telehealth was identified as a factor in the 'Data and information' system part that could be modified to support better access to services. COVID-19 forced the issue. Telehealth consultations are now more widely available with GPs, some allied health providers, like dietitians, and some specialists. 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 barriers still in place.

Firstly, it is not clear who will be 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. People in Ulverstone and West Ulverstone have poorer access to the internet than Tasmanians overall (Tasmanian Council of Social Service Inc. (TasCOSS), 2019), including because of the cost of mobile phone data, and poor reception. They are also likely to have had less education and there is some Tasmanian evidence that telehealth is more likely to be used with people who have more education (Banks et al., 2020b). About half of Tasmanians "do not have the literacy and numeracy skills they need for life in a technologically-rich world" (26Ten). This affects people in the Connecting Care area, where the Connecting Care area, where one-fifth 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. Further, some practices are restricting bulk-billed access to telehealth to existing patients; while there are sound reasons for this, it also means that people who have are already marginalised will continue to lack access to affordable health care.

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 who struggle to attract GPs and where there is already a shortage of GPs.

Increased JobSeeker and other payments

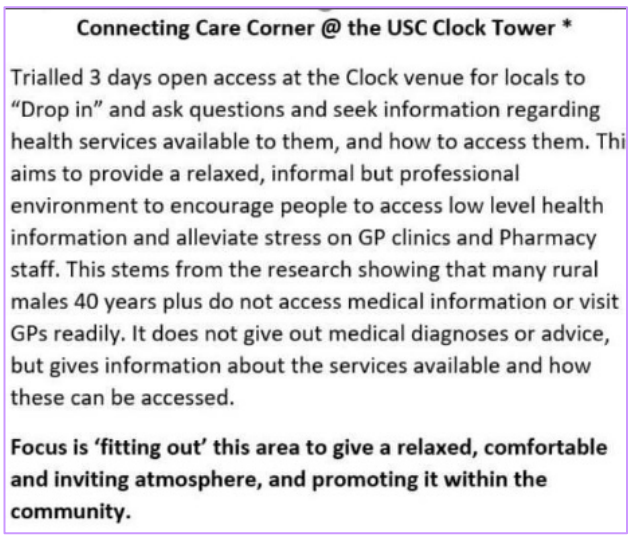
The JobSeeker payment, formerly called 'NewStart', was increased in April 2020 by the addition of a 'Coronavirus Supplement'. This roughly doubled the amount received by many people, including those on Youth Allowance, Parenting Payment and some special benefits. Some CC residents are likely to be benefiting now from this increase. The official unemployment rate here in 2016 varied between 7.3 and 7.8 per cent. In 2016, Tasmania's overall unemployment rate was 7 per cent (Australian Bureau of Statistics, 2016). Unemployment has risen during and post-pandemic.

The increase to benefits was reduced in September 2020, with scaling back over the subsequent months (though things remain unpredictable). There are also predictions 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 the 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 relief 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.

Impacts of the pandemic on the Connecting Care project

In the Connecting Care site, several 'proof of concept' activities could not be rolled out—venues were closed, and volunteering was affected by age exclusions, for instance—when the pandemic was declared. For instance, the information hub at the Ulverstone Secondary College's 'shop front' (Illustration 4), which had been trialled could not proceed due to lockdown restrictions. Where possible, however, activities continued and moved online (e.g., Health Literacy training) and proceeded successfully (Illustration 5).

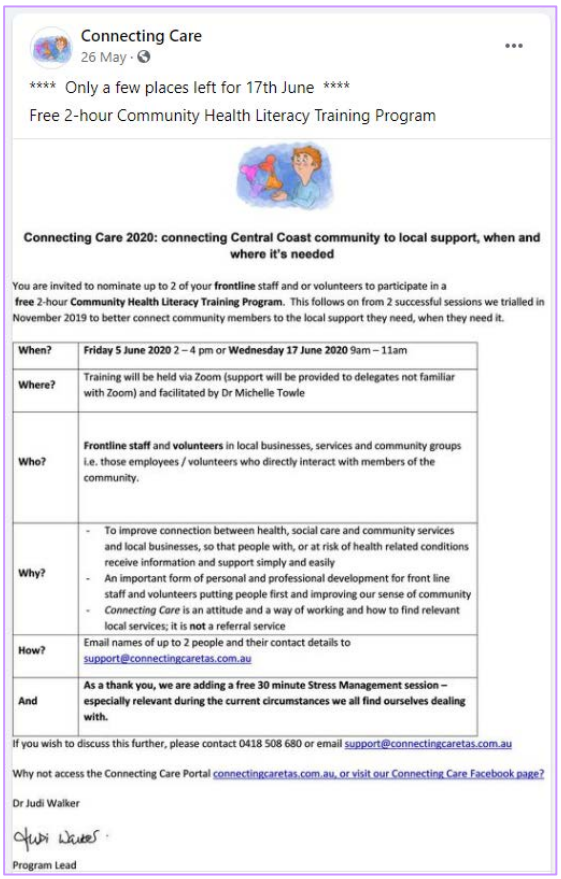


Connecting Care Corner @ the USC Clock Tower *

Trialled 3 days open access at the Clock venue for locals to "Drop in" and ask questions and seek information regarding health services available to them, and how to access them. Thi aims to provide a relaxed, informal but professional environment to encourage people to access low level health information and alleviate stress on GP clinics and Pharmacy staff. This stems from the research showing that many rural males 40 years plus do not access medical information or visit GPs readily. It does not give out medical diagnoses or advice, but gives information about the services available and how these can be accessed.

Focus is 'fitting out' this area to give a relaxed, comfortable and inviting atmosphere, and promoting it within the community.

Illustration 4 (above): Facebook post reporting on the information hub at the Ulverstone Secondary College's 'shop front'



Connecting Care
26 May ·

**** Only a few places left for 17th June ****

Free 2-hour Community Health Literacy Training Program

Connecting Care 2020: connecting Central Coast community to local support, when and where it's needed

You are invited to nominate up to 2 of your **frontline** staff and or volunteers to participate in a **free** 2-hour **Community Health Literacy Training Program**. This follows on from 2 successful sessions we trialled in November 2019 to better connect community members to the local support they need, when they need it.

When?	**Friday 5 June 2020** 2 – 4 pm or **Wednesday 17 June 2020** 9am – 11am
Where?	Training will be held via Zoom (support will be provided to delegates not familiar with Zoom) and facilitated by Dr Michelle Towle
Who?	**Frontline staff** and **volunteers** in local businesses, services and community groups i.e. those employees / volunteers who directly interact with members of the community.
Why?	- To improve connection between health, social care and community services and local businesses, so that people with, or at risk of health related conditions receive information and support simply and easily - An important form of personal and professional development for front line staff and volunteers putting people first and improving our sense of community - *Connecting Care* is an attitude and a way of working and how to find relevant local services; it is **not** a referral service
How?	Email names of up to 2 people and their contact details to support@connectingcaretas.com.au
And	**As a thank you, we are adding a free 30 minute Stress Management session – especially relevant during the current circumstances we all find ourselves dealing with.**

If you wish to discuss this further, please contact 0418 508 680 or email support@connectingcaretas.com.au

Why not access the Connecting Care Portal connectingcaretas.com.au, or visit our Connecting Care Facebook page?

Dr Judi Walker

Program Lead

Illustration 5 (right): Facebook post inviting participation in Health Literacy training

It was evident that some of the capacity and ways of working that had developed during the project could now play an important role. The established Connecting Care PSC portal (Illustration 6) and Facebook page were used to provide important and accurate information about COVID-19, telehealth and mental health, including through videos featuring local experts (Illustrations 7 and 8).

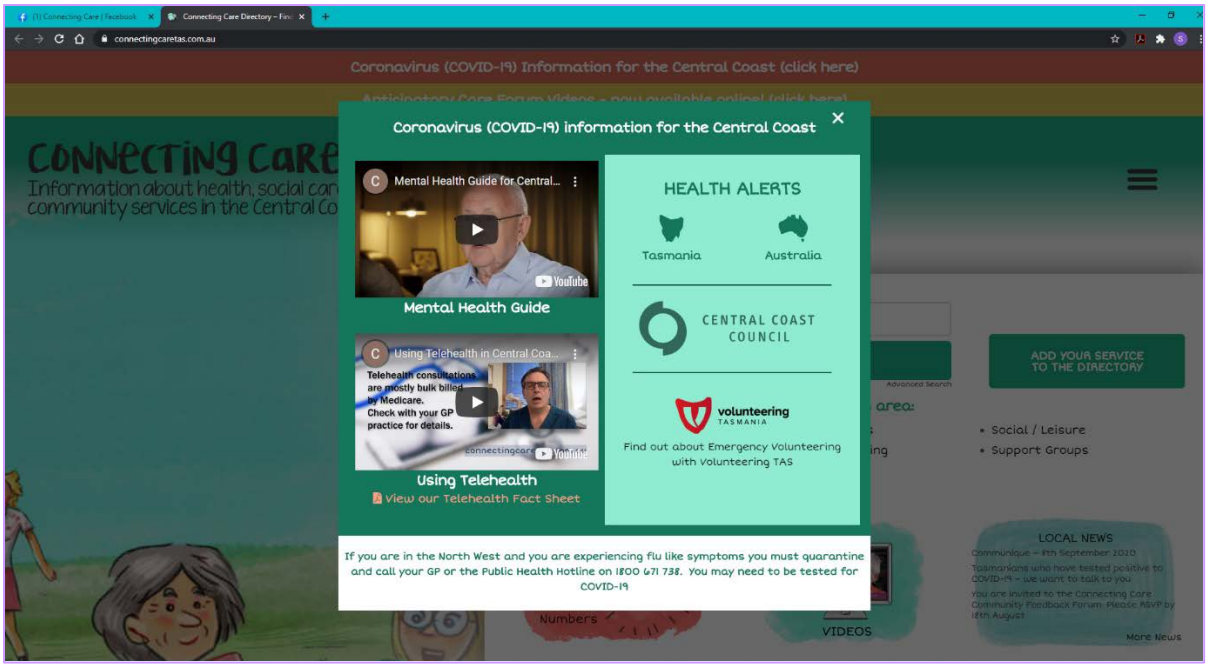


Illustration 6: Connecting Care portal coronavirus information page

Illustration 7: COVID-19 information sharing

Illustration 8: Screenshots from COVID-19 information and support videos

Discussion—what does all this mean

Chronic conditions affect too many people in the Connecting Care site. People here do not have equitable access to health services and some are much more likely 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).

The CC project, in its AC iteration, is a partnership between the CC 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—a GP clinic, the Patrick Street Clinic—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 also reflect on the barriers encountered and the usefulness of the methods we used, action learning and systems thinking. We conclude with recommendations for anticipatory care in this site, and for future work.

Answering the research questions

Significant finding 1: Mental health is a prominent concern in the Connecting Care area. Poor mental health is also affecting people's capacity to take care of their health. There is a need for more focus on initiatives and strategies that support good mental health and prevent mental ill health, and to strengthen local supports and partnerships with a focus on mental health.

Significant finding 2: The project showed that the anticipatory care system is heavily reliant on relationships, and that a health connector (modelled on the AC project's PSO role, and described in more detail in Clarence's Help to Health AC report) with authority and reach could perform this function.

Significant finding 3: The anticipatory care system relies on long-term relationships. The Roundtable initiative shows promise for a more supported and collaborative future of the local AC system in the Cradle Coast municipality. This model may need to include a dedicated project officer to, among other roles, increase inclusion of marginalised people.

Research question 1: Mapping anticipatory care here

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.

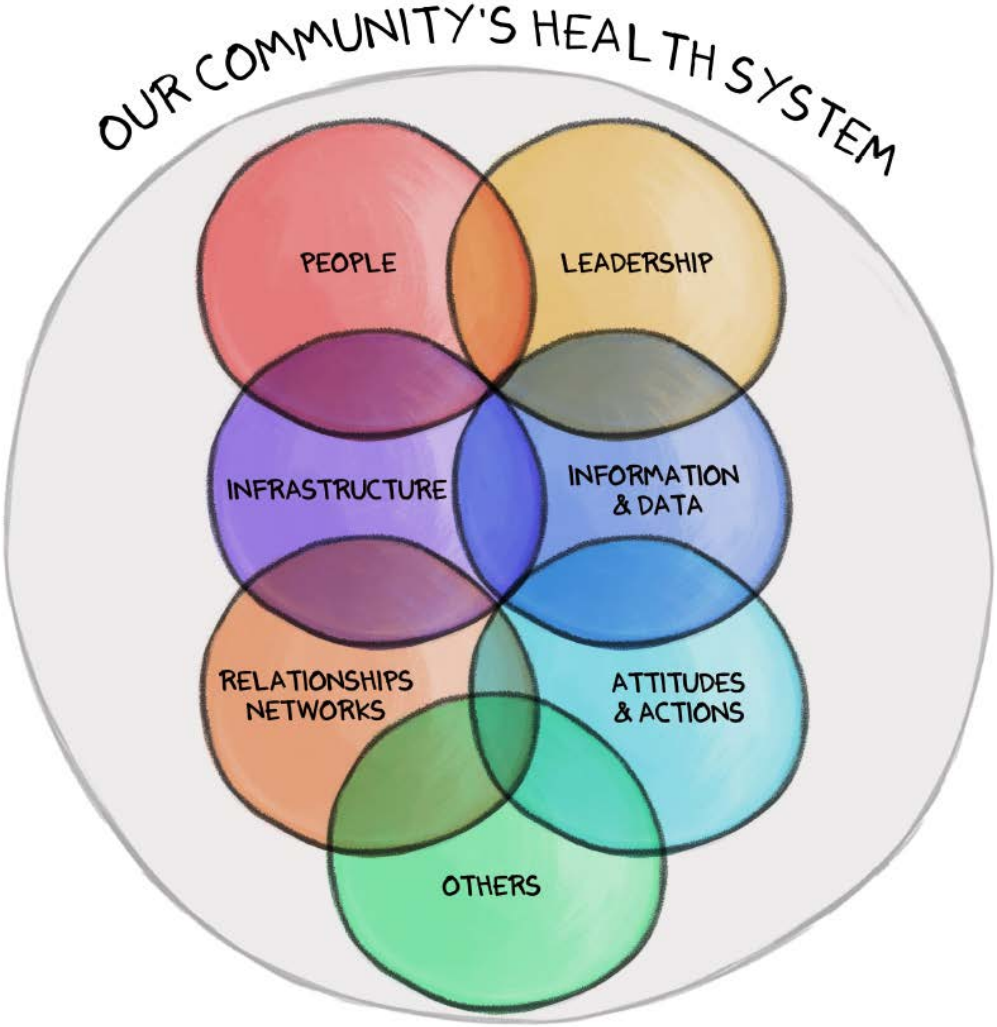


Figure 11: Original systems diagram

The boundaries around the system corralled it as a mostly medical or health service system. This is despite our finding 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. Further, the system's function of keeping people well was often disrupted by a lack of access and service coordination, some linked with the negative impacts of the social determinants of health (including low income). It was also reliant on local resilience and resourcefulness, and on some local organisations that know and work with their community.

At the project's end, Connecting Care had strengthened some existing relationships among services and forged some new ones. 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 Connecting Care team to develop and trial additional locally driven approaches. Through the AC

project, the Connecting Care team has worked with parts of the system that were formerly not involved, and who now better understand their role in AC. This includes local government, schools, service organisations and volunteers, including Ulverstone Secondary College, Collective Ed, and ParaQuad Tasmania. These relationships were formed in response to local needs for a stronger AC system, identified by PSO outreach and the engagement of the CRG, and by the research.

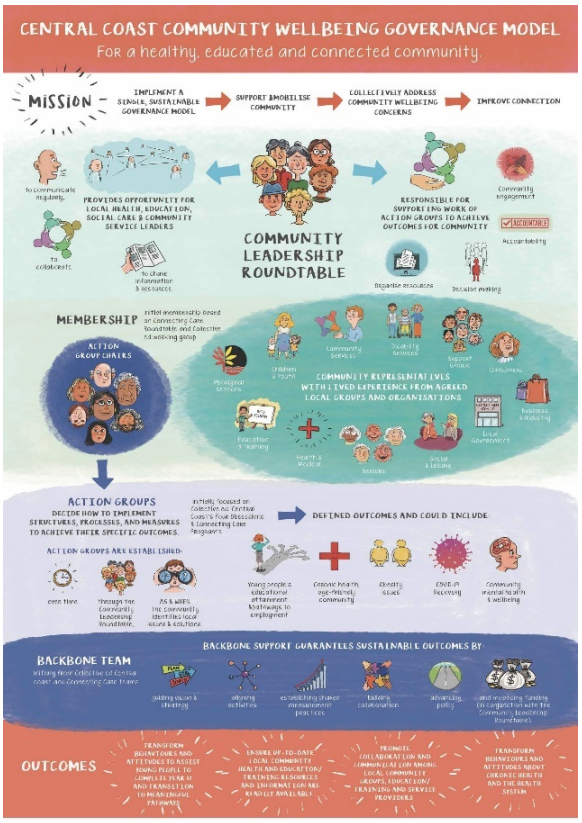


Illustration 9: The Roundtable governance model

Importantly for AC, the Connecting Care team has developed a governance model and terms of reference for a 'Roundtable' (this is described in detail in the Connecting Care final report: Connecting Care, 2020), an initiative that engages local government in supporting the anticipatory care needs of the Central Coast region (Illustration 9). Local government already has an important preventive health role (through immunisation clinics and childcare, for instance, but also through environmental health, public hygiene, and infrastructure. provision to support physical and social activity and connection. The Roundtable informs us more deeply about what role local government could play in anticipatory care across the state. It also has the promise of sustaining and building on the CC project's gains, addressing the problem identified by one of the research participants (and cited earlier), about the lack of:

> *any robust systems that support anticipatory care. 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.*

Project-driven changes to the AC system include:

- more access to information, provided by recognised local experts
- increasing support for people to navigate to get the help they need
- increased recognition of the importance of local identity and engagement in making health information accessible

- a more connected system in which a broader spectrum of people and services now understand their role in anticipatory care and the health and wellbeing of community members
- a model and energy for sustaining project gains through the Roundtable initiative.

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, everything from the practical impact on access from the steepness of a hill, or the presence of attractive local beaches and walks (as mentioned by survey and workshop participants), to the complexities of belonging, and history. In the Connecting Care community, the importance of 'being local' was a strong theme throughout the project and was used to good effect in project activities, including the Portal, Facebook page and information videos.

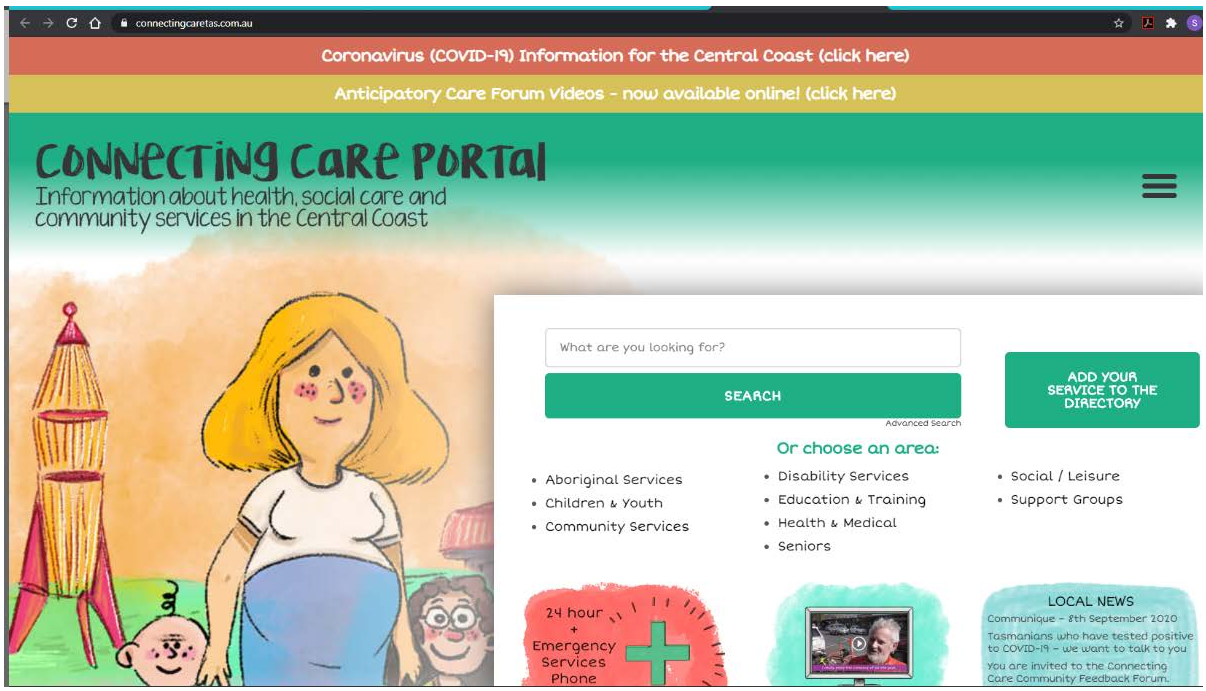


Illustration 10: Connecting Care Portal showing local landmark

Engaging with activities, places or services that support better health relies on those entities being 'safe'—feeling familiar, welcoming, and trust-worthy. The importance of place and belonging was used by the CC team in the information they provided to community (featuring local people and places; see Illustration 10). The absence of this sense of belonging

was also evident, however, in data about the alienation experienced by some young people, the lack of confidence to use some facilities or services, and in the relatively homogenous nature of the CRG and workshop participants. This means there is a need to find ways to make services 'safer' and to include a wider range of perspectives and experiences in future activities. Some CC activities and actions are easing the boundaries between people and health services (e.g., the health literacy training for local services may contribute to addressing this need) while supporting people's sense of place and belonging.

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. The most prominent ways this system part impacts on the AC system are through:

- Short term competitive funding
- Bulk billing model
- The social safety net.

Short term competitive funding models

It is clear (across all sites) that short-term competitive funding is damaging and limiting to the AC system. 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. Shifting national and state policy is a large task, but local sites can advocate for changes to this policy approach and can—as the Connecting Care Roundtable initiative may show—demonstrate the effectiveness of collaboration.

Bulk-billing model

The second policy problem is bulk-billing. The bulk-billing model operating in Tasmania makes GP and other medical and allied health consultations too expensive for many in the CC area.[12] The 'gap' is too large, and the upfront payment required can be beyond reach. That this was met with surprise by some local GPs is problematic; service providers need to understand the factors that are shaping the health behaviours of their community if they are to maximise their beneficial role in the anticipatory care system. Limited access to bulk-billing means that too many people do not seek preventive health or early intervention in health conditions—especially when access is affected by judgmental or stigmatizing attitudes among providers, or processes that require people to repeatedly justify being bulk-billed, putting 'patients' into a demeaning supplicant position. The lack of transparency about bulk-billing practices adds to this problem: too many community members are reluctant to seek GP appointments because they cannot easily find out the cost of a

[12] Dentistry, important for preventive health is an example of a part of AC that remains beyond the reach of many people.

consultation. Despite efforts across the AC project sites to get information, how bulk-billing decisions were made remained largely hidden.

Current funding arrangements and business models also constrain many GPs from reaching out into communities and engaging in local health promotion work. They also reduce the attractiveness to general practice graduates of working in places where people have complex chronic and other health needs and little money, contributing to low local GP numbers in precisely those places where the illness and illness risk burdens are greatest. It may be impossible for GPs to run a viable practice in some communities under the present policy settings. During the project some practices in project sites across Tasmania were threatened with or actually closed, and the COVID-19 pandemic may result in more such losses (Daly, 2020; Knaus & McGowan, 2020; McKenna, 2020).

The AC system relies on a strong preventive health role for GPs, and this is not possible with the present policy settings. GPs could, however, improve access by making their bulk billing policies consistent and explicit.

The social safety net

Poverty in some parts of the CC area is affecting how 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 CC community can shift during the life of this project, but they shape how the system overall works and who it reaches.

Local government and other services, though, have a role to play. 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. And local government and health services, collectively and working in partnership through the Roundtable, can use their authority and status to lobby state and national government.

Research question 2: Opportunities for enhancing anticipatory care here

The analysis showed three opportunities for enhancing the AC system in the Connecting Care site. The Findings section reports what we have learned about the impacts of local project actions.

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

The Connecting Care team developed a governance model for the Roundtable, as well as trialling four 'proof of concept' projects, information hubs, resource directory (the portal), health literacy training, and the GP audit. There is evidence that these initiatives can improve the operation of the AC system for people in the CC site (Table 4).

Table 4: Impact on AC system of some project activities

The Roundtable (in development)	• Offers sustainability to build on gains made by the AC project • Increased connection between service providers (an important outcome for the AC system) • Increase in people and services who understand they have a role in anticipatory care, and who are working to enhance the system • Created a model and terms of reference that can be applied in other sites
Community Reference Group (CRG)	• CRG built collaborative relationships and developed locally appropriate ways to support anticipatory care
Information Hubs	• Several models of information provision trialled (e.g., printed material, Health Expo, social media, shop-front, web portal) • Used local experts and locations, responding to the need for safe and familiar environments • New relationships (e.g., with Salvos, with Ulverstone Secondary College, with Beacon Foundation) created • Trials enabled CC team to learn how to tailor future delivery
Resource directory	• Development of the directory increased networks and collaboration • Increased knowledge of elements of the AC system locally • Some evidence of reduced barriers between health professionals and community members • Some services have increased awareness of the need for accessibility • Provides information about local resources for health (no evidence of impact on system navigation yet)
Health literacy training	• Informed by the 'The Right Place' model established in Huon Valley municipality, and rolled out in Clarence's H2H anticipatory care project • Training method trialled and appears successful • Some evidence of new relationships and shared approaches among participants
GP and community activities	
• GP audit	• Findings presented to participating practices; detailed report on the audit has not been provided
• RACF preventable hospitalisations	• Findings presented to GPs and participating facility; reported in CC final report (2020) with recommendations
• Social prescribing	• Project outlined; not conducted during AC project
• COVID-19 and palliative care	• Project outlined; not conducted during AC project

Research question 4: What role does the local lead organisation—Patrick Street Clinic—play in anticipatory care, and can it be strengthened?

The selection of Patrick Street Clinic (PSC) as a lead organisation in the AC project assumed the traditionally central role played by GPs in the AC system. The project therefore provided an opportunity to ascertain what role a GP clinic, embedded in a local community, can play in an Australian setting. PSC has an expert role in medical health, acknowledged by a broad spectrum of the community, and one of its principles, in particular is recognised as a leader and advocate for primary and preventive health.

The UK anticipatory care model is built on 'routine encounters', a non-fragmented system, and equitable access to a range of services (Watt et al., 2011). Patrick Street Clinic's role in the AC project has demonstrated that some aspects of the UK model are in place. They are able to provide 'routine encounters' for some patients, building relationships and longitudinal knowledge in the process. Front line staff—receptionists, for instance—act as important contacts, managing the long-term relationships in the practice. The audit conducted in the project, and an earlier experience of care coordination—has shown that PSC has systems in place to reduce fragmentation of care for people with chronic illness (within the practice). And for some patients, there is the possibility of access to a range of services, several of them co-located in the PSC premises.

The clinic is regarded as a leader in clinical training (medical student placements and an academic GP on staff) and employed a high status, experienced and locally known project lead, Professor Judi Walker, who was able to drive the project. This decision, and the subsequent decisions to out-source some activities (e.g., the PSOs (G, P, V & H), and evaluation) enabled the focus to remain on core business. Further, their status and role as one of two GP clinics in this community enabled them to bring people into the project, including the project lead, the Mayor, and the CRG and workshop participants. It also supported them to, through the local lead, build or develop relationships with several organisations and services that had previously not been presumed to be involved in anticipatory care. This has expanded our knowledge of what makes up the AC system. We have also seen how crucial it has been during the pandemic to have accurate, evidence-based and authoritative information provided by familiar and trusted people. here in the CC area, new skills and capacity to create and share that information have been created through the AC project.

As UK experience has shown, GPs have a central role, through the number of patients they see and through their knowledge of new development via the scientific literature, in identifying emerging population and public health issues in their communities. At PSC, this capacity is enhanced by their training role for medical students and the research those students undertake while at the practice. The general practice peak body, the RACGP, confirms that GPs work for preventive health (and in anticipatory care) through conducting screening, treating the presenting problem as well as spending time on planning and

prevention and on building trusting relationships with patients (Royal Australian College of General Practitioners (RACGP), 2015, 2019).

It is not possible, however, to re-create the ideals of the UK model here. Establishing long-term, trusting relationships with patients is only possible where those patients can afford to continue the relationship, and where there is an adequate supply of general practitioners to support community needs. With inconsistent and unclear bulk-billing, affordability is a problem. This financial problem is largely driven by national regulatory frameworks and restrictions set by policy; bulk-billing, rules controlling where and in what circumstances international medical graduates can work, and a dearth of item numbers to allow for ideal care are all policy-related problems. These factors mean that those hard to reach people, usually people who are poor, or who have other difficulties, are unlikely to get the preventive medical health care they need, because the up-front payment is too great, they are not sure they will be bulk billed, there's not enough time in a bulk-billed consultation for anything other than the presenting problem, or there is a shortage of GPs. These are barriers to reducing the risk of and from chronic illness. And people with chronic illness or with disability are much more likely to be living in poverty. Dr Djackik, an AMA spokesperson, has made public statement about some of these dilemmas affecting health in the north west:

> "The GP shortage is best illustrated if you go to the rural workforce website. Every single practice on the North West Coast has got an ad on there for a GP it's universal from the West Coast to Smithton, Sheffield, Ulverstone, Devonport, and Port Sorell and all of us would happily take more workforce and put it to good use" (Emil Djackik, quoted in *The Advocate*, 10 December 2019)

Policy also pushes business models within many GP clinics that affect the anticipatory care system by:

- reducing access to bulk-billing
- limiting opportunities to include prevention in consultations
- creating competition (which usually reduces cooperation)
- reducing information sharing about the costs of services
- reducing the chance of health professional doing outreach and embracing social prescribing.

The effect is to reduce transparency and increases confusion, prevent the sharing of some things that have been learned in this project, and make the system unreliable for too many people. In systems terms, these are policy and process, and attitudes and beliefs barriers.

In terms of project management, PSC was also affected by:

- limited connections with disadvantaged groups in the community, making it difficult to reach those most at risk

- limited engagement with the UTAS AC research team due to the absence of a dedicated PSO with clear delegations to engage and undertake the tasks being undertaken by PSOs in other sites
- apparent tensions regarding the project methodology and research processes (medical verse social science approaches) and philosophical underpinnings, (i.e. individual verses social determinants of health approaches)

While GPs play an important role in AC, placing a GP practice as a lead was problematic for the reasons outlined above. Further, PSC stepped back from day-to-day engagement in the project, letting the local lead and the CRG develop and implement action proposals, and overseeing and supporting some in-practice activities (the audit, the portal, medical student projects). This meant that PSC did not significantly shift their role in or understanding of the AC system, one of the potential and hoped for outcomes of the selection of a GP clinic as a local lead agency.

The AC project gained traction when the CRG was established and there was in-principle agreement that the project should be led by the CRG. This has supported the development of some relationships and of a Roundtable model that can sustain a community-wide approach to supporting the anticipatory care system. Further, although there were provisions within the AC funding guidelines to reimburse GP time, this was not taken up or built into the project business case and plans developed at the local level. Funding being made available for GP time does not always translate into GPs providing the time.

The role of GP clinics, including perhaps in other sites, could be strengthened by a policy environment that recognises, and funds, their role in preventive health. It may also be that there is a range of business models in Australian general practice, some of which offer alternatives that support GPs to take an active role in anticipatory care. Two examples are general practice cooperatives (e.g., Canada's Victoria Health Cooperative, or the Westgate Health Cooperative Ltd.), and Aboriginal Community Controlled Health Services (e.g., Flinders Island Aboriginal Association Inc.,[13] and Tasmanian Aboriginal Corporation). Our knowledge of the role of GP clinics in anticipatory care in this and the other AC project sites will be reported in more depth in the project final report to the Department of Health.

Barriers

The effectiveness of the CC actions and activities has been affected by structural problems.[14] We noted, above, the importance of policy and processes in the AC system; they can hamstring the system overall, as well as the local initiatives. Some policy-related barriers

[13] FIAAI is the lead organisation in the Flinders Island Anticipatory Care Action Learning Project.
[14] In common with all project sites, project activities have also been affected by the COVID-19 pandemic.

specific to GP clinics were discussed in the preceding section; additional barriers are discussed below.

Policy settings that reduce options for taking a SDoH preventive approach

There are numerous policy settings reducing the possibilities of building an anticipatory care system that takes the social determinants of health (SDoH) into account:

- Short-term competitive funding
- Narrow business models operating
- Lack of support for outreach
- Continuing poor distribution of necessary services (e.g., the continuing lack of adequate, local bulk-billing GP services) and increasing moves to online service provision despite problems with digital inclusion in Tasmania (Tasmanian Council of Social Service Inc. (TasCOSS), 2019)
- Absence of flexible funding and a policy environment that supports longer term, community driven and designed approaches to improving health at local level
- Continued difficulty reaching the 'unusual suspects'—people who are disconnected from services or community for various reasons
- The prevalence in policy of a medical model of health, which excludes the full range of perspectives community members have about health, and limits what and how services are delivered
- A persistent attitude that poor health is a personal problem or failing, driven by a lack of interest in or responsibility for one's wellbeing, rather than a social problem. This was frequently evident in the attitudes of some service providers
- That GPs' role in anticipatory care is contested; although they are expected to play a central role in preventive health, in fact the current policy settings mean there is little scope for GPs to work in that way
- Continuing lack of access to and availability of health resources and services, for example, access to GPs, ability to pay for health services
- Social determinants of health that require significant long-term strategies to address, namely housing, transport, food security, etc.

We now focus on three of these, the 'personal responsibility' mantra, short-term competitive funding and narrow business models.

Health is a personal responsibility—at the whim of larger forces

Despite compelling evidence that health is shaped by factors beyond the control of the individual, our analysis shows that many people in the CC area continue to believe that community members should take greater responsibility for their own health. This belief, perhaps in part a misunderstanding about the key themes in the data analysis, extended to some members of the project team and to health professionals:

> *[There are] Individual and organisational beliefs and attitudes about health and the health and social care system [...] highlighting our reluctance to take responsibility for our own health and to truly put individuals, rather than organisations and systems at the centre of health and social care.*
>
> *[These are] attitudes that somebody else is responsible for my health and wellbeing. People not really taking ownership of their health—that was a bit of a concern*

Individuals do indeed have some role to play in maintaining or improving their health, but the evidence of the role of the social determinants (and of genetics) is strong. This means that this way of thinking about health risks blaming unwell people for their condition; sociologists refer to this problem as 'victim blaming' (Crawford, 1977, 2006). Some of the individualist paradigm is based on a belief (evident in some of the project data) that damaging health behaviours are the product of ignorance. But this "politics of ignorance" serves to "reproduce power relations in which particular groups are constructed as lacking capacity to act on knowledge, whilst maintaining others in privileged positions of knowing" (Farrell, Warin, Moore, & Street, 2016, p. 1). Even among people who follow 'healthy lifestyles' there are class based patterns of ill-health, and lifestyle factors (including diet, smoking, alcohol consumption and exercise) may only account for a quarter of health inequalities (Barry & Yuill, 2016). Furthermore, the literature argues, and the survey and qualitative data has revealed, behaviours and choices about diet and exercise are constrained by resources, the behaviour of peers, and by motivation and confidence.

Short term competitive funding

Short-term, competitive funding has been found to be a barrier to the anticipatory care system across all the sites. 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). 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), 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.

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, 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 (not outputs and activities) and allow communities to get on with it. 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.

Business models of services in the AC system

As discussed above, the business model operating in too many health services, including general practice clinics, affects the anticipatory care system by reducing access to bulk-billing, reducing information sharing about the costs of services, and reducing the chance of health professional doing outreach. While this policy is controlled at government levels, health services and professionals can lobby to affect procedures and ways of working. One example of the need for a review of policy is the model that determines where international medical graduates (IMG) can work in GP clinics; a second is the provision of subsidies by the State Government for education in rural and remote areas, seemingly without any attached evaluation.

The business models operating within health provider businesses also tend to rely on measures which cannot capture the *quality* of experiences. What, for instance, can we learn from the fact that a practice has a particular number of patients on its books? Where there are few alternatives, being a regular user of a service *may* indicate satisfaction, or simply acceptance. Other measures are needed to ensure that services are inclusive, welcoming and appropriate for the community Those sorts of measures would give a more accurate picture of the impact of activities. The Australian Community Care Outcomes Measurement (ACCOM) tool offers a model for measuring both the quantitative and qualitative dimensions of service provision (Cardona, Fine, & Riley, 2020).

In the Connecting Care site, business models have also impeded the sharing of research findings (practices audit). Findings from research funded by the DoH were not shared, in spite of a contractual obligation to do so, on the basis of risk to commercial advantage. Project sites and UTAS are under a contractual obligation to share findings to support better anticipatory care in Tasmania; there is also value for the wider Australian population, given that all GPs in Australia have access to the same Medicare item numbers.

The usefulness of the methods

Action learning

Action learning was a good fit for the AC project, where much of the learning took place in the CRG and PSO activities. The CC team were involved in cycles of Observe, Reflect, Plan, Act, to review and adapt plans and proof of concept trials. Local responsiveness to the challenges of COVID-19 is a good example of this process. For the UTAS researchers, 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, including the

language we used, how we presented findings to the sites and adjustments made to the CLD process over the life of the project.

There were things that took time to get right. For example, the design and delivery of the community workshop in 2019 did not increase our understanding of the needs of the 'hard to reach', an important task in the project. On reflection, a series of smaller sessions, some delivered in community meeting places like the Neighbourhood House, Yarning Circles, Parents and Citizens' meetings, or sports clubs, for example, would have brought in some voices and experiences of marginalised people.

It was also not always easy 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. A related problem was that across the project sites, lead organisations took different approaches to role and responsibilities; these approaches sometimes meant that in the Connecting Care site, there were challenges in how best to balance and fund the research and outreach components of the PSO role. As well, a member of UTAS's AC research team was, for a short period, asked by the local lead to take on some of the local PSO roles.

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 CC 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 necessary relationship work to be done to develop the level of trust between lead, PSOs, DoH Principal Project Officer and UTAS necessary for that agency to be taken on. The distance from the UTAS research team's base in Hobart to the Connecting Care site reduced the time available for that work. We were fortunate to have a locally-based researcher, active in the Connecting Care site; she was able to gather local data, as well as do some of the needed relationship work.

Systems thinking and tools

Systems thinking was cautiously welcomed by the CRG members, despite little experience with this approach. 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. From a research perspective, these sessions were particularly effective, both for revealing and building knowledge, and for increasing collaboration between the participants and the researchers. Working on the CLDs identified places where the local team could intervene to enhance the AC system. A second valuable systems thinking tool is 'systems traps' (Meadows, 2008). UTAS and some members of the CC team have used this tool to identify and find ways around real and potential stumbling blocks.

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., across the AC sites in Tasmania, the 'problem' of the role of GPs in AC has sometimes dominated). If these sources are weighted towards the loudest voices (and missing the hard-to-reach), solutions can only ever be partial. This underlines the value of action learning; when missing groups are identified, the team can work to identify and include them in future action learning cycles, when there is time.

We need to work harder to find ways to introduce ideas like systems thinking and tools like the CLD process early and to encourage use of them—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 first-hand (rather than through interpreters like researchers or members of the local site team) much more about their experiences of the system, and thus support both genuine participation and local solutions.

Summary

The AC project in the 7315 postcode area 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 a little more equitable. Work by the CC team has fostered collaboration across several sectors, 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 build on the changes.

In the CC site, actions and activities have enhanced each of the elements that Watt and colleagues (2011) said are necessary for anticipatory care. The AC Action Learning Project 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 the AC system
- Networks, with shared AC goals, language, and opportunities for health advocacy
- Clear evidence for the importance of a health connector (or connectors) to the AC system's function
- Support for the role of GPs in anticipatory care, and knowledge of the policy changes that could support that role better.

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 develop the trusting relationships needed for effective action learning
  - more time is needed to further develop connections with health service system providers (e.g., neighbourhood centres, schools, sporting facilities) and to embed the Roundtable initiative
- Participation
  - although the lead organisations and collaboration with services extended the reach of the project into some of the more marginalised members of the community, there remained barriers to hearing from and including them in the project
  - there was a need for more planning for inclusion that factored in the inequities that shape people's ease of access, or comfort with engagement
  - some of the methods used by UTAS and/or the Connecting Care team were not useful for some participants (and potential participants).

Potential and future direction

- The CRG has shown its capacity to connect services, people, leaders, and residents, to keep a focus on health goals, and to drive health changes for this community
- The development and implementation of the Roundtable model is an opportunity to see what preventive health benefits there can be from a whole-of-community network
- Strengthening local health systems requires concerted effort and dedicated resourcing
- The actions taken have built foundations that could be built on with the right resourcing. The CLD also shows areas of high interconnectivity (and therefore potential impact) that provide future potential system focus points.

Recommendations

The AC project has demonstrated that enhancing the anticipatory care system is possible at the local level, through Connecting Care 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.

For local action

There are opportunities to maintain and build on what has been gained.

The Connecting Care initiatives

- Build on the individual, service, community, and AC system benefits from the CC proof-of-concept projects through the Roundtable initiative
    - This includes bolstering collective responsibility for AC
- Increase the focus on mental health and young people
- Invest in building volunteer numbers, capacity (including access to accurate information, and soft infrastructure skills) and reach to socially isolated people will enhance the AC system in the 7315 area
- Continue the Right Place model of building health literacy, communication, and relationship skills among providers to support early intervention and appropriate referrals (e.g., pharmacists, community health connectors, carers)
- Maintain the CRG working groups as needed and find means to support them to include a greater diversity of community members

Business models and key performance indicators (KPIs) have historically ignored qualitative measures of 'soft infrastructure' and change in favour of quantitative 'number of service' measures. These cannot adequately reveal how services in the AC (or broader health and wellbeing) system are performing.

- Review KPIs for the Roundtable to reflect externalities, soft infrastructure and experiential dimensions of performance

The Tasmanian AC project overall has demonstrated that there needs to be dedicated effort and resourcing to effect change in local AC systems:

- Establish a role, roles or approaches to support and enhance the AC system including through:
    - physical activity, social connection and information sharing initiatives (e.g., Information Hubs, maintenance of the Resource Directory, supporting Roundtable actions, and outreach)
    - relationships with existing and new service providers and researchers to strengthen coordinated approaches to improve health and wellbeing across the Connecting Care area
    - innovation to address AC needs.

For PSC processes

Partnerships and collaboration across the system are essential. The PSC is a leader in health in the local and regional community, and has a central role in building and sustaining collaboration across this community and shifting attitudes to support AC. PSC can:

- Review KPIs in PSC to reflect externalities, soft infrastructure, and experiential dimensions of performance
- Review bulk billing policies and make public its bulk-billing policy and guidelines
- Mentor medical students on placement to investigate ways to enhance the anticipatory care system and chronic illness prevention
- Share evidence and local GP knowledge to support anticipatory care, including the findings of the GP audit to support better clinical management of chronic illness across Tasmania
- GPs continue to use the CC portal for health promotion messages
- Model outreach and collaboration to other local service providers as key tasks for all service providers working across the municipality
- Lobby for policy-level recognition of the SDoH factors affecting the community and continue to advocate for better provision of GP and other health services locally.

For local, State and national policy action

All levels of government have roles to play in efforts to alleviate chronic illness.[15] 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:

- Recognise that GPs play a central role in local AC systems, but that their capacity is significantly impacted upon by current business models and policies governing the ways in which GPs operate. Policy makers (in government and in GP and health provider peak bodies) need to:
    - Review and rewrite policy to remove barriers to health providers playing a more beneficial part in anticipatory care
- Local, State, and federal health initiatives need to develop KPIs that reflect externalities, local context and soft infrastructure, including relationships and experiential dimensions of performance
- KPIs need to factor in the need for specific service provision to address the problem of equity; resources and actions need to target resources to those most in need
- KPIs should specifically target the issue of equity; resources and actions need to be targeted to those most in need

[15] These roles will be explored more fully in the final report.

- Factor the importance of place and belonging into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision, town planning, and social housing

Current, competitive 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 consider the adoption of the adoption of relational approaches to contract management and community-level or place-based budgets where resources are pooled and invested to promote long term health and wellbeing
- Funders to work as partners, providing guidance and monitoring of process (e.g., community engagement, how resources being utilised/targeted, without being prescriptive)
- To trust local communities to identify their own priorities and strategies to address those priorities

GPs' role in the AC system can be better supported if they adopt clear, transparent information and easily understandable guidelines explaining their bulk-billing policy and practices:

- Continue bulk billed telehealth services, subject to evidence that this is improving access to GPs for members of marginalised communities who may also have poor internet and telephone resources
- Review national and state regulation of GP services to counter supply shortages
- Review national and state regulation of GP services to increase equity of access to bulk-billed telehealth (e.g., the recent guideline that only people who have a regular GP can use bulk billed telehealth reduces access to this service for many who do not have a 'regular' GP)[16]
- Review subsidies for rural and remote GPs to do outreach and education, with the aim of better supporting and evaluating effectiveness and reach
- Review subsidies for GPs servicing rural and remote areas to include outlying and disadvantaged communities.

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 co-design community

[16] Many people in areas with poor supply of GPs are not on a GP's 'books' and so may be excluded from bulk billed telehealth.

specific responses. Assessing the longer-term health dividends is beyond the scope of the study:

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

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 team and community, and to adapt processes and tools for maximising participation
- 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 like researchers or members of the local site team), and thus support both genuine participation and local solutions.

Working together, the members of a community can enhance the anticipatory care system, but there are clear benefits from the direct research experience and evidence from the involvement of UTAS and the Department of Health. Building more effective and inclusive AC systems requires:

- Independent research support for evidence-based planning and action learning, systems thinking, ongoing reflection and review (i.e., university support)
- Policy and contracting support and management, and access to resources and information (i.e., DoH support)
- Community-based support for the identification and driving of change based on local needs and ways of working.

The contributions made by each group are particular and cannot be 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 Connecting Care 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 Connecting Care site

We used quantitative and qualitative data sources.

Table A3a: Quantitative data—from existing sources

Source	*What*	*How used*
2016 Census data	Population profile statistics for each suburb in the CC catchment: 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.
Primary Health Tasmania, the Australian Health Atlas	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.
UTAS literature review	Location of non-GP health or wellbeing services in the area; availability of bulk-billing; numbers of GPs; research findings about the area (e.g., Ahmed et al., 2017b; Department of Health, 2019; Tasmanian Council of Social Service Inc. (TasCOSS), 2019).	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 CC area by UTAS researchers, to June 2020

	Participants/documents
Interviews and focus groups	61 people
Community workshops	41 (2019) + 38 people (+ researchers)
Survey	146 people
CLD workshops	13 people (some attended both)
Reflections with/by PSOs	8 documents

Fieldnotes (from community and CLD workshops, CRG and exec meetings, site visits)	56 documents

A note on surveys

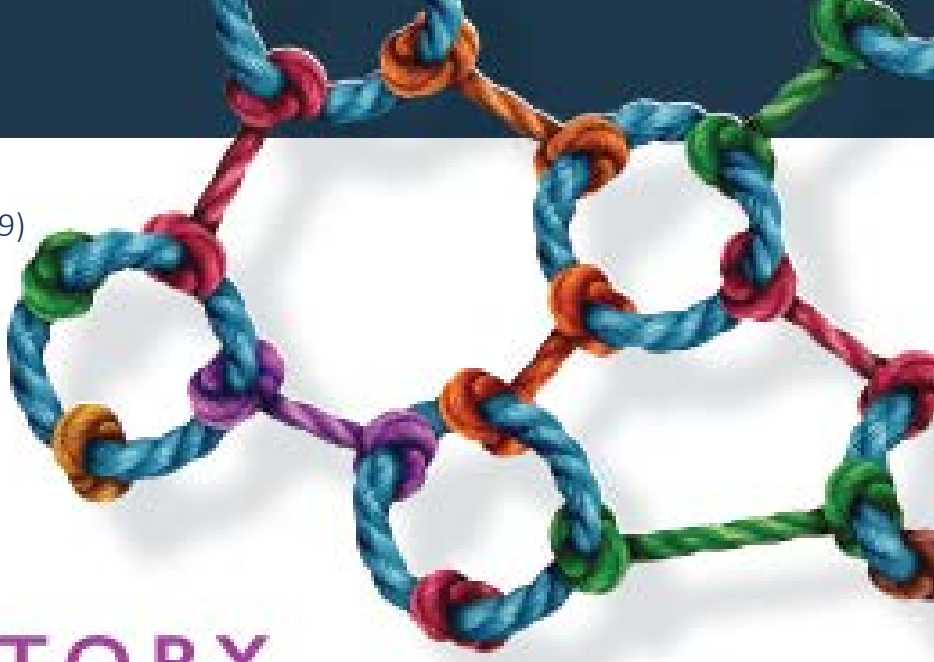
We needed to understand how people in the AC Action Learning Project communities experienced anticipatory care, and the health system more broadly. Interviews and focus groups were appropriate for some members of the community; they rely on potential participants being identified, those people trusting 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.[17] 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 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.

[17] 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

Connecting Care:

A GP led Health Initiative for Ulverstone

PRELIMINARY FINDINGS FOR THE 7315 AREA

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

The Australian Prevention Partnership Centre

saxinstitute

University Tasmania | Institute for the Study of Social Change

Department of Health

Tasmanian Government

Anticipatory Care: An action learning project in communities of place and culture

Report on the findings in Community 3: 7315 area for "Connecting Care"

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 are working 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)

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, Professor Judi Walker) and the Project Support Officer/s (PSO) (in 'Connecting Care' the PSOs are Holly Stubbs, and Gary Walker and Penny Allen from the Rural Clinical School). UTAS is also working with each community directly

through data gathering (e.g., interviews, focus groups, workshops, observations) and through the Community Reference Groups (also known as 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.	Local project lead and PSOs support UTAS research and work 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 members present and more widely
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 and Local Project Steering Committee determine 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.	Local project steering committee (lead organisation, including project lead and PSO/s), on the advice of the CRG, implement action (with UTAS support as needed)
9.	UTAS continually monitors impacts of the action/s, 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:

7315 RQ	What is the role of a GP clinic in Anticipatory Care?

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*".[18] 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'[19] 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. These quantifiable and experiential aspects of health are reflected in the Anticipatory Care project's Discussion Paper (Jan 2018),[20] 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)
- 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)

[18] Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948.
[19] Sir Michael Marmot's work was first reported in the Lancet: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)71146-6/fulltext
[20] A weblink to this document will be provided to the Project Lead.

- 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).

This is represented in the Tasmanian Anticipatory Care framework, which guides the project (presented in Attachment 3; hard copy is available on request).

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.

Confidentiality

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.

Table 2: Quantitative data—from existing sources

Source	*What*	*How used*
2016 Census data	Population profile statistics for 7315: ages, sex, diversity, employment, income, education, volunteering, households, etc.	Data is being used to understand the demographics of the 7315 area. This data also enables comparison with Tasmanian averages, and with the other project sites.
Primary Health Tasmania, the Australian Health Atlas	Health status and health behaviours information for 7315 (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.
Tasmanian Palliative Care data	Statistics about dying at home	To support and help further development of existing palliative care program
Patrick Street and Victoria Street Clinics	GP audit data	Refine practice processes to support people with chronic illness
UTAS literature review	Location of non-GP health or wellbeing services in 7315; availability of bulk-billing; numbers of GPs; social research findings about 7315 area (e.g., TasCOSS report on Men's Sheds)	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.

This information is being used to help create a statistical picture of anticipatory care in the area; it was also used to select the Ulverstone area as one of the suitable project sites. Some parts of this statistical picture are provided at Attachment 5 and were reported in the May 2019 Community Workshop posters.

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

Table 3: Data gathered in 7315 area by UTAS researchers to 1 May 2019

Participants	*Interviews*	*Focus groups: no. of participants*	*Workshop attendees*
GPs		10	3
Clinic patients		14	
Health professionals	3		9
Community services professionals	3	6	5 (1 also interviewed)
Government department personnel	6		7 (3 also interviewed)
Personnel in Service organisations or groups	4		5 (3 also interviewed)
Other community members	3		11
Total	19	20	41 (7 also interviewed)

UTAS researchers are using qualitative data to find out how people in the 7315 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 on 1 April 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 19 individuals; focus groups have been conducted involving 20 people, and 41 people attended the first community workshop. [Note: Seven of those attending the workshop have also been interviewed]. Observations include 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.). Observation fieldnotes were also made by researchers at the April 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.

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, but gives an indication of the prevalence of particular concerns or views among those present. A summary of the workshop material is provided at Attachment 6. To date, most qualitative data gathering in this community has been with people in roles with a link to anticipatory care and health and wellbeing more generally, or with current experience of being treated for a chronic illness. We need to broaden this to better reflect the breadth of knowledge and experience in the community overall, and to include 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 use medical services but also don't access non-medical health and wellbeing supports and hence may be at risk of developing a chronic condition.

Survey data

Finally, the GP students and project staff are 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. The survey is being 'interviewer-administered'; the interviewer 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 community[21] and to enable UTAS to build 'social network maps'. The surveying is intended to continue over the life of the project, and survey responses are being analysed by the UTAS team.

Data analysis and synthesis

Bringing together the data that have been gathered and working to analyse and 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:

[21] PSO engagement with all parts of the community will support implementing (and adjusting) 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 7315 area.

Preliminary results

UTAS is reporting these findings as part of our role in providing evidence to the local community, through the Community Reference Group, to support planning for enhancing anticipatory care in the 7315 area.

Our first report of the findings was made at the April 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.[22] 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.

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 Shed, the palliative care system, volunteering), as well as things that do not work or are confusing (e.g., experiences of being 'hand-balled' around the health system, bulk-billing decisions, or being unable to navigate through it). We have used the analysis to identify what makes those parts effective or what stops them from working, and identified five overarching themes, and four possible opportunities for intervention.

Five themes

Beliefs and attitudes	Individual and organisational motivations, assumptions, and judgments, and understandings of their role in the health system

Beliefs and attitudes shape how people and organisations behave and what they expect of themselves and others.

[22] 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.

Examples from the data include "Health is an individual responsibility", "Some people are not motivated to care for their health", and "If people knew more about what is healthy behaviour, they would act differently"[23]

Silos	The practices, beliefs and attitudes, processes, expertise, organisational or professional rules, legislation and policy, competitive funding, and specialisations that create boundaries around organisations or services

Silos can create internal cohesion and safety, but are also barriers to external sharing, cooperation and collaboration and result in 'hand-balling', mistrust, and fragmentation

Examples from the data include "It is hard to navigate the system to get the care I/the patient needs", "I don't know what those services do", and "We know care coordination makes a real difference to chronic illness experiences"

Resources	Resources include people and their skills and knowledge, infrastructure, data, money, leadership, diversity, food, and the environment

Resources can support health practices and behaviours but are not equally distributed or available and are only useful when processes are coherent and navigable

Examples from the data include "Ulverstone has so many services; there is something here for people at any level", "We have very active volunteers here", and "Lots of people are not using the services and activities here because they don't know about, cannot afford, don't trust, or cannot get to them"

Leadership	In 7315 leadership takes the form of people who are good sharers, navigators, and networkers who have credibility and expertise and are trusted

Leadership can be linked with a role (e.g., GP, school principal, Neighbourhood House leader), 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 realized that my way of dealing with a health problem could be useful for others and found ways to share it", and

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

	"We have some spare resources—let's find ways to use them for the greater good"
Mental distress	Mental distress includes diagnosable conditions (e.g., anxiety or depression) as well as grief, loss, social isolation or disconnection and substance misuse Seeking and receiving help for mental distress can be difficult because of service deficits (including problems with processes and silos), attitudes and beliefs including stigma, a lack of resources and the behavioural parts of conditions Examples from the data include "I can't get help for my family member because the waiting lists to see the specialist are too long/they are too far away", "We are working hard to create an emotionally or psychologically safe culture among staff so we can better support our clients", and "People want to die at home, but how can we make sure carers get the support they need to make that work—now, and once the person dies?".

For the purposes of planning to enhance anticipatory care, it is useful to concentrate on the 'biggest' idea.

Our analysis shows that the common thread in the 7315 area links the need for health system navigation, coordination, coherence, connection, and collaboration and the problems of a fragmented system with incoherent or overly complicated processes.

Four possible opportunities for intervention

It is difficult to directly change silos, levels of resourcing, beliefs and attitudes, leadership or mental distress within the scope and timeframe of this project. However, there are opportunities to make a difference by adjusting *processes*, and by working to increase *access*, *safety* and *connectedness* for community members.

Processes

Processes underlie all parts of the anticipatory care system and are shaped by attitudes and beliefs, by rules, policies and practices in and between silos, by leadership and by resources. Processes:

- can be incoherent—messy and disordered, and/or hard to understand
- may make work inside 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 leaders, or make them invisible

Access, Connection and Safety

The findings show that exclusion or restriction, isolation,[24] and emotional and physical risk are barriers to effective anticipatory care. Making changes to processes can break down some of these barriers.

Access. The data provides several examples of the ways in which people might be excluded or restricted from an activity or service, as well as where accessibility could be enhanced (e.g., making processes clearer, removing physical barriers like doors too narrow to admit a wheelchair, or making sure any information provided is responding to a community need, and uses language or images that meet the needs of the intended audience).

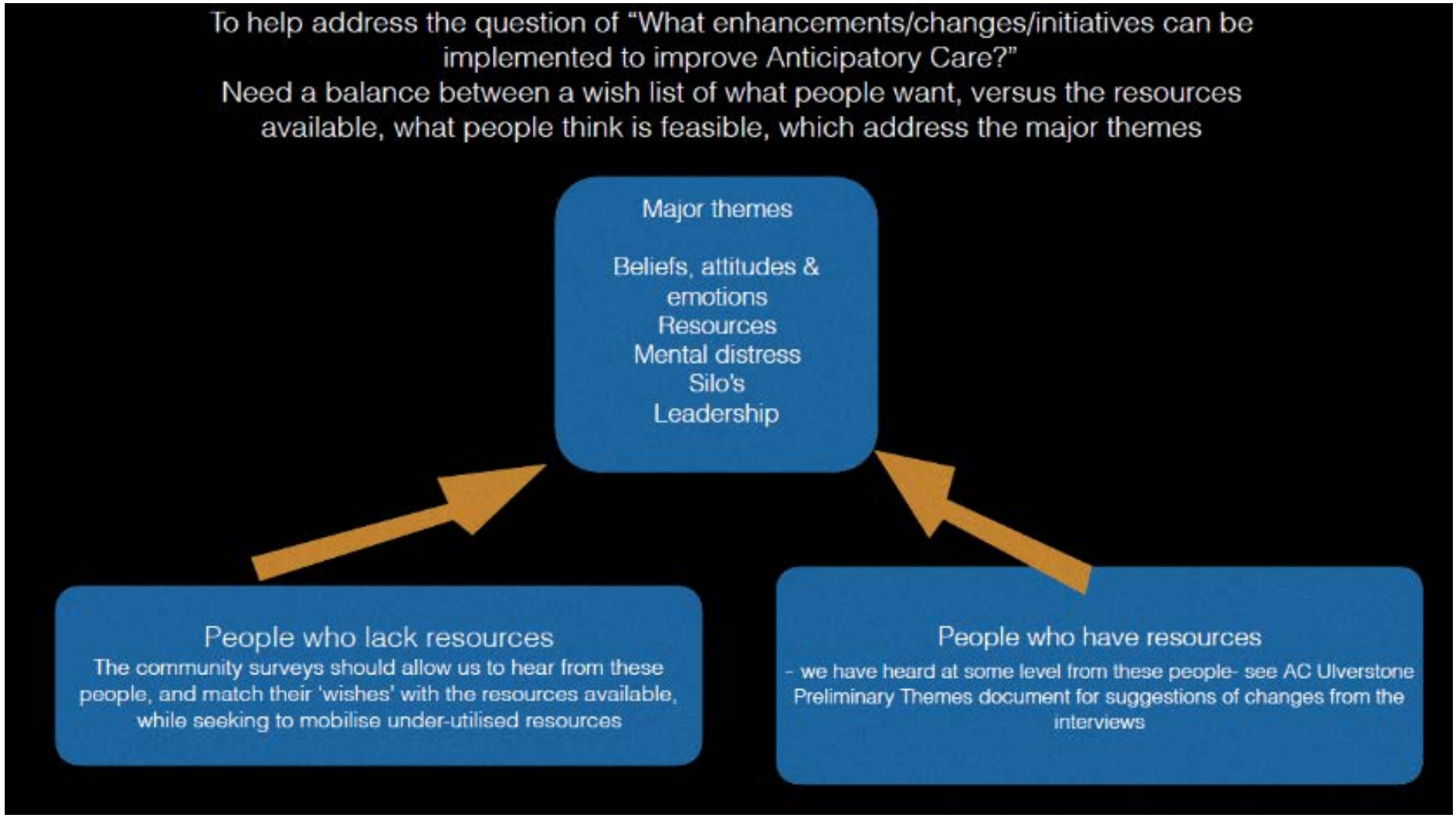
Connectedness. There is strong evidence that increasing connectedness, between services and between individuals has significant benefits (e.g., 'social prescribing', and care coordination).

Safety. All parts of the anticipatory care system need to be physically, 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.

The analysis suggests that the anticipatory care system in the 7315 area can be enhanced by adjusting processes so that access, connection and safety are increased. This is a possible focus of plans and actions by the Community Reference Group and Patrick Street Clinic. Figure 1, below, illustrates the present state and constraints.

[24] Many examples of social isolation are linked with the role of being a carer for a partner or family member, and with the loss of that person.

Figure 1: A way of framing current understanding from the data



Next Steps

The following are two worked examples of building on the research findings to enhance anticipatory care in this community. The first used the findings to identify three themes and possible approaches to address them. The second used the themes identified in the findings to develop one possible response (this example was presented to the CRG at the 2nd May meeting; see slides 17, and 19 from the Presentation, Attachment 7). These examples offer guidance on ways to use the evidence and existing services and resources to build connection, access, and safety and processes that support effective anticipatory care.

The following questions may be a useful decision-making guide:

- Given the findings, what are the 3 top priorities that you think *Connecting Care* should work on?
- 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?
- What are 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.

Action plans from the CRG will go to the local project steering comm for endorsement and implementation.

Example 1

Concern	*Possible responses*
Attitudes/mental health issues/better health supports (this includes the spectrum of the 'worried well' to those with multiple issues/comorbidity, and includes providing more health support generally)	Respite beds—reducing preventable hospital admissions
	More support in nursing homes to prevent hospitalisation
	Social prescribing—can be very low level, but relies on having up to date and comprehensive information and personal knowledge helps
	Community initiatives, e.g., via Rotary/Red Cross—extension of Mates initiative (connects a person with a mental illness with a volunteer to help them form a friendship), could extend Meals on Wheels, etc.
	Greater use of home visits, e.g., building on THS initiatives: ComRRS, CoNECs, Pharmacy Home Medicine Review
	Greater use/coordination of volunteers—increases volunteers' health and provides resources for health initiatives; to some extent the greater the opportunities for volunteers the more volunteers might participate
	Greater use of Telehealth and other electronic initiatives
	Greater use of Social Workers to address socioeconomic issues that impact on people's health, e.g., normalise going to a Social Worker, similar to seeing GP
Lack of information/good way to make accessible	One Stop Shop/Health Hub/Drop-in Centre—providing just information and/or co-locating services; possible location Ulverstone Secondary College (how would this be staffed/ resourced?). This could be on a spectrum from the informal Dodges Ferry model of "Health by Stealth" (e.g., Youth Drop-In Centre)[25] to more overt model, or something in between
	One central directory (e.g., Council already has one, 72 pages, but not widely known. Are there things missing? Is it able to be constantly updated? Is it sufficient to have a directory or do many people really want someone to provide more personalised assistance than a directory can provide?)
	Information for GPs and allied health professionals
	Regular Expo/Fair—people can meet providers face to face
Need more collaboration/ communication	Form an Action Group, e.g., representatives from all those keen to see improvements in health and wellbeing
	Joint projects, might rely on applying for grants
	Use newsletters either existing (Central Coast Voice/Council) or new
	Noticeboards
	Other joint projects

Example 2 can be seen as a development of one possible response in Example 1.

[25] There are examples in local government areas, including at Wynyard.

Example 2

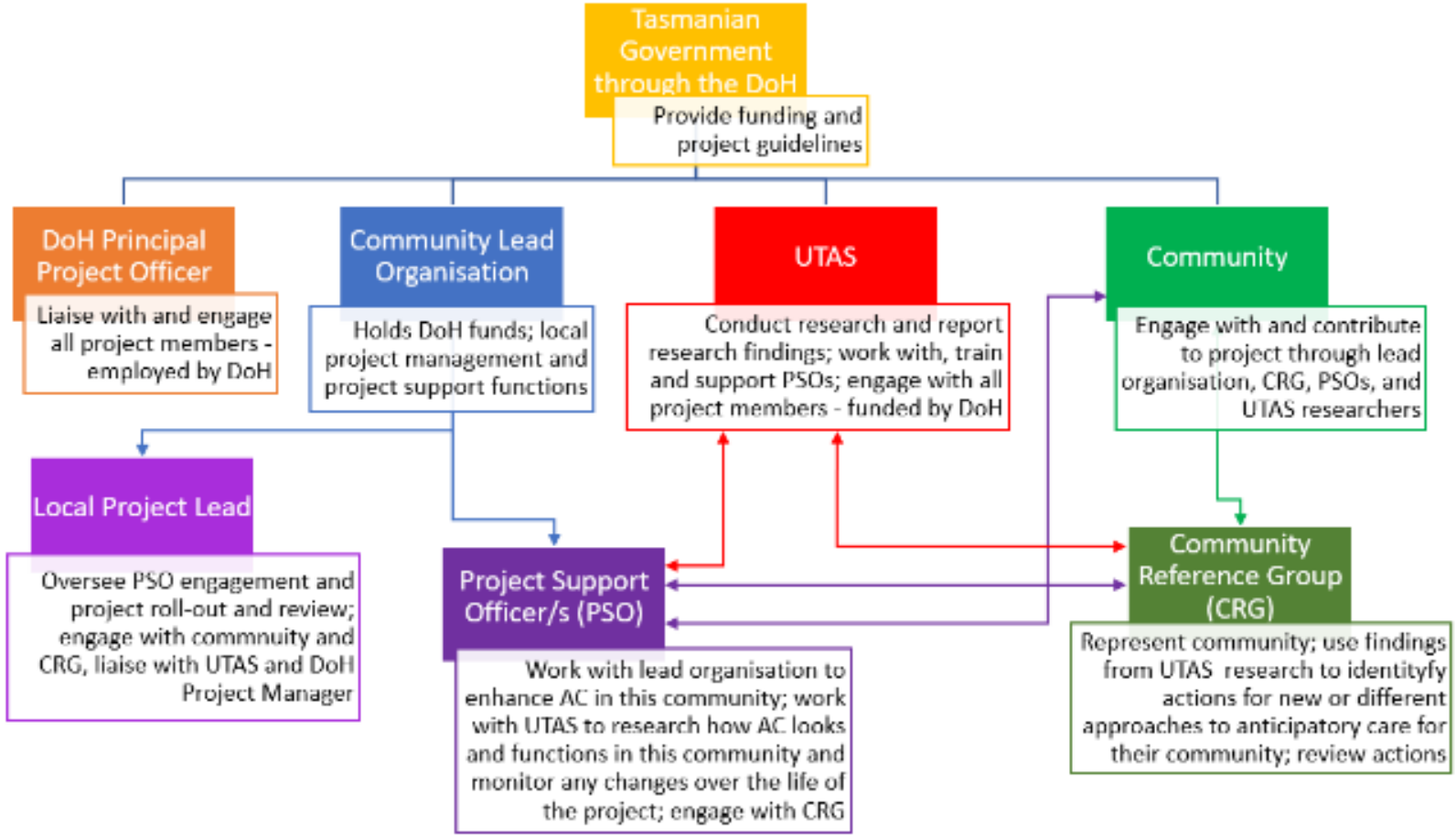
<table>
<tr><th>Concern</th><th>Resources or ideas</th><th>Bringing it together</th></tr>
<tr><td rowspan="8">Navigating for health is a problem for everyone.
It is made difficult by silos, by attitudes and beliefs, by lack of resources, and made harder by mental illness.</td><td>Workshop, focus group and interview participants talked about the need for:</td><td rowspan="7">A One-stop Shop or Health (information) Hub that uses the existing ‘shop front’ (Ulverstone Secondary College Town Hub), is staffed by volunteers (with skills, expertise and training), is enabled by connections and relationships with health and wellbeing services and supports, builds trust between community members and builds local capacity, is supported by up-to-date information and plain language material, and is responsive to community and clinicians’ needs</td></tr>
<tr><td>a directory</td></tr>
<tr><td>or a person to help</td></tr>
<tr><td>health expos</td></tr>
<tr><td>lay or professional expertise and leadership</td></tr>
<tr><td>Electronic health resources for GPs and allied health professionals</td></tr>
<tr><td>online or hard copy solutions</td></tr>
<tr><td>an available shop-front</td></tr>
<tr><td colspan="2">This solution makes process coherent, enables access, increases social connectedness and makes ‘navigating’ for health safer and easier.</td></tr>
</table>

A note on completeness

The 7315 area was the last community to enter the project (January 2019), and the project timeframe is tight (ending in December 2019). This has meant that the data gathered is not as comprehensive as it has been in other community sites to date, and the analysis is incomplete. There are participant types and areas of anticipatory care here that we have relatively little information about (as noted in the Presentation, Attachment 7 Slide number 7); the qualitative data at present is heavily weighted towards people in formal health or community services roles. Time limitations and capacity have prevented us going beyond this cohort but this will be important information to be gathered as we proceed. The experiences and potential solutions they will offer may be very different from those that health and community services personnel report or expect.

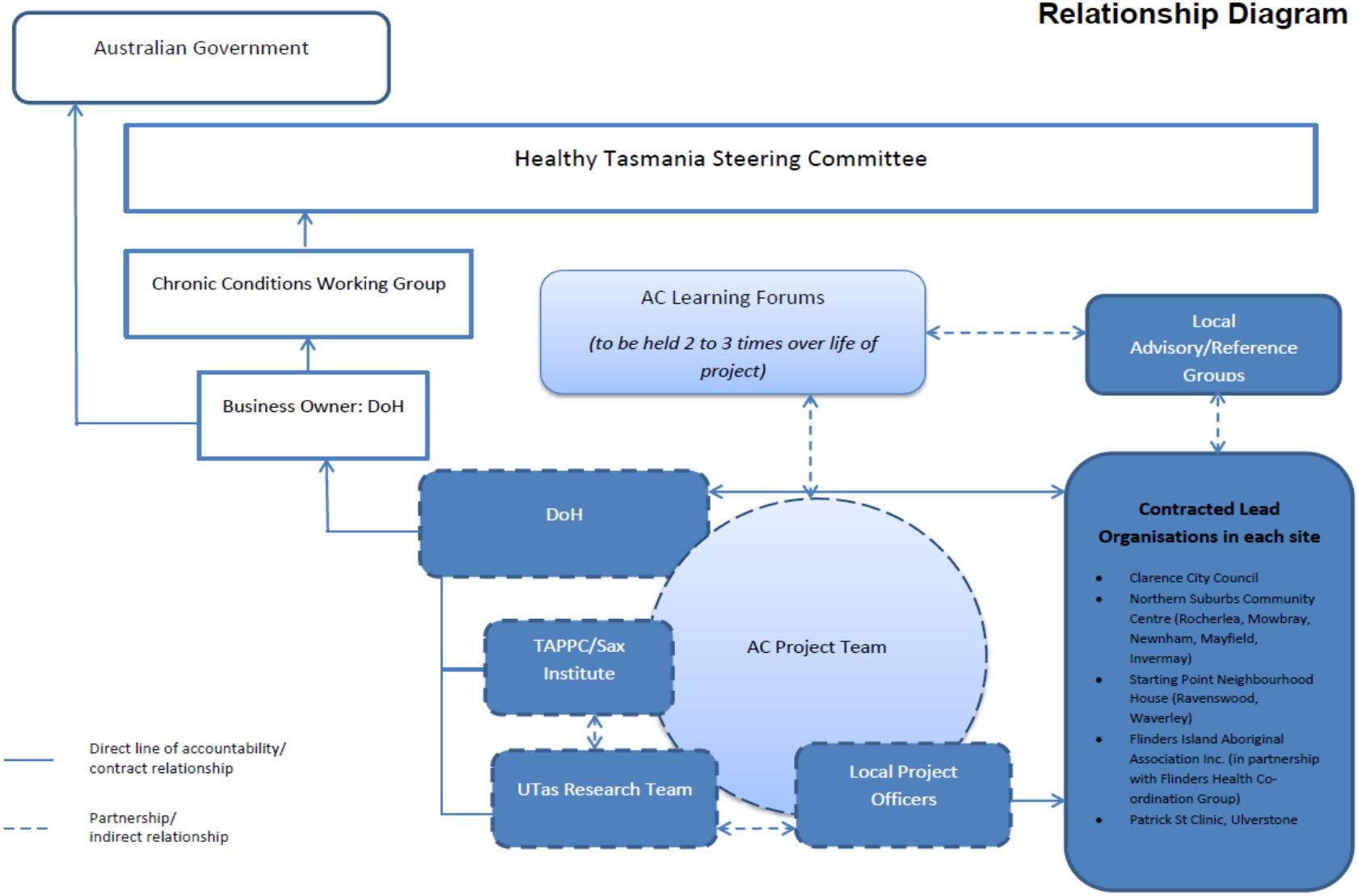
Therefore, in reporting the findings above, we have paid attention to themes that were the most prominent, or that have also been found in the other project sites. As data gathering and analysis continue, the updated findings will be reported to the CRG for use in the planning or modification of actions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

Attachment 1: Anticipatory Care project roles and relationships



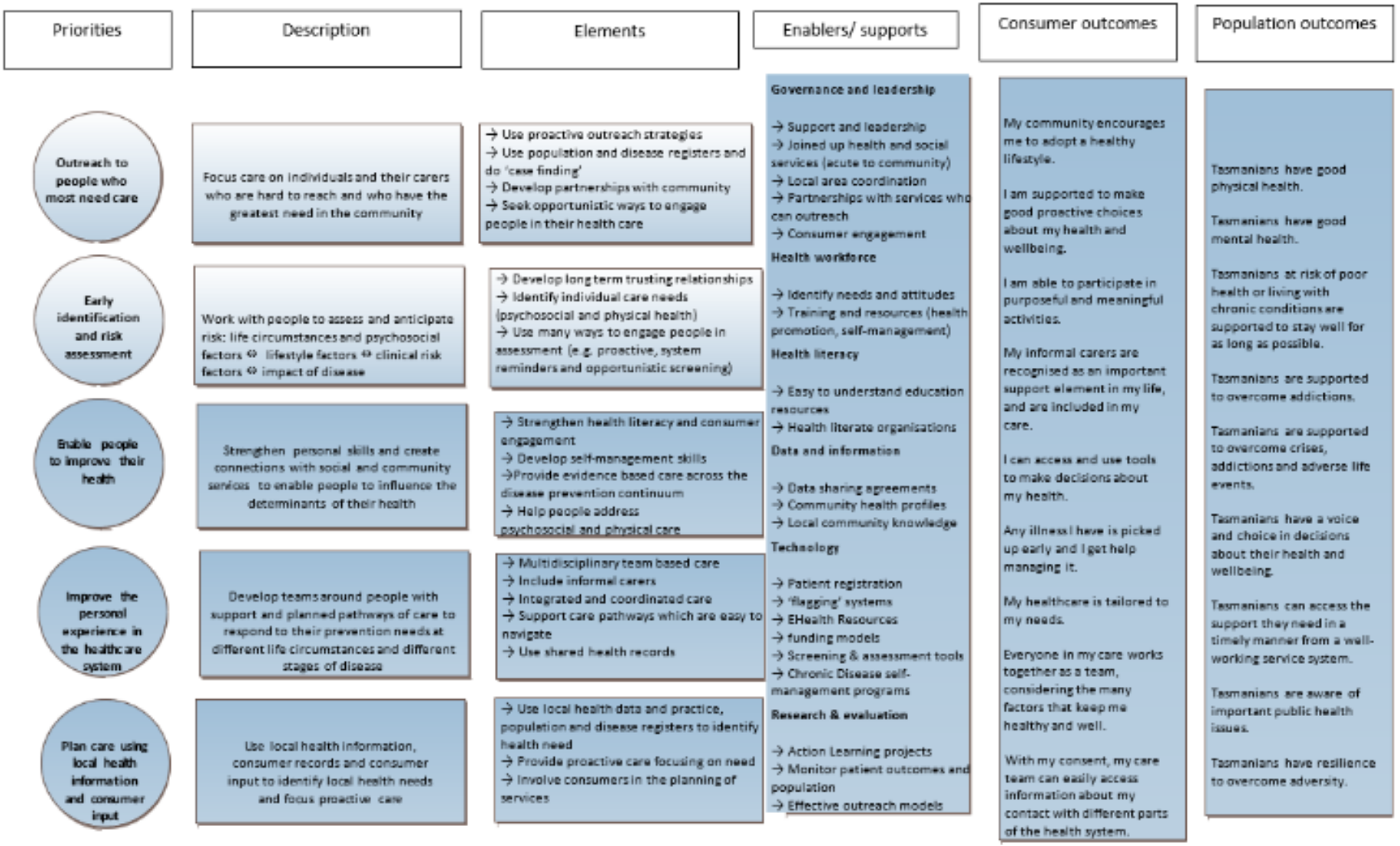
Tasmanian Anticipatory Care Project:

Relationship Diagram

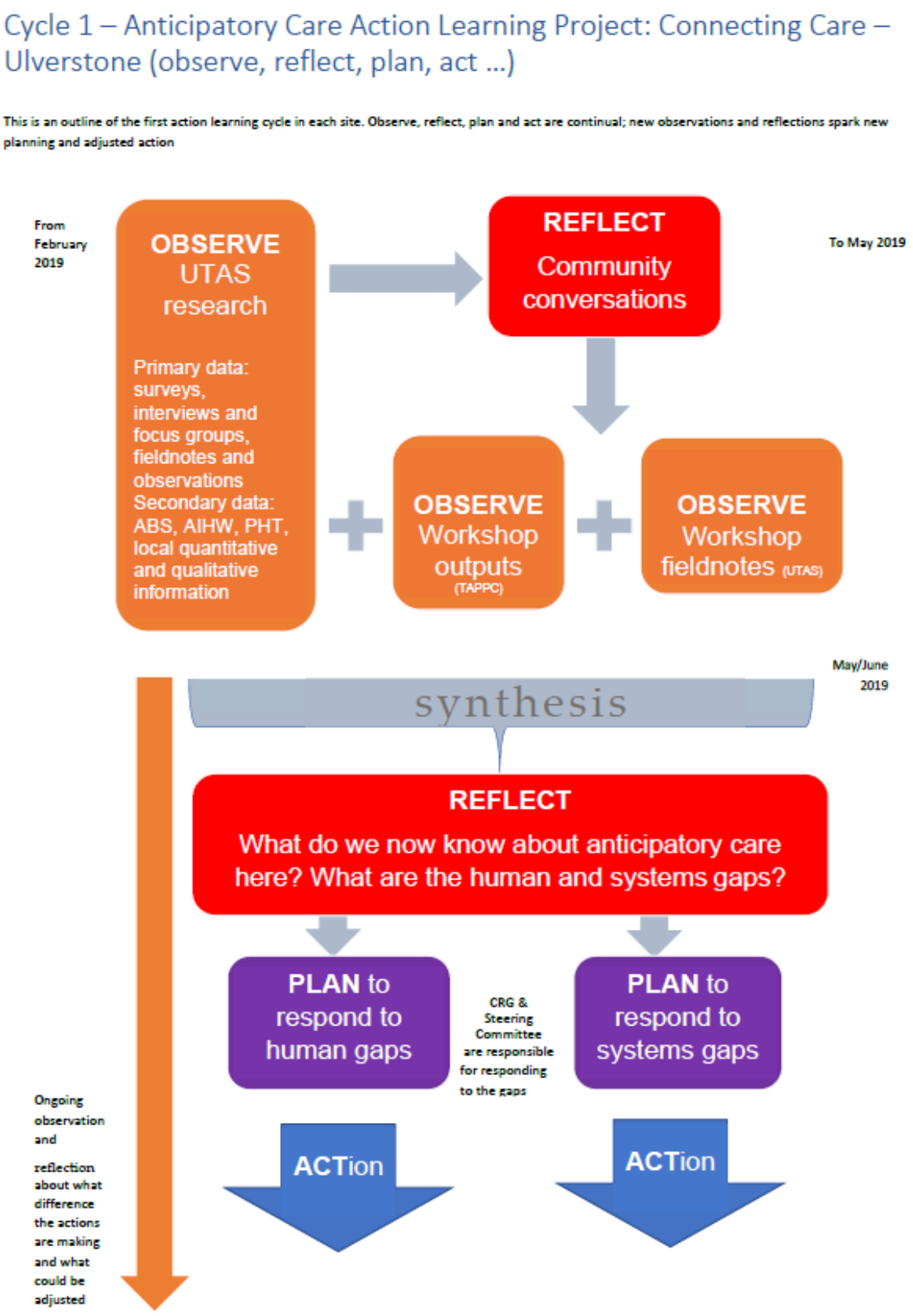



The ANTICIPATORY CARE PROJECT
Sax Institute/TAPPC
EVALUATION
4 community lead organisations – reflecting, planning and acting to enhance anticipatory care
UTAS
RESEARCH
Was the project worthwhile for Tasmania?
Did it deliver on the intended outcomes:
• Increased knowledge and understanding of the nature of anticipatory care across communities in Tasmania
• Insight into enablers and barriers in those communities in delivery of and access to anticipatory care
• Greater understanding of how communities and health services can work together to engage 'at risk' Tasmanians in primary health care for assessment and management of their health
Addressing the human gaps —reducing barriers to accessing anticipatory care for a particular group/s
Addressing the system gaps — addressing two or three pressing system barriers
Community partners will evaluate their own local activities, according to their frameworks, and reporting demands.
What does anticipatory care look like in this community? What are the shared elements and what are not (relationships, boundaries, etc.)?
What is working, and who is it working for? What is not working, or who is not benefiting?
What elements of the existing system can be influenced (and are they within the capacities of local actors)?
What gets in the way?
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?
Site-specific questions:
Community 1: What is the role of local government in anticipatory care?
Community 2: What is the role of neighbourhood houses in anticipatory care and can this be strengthened?
Community 3: What is the role of a GP clinic in anticipatory care?
Community 4: How does anticipatory care look and function in an isolated and under-resourced community?

Attachment 3: The Anticipatory Care framework



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



Attachment 5: Indicative statistical material about the 7315 area

Table 1: Demographic data for Ulverstone (post code area 7315), Census 2016

Characteristic	Number	Percentage (in municipality)	Tasmanian comparison
Population total	14,658		509, 965
Female	7,566	51.6%	51.1%
Male	7,092	48.4%	48.9%
Median age (national = 37)	47		42
Pre-school age (0–4)	725	4.9%	5.6%
School age (5–19)	2,640	18%	18.2%
Working age (20–64)	7,886	53.7%	57%
Post-work (65 –84)	3019	20.5%	17.2%
85 and older	398	2.7%	2.3%
needs assistance with core activities		10%	6%
Aboriginal people	1,107	7.55% of municipality	4.6%
Female	556	50.2%	50.9%
Male	551	49.8%	49.1%
Median age (national = 23)	25		24
Language spoken at home			
English (only)	13,618	92.9%	88.3%
Dutch	41	0.2%	0.1%
German	22	0.3%	0.3%
Tagalog (Philippines)	16	0.1%	0.1%
French	14	0.1%	0.2%
Italian	14	0.1%	0.2%
Children per family (all families)	0.6		
Children per family (families with children)	1.8		
Single person households	1,814	30.8%	29.6%
Housing			
Private dwellings (occupied)	5,893	89.5%	86%
Separate house	5,182	87.9%	87.6%
Owned (outright or mortgaged)	4,192	71.3%	69.2%
Rented or other tenure	1,512	25.7%	30.7%
Average people per household	2.3		2.3
Median weekly household income	$956		$1,100
Median monthly mortgage repayments	$1,200		$1,300
Median weekly rent	$210		$230
Health care card holders (% of pop)		8.6%	9.4%
Average motor vehicles per dwelling	1.8		1.8
Private dwellings without a motor vehicle	370	6.3%	7.5%
Internet accessed from dwelling	4,289	72.9%	78.0%

Work (aged 15 and over)			
Worked full-time (paid)	3,263	51.3%	52.3%
Worked part-time (paid)	2,235	35.2%	35.0%
Away from work	393	6.2%	5.7%
Unemployed	464	7.3%	7.0%
Did voluntary work through organisation or group	2,813	23.1%	21.3%
Industry of employment			
Fruit and vegetable processing	239	4.1%	0.4%
Aged and residential care services	239	4.1%	2.8%
Supermarket and grocery stores	208	3.6%	3.0%
Primary education	193	3.3%	2.6%
Secondary education	156	2.7%	1.7%
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			86.3%
Bachelor or above	1,314	10.8%	16.2%
Advanced diploma/diploma	834	6.8%	7.5
Cert IV	364	3.0%	2.9%
Cert III	2,133	17.5%	14.8%
Year 12	978	8.0%	12.0%
Year 11	576	4.7%	4.7%
Year 10	2,583	21.1%	17.4%
Year 9 or below	1,750	14.3%	10.3%
No educational attainment	25	0.2%	0.4%
Religious affiliation			
No religion	5,150	35.1%	37.8%
Anglican	2,740	18.7%	20.4%
Catholic	2,209	15.1%	15.6%
Not stated	1,332	9.1%	9.7%
Uniting Church	1,059	7.2%	2.0%
Travel to work			
Car, as driver	4,195	71.5%	65.3%
Car, as passenger	261	4.4%	5.8%
Bus	-	-	2.4%
Walked only	162	2.8%	3.0%

Source: Statistical information is from the Australian Bureau of Statistics, 2016 Census QuickStats: http://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/POA7315?opendocument

Table 2: Health risk data for Central Coast LGA (includes Ulverstone) and Tasmania

	CC LGA	Tasmania
% self-assessed health fair or poor (2013)	20.1	19.0
% current smoker	13.1	15.7
% daily smoker	11.5	12.1
% smoking during pregnancy	14.1	13.8
% low birth weight babies	6.6	7.1
% overweight/obese BMI	66.6	60.1
% obese BMI	21.7	24.3
% Alcohol consumption levels causing occasional harm => 4 standard drinks at least yearly	32.0	45.0
% Alcohol consumption levels causing lifetime harm => 2 standard drinks at least weekly	20.8	20.8
% insufficient moderate/vigorous activity, <150 min moderate/75 min vigorous/week or combination	14.9	14.9
% insufficient muscle strengthening activity, <twice weekly muscle strengthening activity	72.1	70.2
% inadequate fruit consumption, <2 serves daily	62.6	59.6
% inadequate vegetable consumption, <2 serves daily	91.9	91.0
% psychological distress high or very high		11.4
% persons with three or more chronic conditions	22.1	21.5
COPD [avoidable] deaths (ages 45-74)	10.9	13.7
diabetes [avoidable] deaths	8.0	7.9
suicide and self-inflicted injuries [avoidable] deaths	13.6	13.3

Source: Ahmed et al. (2017a)

Table 3: PPH for Ulverstone, for the four years from 2012/13 to 2015/16

Suburb	Total PPHs	Age standardised rate per 1,000 (Mean rate Tasmania = 23.32)	PPH chronic conditions Age-standardised rate per 1,000 (Mean rate Tasmania = 11.6)
Ulverstone	1,140	32.6	16.4
West Ulverstone	152	7.5	4.5

Attachment 6: Summary of Community Workshop outcomes

ULVERSTONE—Connecting Care—Identifying priorities for action

This table is a summary of the big local themes that have been identified from the consultations and research.

	ATTITUDES AND ACTIONS	INFRASTRUCTURE	PEOPLE AND HEALTH	RELATIONSHIPS	LEADERSHIP	HEALTH SERVICE DATA & INFORMATION
BIG LOCAL THEMES	Stigma is a barrier to people in need accessing services, especially AOD, sexual health—everybody knows each other here How to link people to care that is available? Clients not being told costs Youth access Cost and distance Removal of funding from primary health services e.g., neighbourhood houses, community health, AOD, GPs Silos Attitudes to alcohol Multiple agencies not talking System overload Private health cover confusing	Facilities in Ulverstone are underutilised Great facilities (soccer, basketball, swimming, hiking, nature)—transport and cost barriers to accessing Care co-ordination program cut; GP overload Bulk billing—not sustainable for GPs Poverty—costs to access MBS needs overhaul	Isolation (real and perceived) Mental health Need programs to support wellness and belonging—good advertising; expo style things Access Inclusivity (ages, gender, SES) Cost, transport barriers Poverty in the community affects access to care Internet access (not all people can access info online) Awareness—improvements to health literacy are needed Under-utilisation of infrastructure Lack of public transport Access to services—information not well distributed Sea changers—do we really open our doors to newcomers? Stigma attached to low socio- economic families/communities Increase preventative care and in-home care	Connection exists; providers are connected but this doesn't always translate for consumers Paper work and red tape—Centrelink forms/applications Systems are too complex e.g., My Aged Care Silos not working Need for better co-ordination of services Transport to access dentists/specialists Hard to get doctor if new to community HACC—long waits Systems so complex we need to employ navigators	No central approach to finding services Different organisations leading health in community but not linked up; no central approach (Mission, Patrick St, Rotary) Lots happening but no central approach—role of Council? Older community in Ulverstone—computer literacy (22% of Tasmanians don't have internet access) Care Co-ordination Nurse funding cut	Community nurses have been phased out; no continuity of care now Concerns over data safety and privacy Communication and data sharing—services and hospitals not talking to each other; different software systems; better sharing of information Changes to community nursing have damaged the system—want this to be refunded My health record not working (same for NDIS and My Aged Care)

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

- Navigation of system/information (complexity, trials, fixed funding)
- Accessibility (transport, cost, information, inclusivity, internet access)
- Awareness (of health, services, health literacy, diversity, having information)
- Need for a care coordination program
- Health hub for the community ('one stop shop', find out about local opportunities)
- "do leadership differently"
- Policy changes (community nursing, funding for prevention)

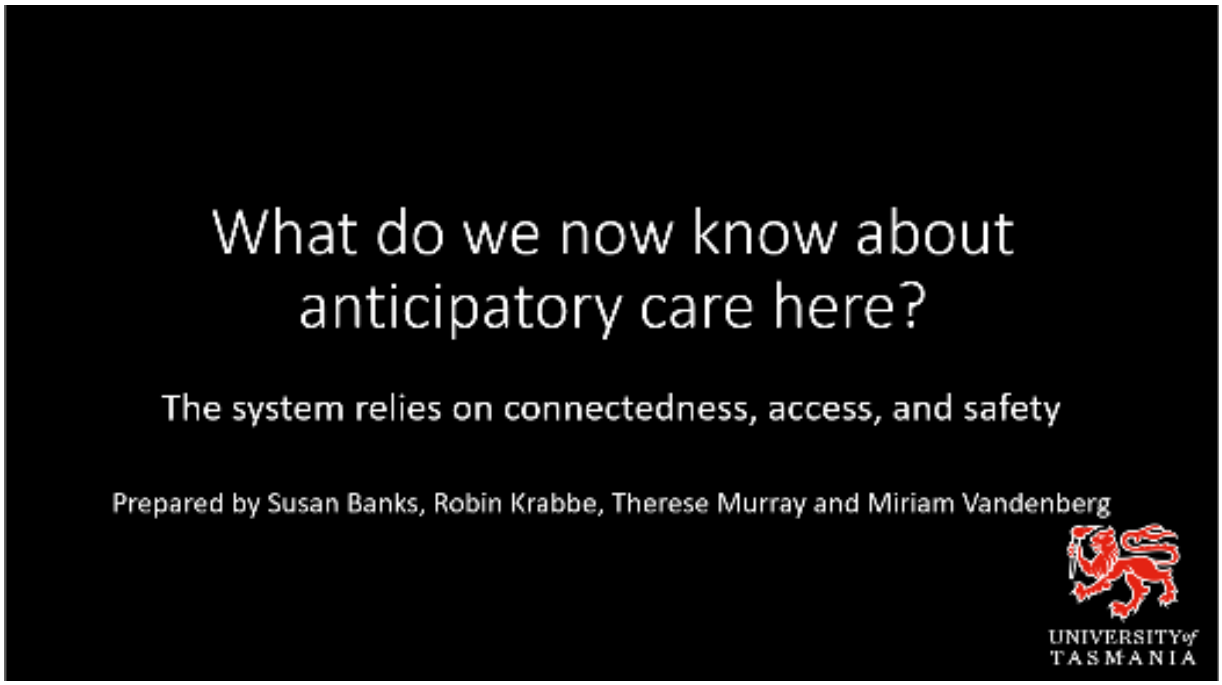
Below is a summary of things that workshop participants reported are working or could be further strengthened to support the health and wellbeing of the community.

	ATTITUDES AND ACTIONS	INFRASTRUCTURE	PEOPLE AND HEALTH	RELATIONSHIPS	LEADERSHIP	HEALTH SERVICES INFORMATION
THINGS THAT COULD BE STRENGTHENED/ BUILT ON	• AOD organisations work together in best interests of clients; no ownership of clients; government reporting now looks at outcomes rather than numbers • Person relationships are good between GPs and other allied health teams • Willingness of community to work together	• Sport and recreation facilities • Dementia café • Good parks and green spaces • Integrated care in one place, e.g., physc, GP, DE	• Well-equipped GP practices • Increased services going to schools • Accessible local Aboriginal health service • Good community between services and clubs • Older population bring wisdom • Sense of community • Emergency services • Great parks and cycle tracks • Growing awareness and destigmatising of mental health • For small community, high number of volunteering services and clubs • Palliative Care—more people able to die at home on NW	• Community nursing going well • Schools developing and nurturing relationships with kids four health • Non-government organisations available in hospital • GPs know their patients well—good access to home visits • Cancer Council • My Health Record a good concept but underutilised	• Schools providing a base for services relevant to kids • Service clubs • Water St Day Centre • It's OK to ask • School program reboot- teaching students to self-regulate health and wellbeing	• My Health record working for some and NDIS and My Aged Care • Care Co-ordinator worked but not funded anymore • Telehealth—can we scale up

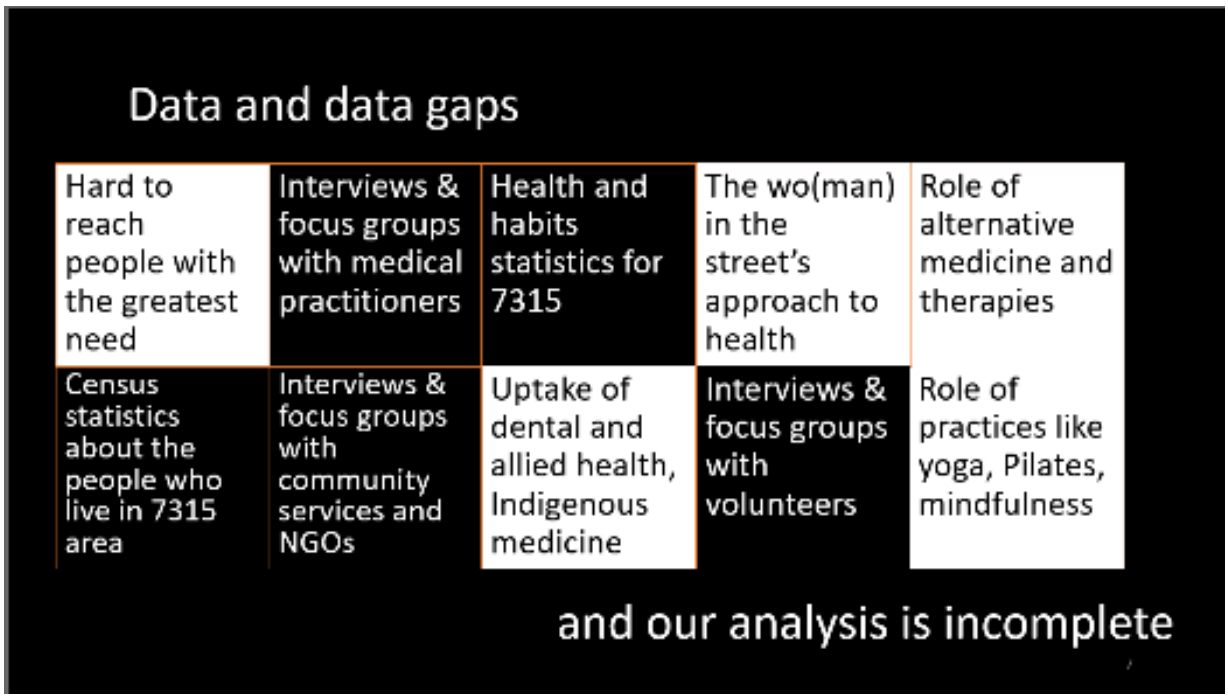
Below are areas that have been identified as areas for further investigation.

THINGS FOR FURTHER INVESTIGATION	
	• Service Directory or health hub or 'fair days' for service providers • Programs could be funded from savings made by preventing costly hospitalisation • Internet access (particularly for older people)—how we communicate information • Too much information and too little information—too much information via Dr Google but also little control and understanding of own information, e.g., My Health Record, My Aged Care, NDIS • Changes to community nursing—what has been the impact on the system and care local people can access? • Sea changers—do we really open our doors to newcomers? • Telehealth—can we scale up?

Selected slides from the Presentation to the CRG, 2nd May 2019.



Slide 7



Slide 17

What might focusing on the glue and the lubricants look like?

Example – The data shows us that **navigating for health** is a problem for everyone.

It is made difficult by **silos**, by **attitudes and beliefs**, by lack of **resources**, and made harder by **mental illness.**

Workshop and interview participants talked about the need for a directory, or a person to help, about health expos and lay or professional expertise and leadership, and online or hard copy solutions. A shop-front was offered, so …

Slide 19

A One-Stop Shop or Health Hub

- Uses existing 'shop front'
- Staffed by volunteers (with skills, expertise and training)
- Enabled by connections with health and wellbeing services and supports
- Building trust between community members and local capacity
- Supported by up-to-date information and plain language material
- Responsive to community and clinicians' needs

This solution makes *process* coherent, enables access, increases social connectedness and makes navigating for health safer.

Appendix 5: Invitation to the causal loop session

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, Connecting Care

The survey was conducted over 2019, with 146 people responding. Not all participants completed all survey questions.

Age

Mean age for participants is 52.68, with the youngest person being 16, and the oldest 88. The median age is 60, which is higher than for the 7315 area as a whole (median = 47), so the survey respondents are significantly older than the general population (see Appendix 6 for additional information).

Home location

Seventy-four people gave "Ulverstone" as their address. Of the remainder, 16 said "7315", 11 "West Ulverstone", 8 "Turners Beach", 6 "Penguin", 4 "Gawler", 3 each "Devonport" and "Forth", 2 each "Latrobe", North Motton and "Shearwater", with the remainder stating "Abbotsham", "Castra", "Cuprona", "Gunn's Plains", "Kindred", "Leith", "Ocean Vista", "Port Sorrell", "Preston", "Sheffield", "Somerset", "Stowport", "Sulphur Creek", and "Wynyard". Not all these locations are within the 7315 area.

Sex/gender

Sixty men (41.1%), eighty-five women (58.2%), and one 'other' person completed the survey. The sex ratio in the 7315 area is 48.4% men and 51.6% women.

'Being healthy'

Participants were asked "What does 'being healthy' mean, feel or look like to you?", as well as whether there were things they wanted to change about their health, and what those changes were.

The overwhelming theme in the responses to this question was about 'being able'—able to move freely, live a normal life, do the things the person wants to do, and so on. Having energy and capacity—unrestricted by pain—was also an important aspect of a sense of health. Seventy-one people (48.6%) included mental health in their response, for example, "*To be healthy is to be well balanced both mentally and physically*", and "*Being balanced in my mind, my body, my mental health and my spirituality*"; almost all mentions of mental health were linked with the need for a balance of physical and mental wellbeing.

Compared with the overall sample, women were much more likely than men to include mental wellbeing in their response (76% of the people mentioning mental health were women). It is also clear that older people were much less likely to mention mental health in their response to this question (Figure A1).

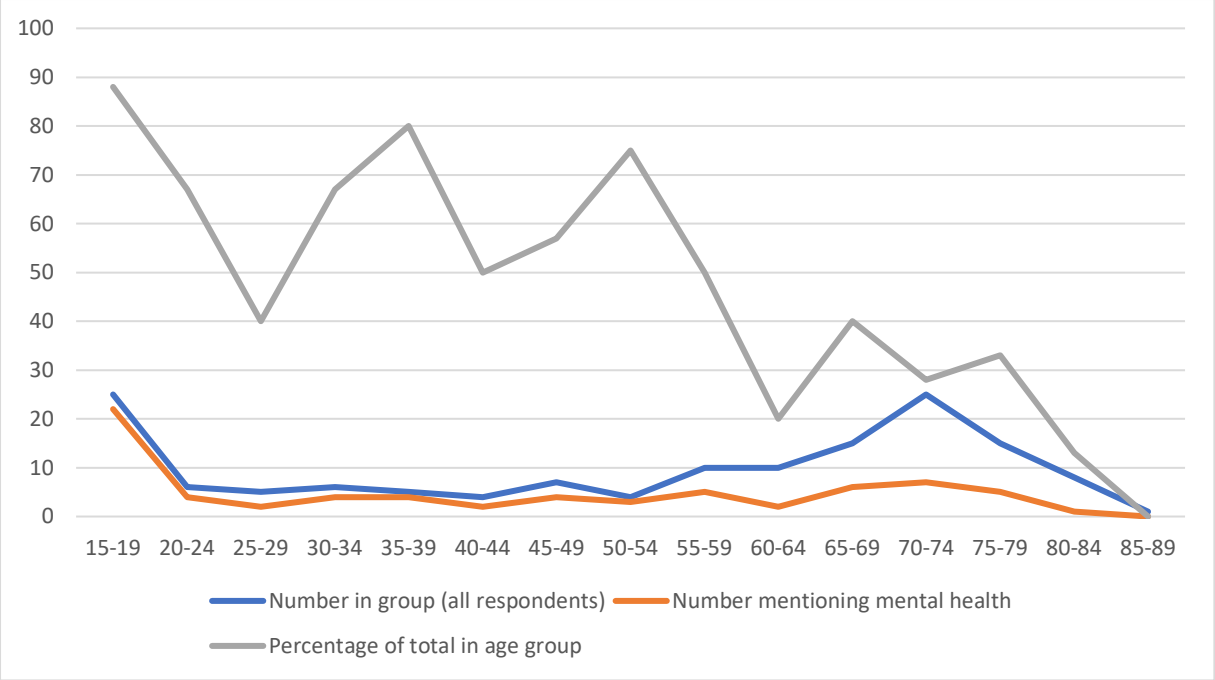


Figure A1: How age correlates with inclusion of mental wellbeing in overall sense of health

The majority of people (n = 108; 74.5%) wanted to make changes to some aspect of their health. Of those who did not want to make changes, two people also responded by noting what changes they wanted to make. Their responses are: "*Not have [chronic condition]*"; and "*Being realistic with her age*". We categorised responses into the major themes evident. People listing multiple changes they want to make are older and the youngest person to mention pain is 37; most are in their late 40s or older. This mid-40s point also appears to be when people start to mention that the change would be to be able to do the things they wanted to (unimpeded by pain, lack of mobility, chronic illness or weight). As one 49-year-old put it, "*Be back to a health[y] body [I had] on my 15th birthday*". Further, and in keeping with the results for the question about what health means, feels or looks like, having better mental health features most strongly in people aged younger than 30.

Being more physically fit and mobile was the most common change identified by participants (40 mentions; 37%). People wanted to get fitter for its own sake, or so as to reduce fatigue, improve mobility or, in one case as protection: "*develop my muscle groups to maintain muscle and bone strength as I get older*".

Weight loss was mentioned by 24 people (22.2%), for three of whom the driver was to reduce risk of or from diabetes. More people wanted to be free from an existing illness or chronic condition (35; 32.1%). Chronic conditions listed include Parkinson's disease, high blood pressure, heart disease, diabetes, asthma, cancer and arthritis. This figure may reflect the fact that a proportion of the surveys were completed in a GP clinic waiting room, and with a chronic condition group.

Feeling mentally better also ranked high (n = 18; 16.7%). People noted a wish to be "*feel more emotionally stable*", and to "*decrease anxiety levels [to be] more socially out there with different*

peoples". Specific mention of needing to reduce social isolation was made by four people; reducing stress was mentioned by three people.

Sixteen people (14.8%) wanted freedom from pain. Participants also mentioned wanting to change an assortment of health habits—including smoking, eating junk food (and easy access to it), and getting more sleep, and a desire to reduce their reliance on medications.

Self-reported health

All but one survey respondent (n = 145) answered the self-reported health question. Results are shown in Table A1. Excellent health was reported by 15 people (10.3%), good by 77 people (53.1%), fair by 43 people (29.7%) and poor by 10 people (6.9%). Grouped into two broad categories, 63.4 per cent rated their health as excellent or good, and 36.6 per cent as fair or poor. This is a significantly poorer result that for Tasmania as a whole (Department of Health, 2019); in 2019, 78 per cent of Tasmanians, and 77 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). The poorer self-reported health in this survey may be partly a result of some surveying being conducted in the waiting room of a general practice clinic, where people are likely to be unwell, but are also likely to be focused on their health (or absence of health).

Another explanation could be that the 7315 population is older than for the State overall. However, we reviewed the survey self-reported health results by age clusters and found that there were no age groups for whom self-reported health was consistently excellent or good, as might be expected if there was a correlation between age and self-reported health. The method was sorting the data by age, and then grouping those respondents in tens (so the first group had a mean age of 80.7, the second, a mean age of 76.7, and so on).

Table A1: Breakdown of self-reported health by age clusters (oldest to youngest)[26]

[26] Average self-reported health here was calculated by assigning values as follows: 'excellent' = 1, 'good' = 2, 'fair' = 3, and 'poor' = 4. Thus, in the top row, the 'score' for the cohort was 27 (1 x4, + 6 x 3, + 2 x 2, + 1 x 1 = 27), and dividing it by the number of scores (people in the cohort): 27/10 = 2.7. An average score closer to 1 indicates more participants rating their health as fair or poor; closer to 4 shows more participants rating their health as excellent or good.

Self-reported health				Number of people in calculation	Mean reported age	Average health self-report	Sparkline
Excellent	Good	Fair	Poor				
1	6	2	1	10	80.7	2.7	
1	4	5	0	10	76.7	2.6	
2	5	3	0	10	74.1	2.9	
1	7	2	0	10	72.4	2.9	
2	5	2	1	10	70.5	2.8	
2	5	1	2	10	67	2.7	
0	5	3	2	10	62.9	2.3	
0	6	4	0	10	59	2.6	
1	4	4	1	10	53	2.5	
1	6	3	0	10	43.3	2.8	
1	6	2	1	10	33.1	2.7	
1	4	4	1	10	24.8	2.5	
0	7	3	0	10	17.7	2.7	
1	5	3	1	10	16.8	2.6	
1	2	2	0	5	16	2.8	
15	**77**	**43**	**10**	**145**	**51.2**	**2.673333333**	

There does not appear to be a consistent relationship in those surveyed between increasing age and poorer self-reported health, as Figure A2 and Table A2 show.

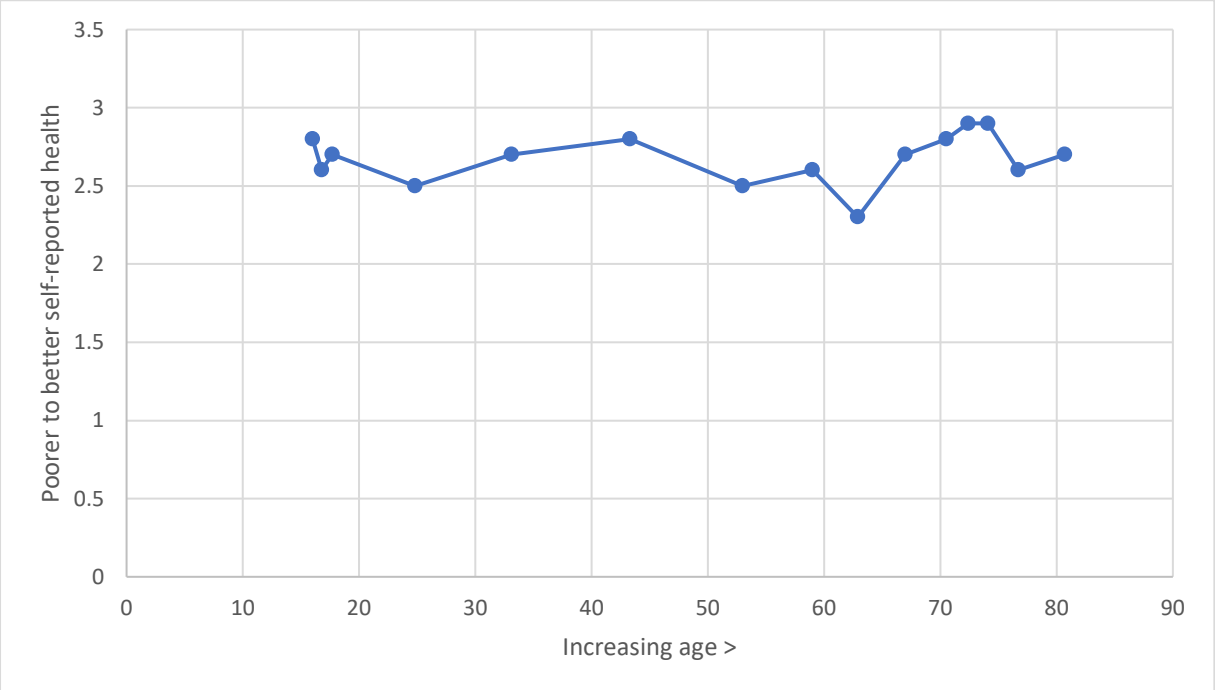


Figure A2: Average self-reported health by increasing age

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.[27] 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 (76.6%; n = 105). These supports were more likely to be women (n = 92; 67.2%)—wives/female partners (n = 33), daughters (n = 17), sisters (n = 18) and mothers (n = 38; 27.7%) as well as aunts, grandmothers and granddaughters (n = 7). This compares with men, to whom 58 people (42.3%) went to talk to about health—husband/male partner (28), sons (7), brothers (11), and fathers (12). Spouses (wives, partners, husbands) were the most relied-upon family support, making up 44.5 per cent. The higher proportion of support sought from women is consistent with the 'naturalisation' of care roles to women (e.g., Williams, 2001).

Friends

Ninety-three people (67.8% of respondents) talked to friends about their health. Mostly, these people were simply described as friends, 'mates' and 'workmates', 'best' or 'close' friends, but there were also some established social groups listed. These include Men's Shed (6 people), sporting or activity groups (golf, craft, bowls; n = 5), church groups (3 people), and service clubs (n = 2). People also noted they talked to people with similar health issues (including through formal groups; n = 2) and that they had started social groups in their neighbourhood (n = 2). Becoming ill was a brake on social support for three people, who wrote "*I don't have many friends since I becoming sick*", "*I find it hard to have a social network or friendship group as my condition limits me in terms of time and energy*" and "*I have lost a lot of my friends because of dementia*".

Other community members

Thirty-nine respondents (of 134 responding to this question; (29.1%) noted that they talk to other—non-health professional—people about their health. Nine people spoke to current or former teachers, seven people spoke to their hairdresser,[28] four to support worker, and three to sports coaches or personal trainers. Five people mentioned clubs (e.g., garden group, golf, and Connect Café). An internet forum was also used by one person as a place to talk about health.

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[27] 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.

[28] This may in part be an artefact of the question, which included the prompt 'hairdresser'.

Health-specific supports

All but six people responded to this question, and 135 (96.4%) said they spoke to a health professional about their health. Most respondents listed 'doctor' or 'GP' (123 people; 91.1%), with a further 11 people reporting that they engage with specialists (e.g., neurologists, skin specialists, gynaecologists). The next largest group of health professionals people reported seeking health support from is physiotherapists (29 people; 21.5%),[29] followed by pharmacists (15 people; 11.1%) and psychologists/counsellors (13; 9.6%). Only five people listed complementary or alternative medicine (CAMs—"holistic health service providers", acupuncturist, chiropractors and naturopaths), though there is an apparently thriving CAMs practice in the town.[30] As one person noted, "*I go to a chiropractor and whenever I get really sick I go to the doctor*".

Thirty-three per cent of respondents (n = 49) sought health support from a friend or family member with a formal health role. Of these, the largest group was friends or relations who are nurses (n = 26; 78.8%). There was also a group reporting that they talked to friends who work in aged care or disability support (n = 11; 33.3%) and a group (n = 19; 47.6%) who turned to friends who were health or allied health professionals (GPs, social workers, occupational or physio therapists, psychologists).

Social activities

Respondents were asked about the social activities they are involved in, and 143 people responded. Of these, 124 (86.7%) said they were socially engaged. Of those who were socially active, 43 people listed only one social activity (34.7%), 59 were involved in two activities (47.6%), and 24 people (19.4%) were taking part in at least three activities.

How does this link with age or with self-reported health? As the figures below show, there appears to be little or no relationship between age and likelihood of engaging in social activities, and the relationship between increasing amounts of social activity and better self-reported health is complex. It may be that better health means people are more able to be active, or that social activity makes people feel more well.

[29] Again, this may be a reflection of surveying in a waiting room, where physiotherapy services are offered.
[30] The survey site may have skewed this result.

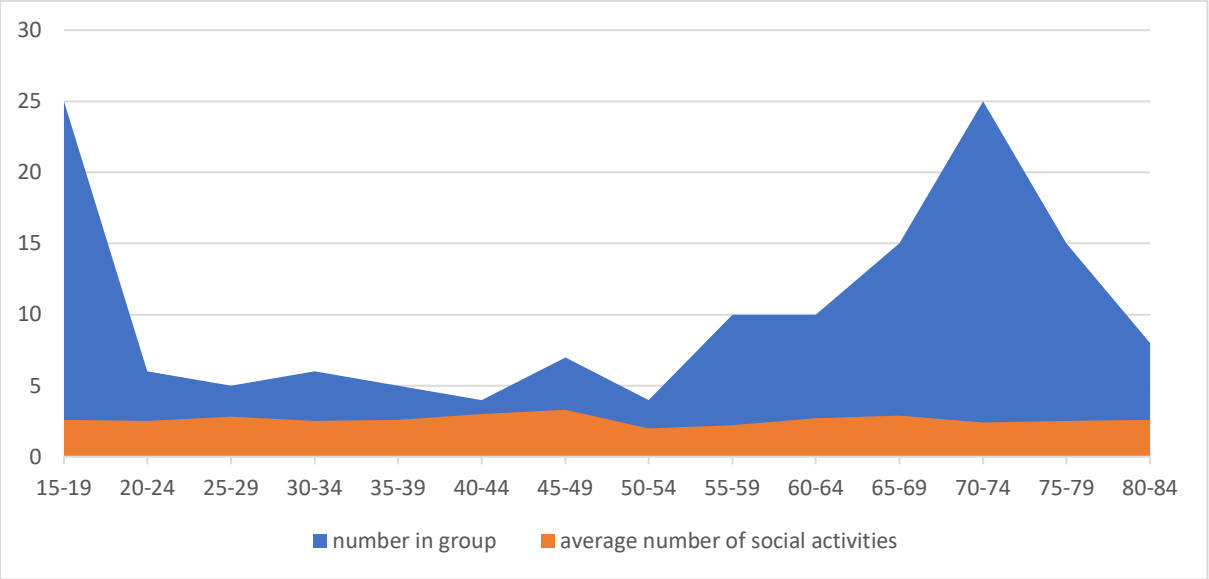

Figure A2: Average number of social activities and age

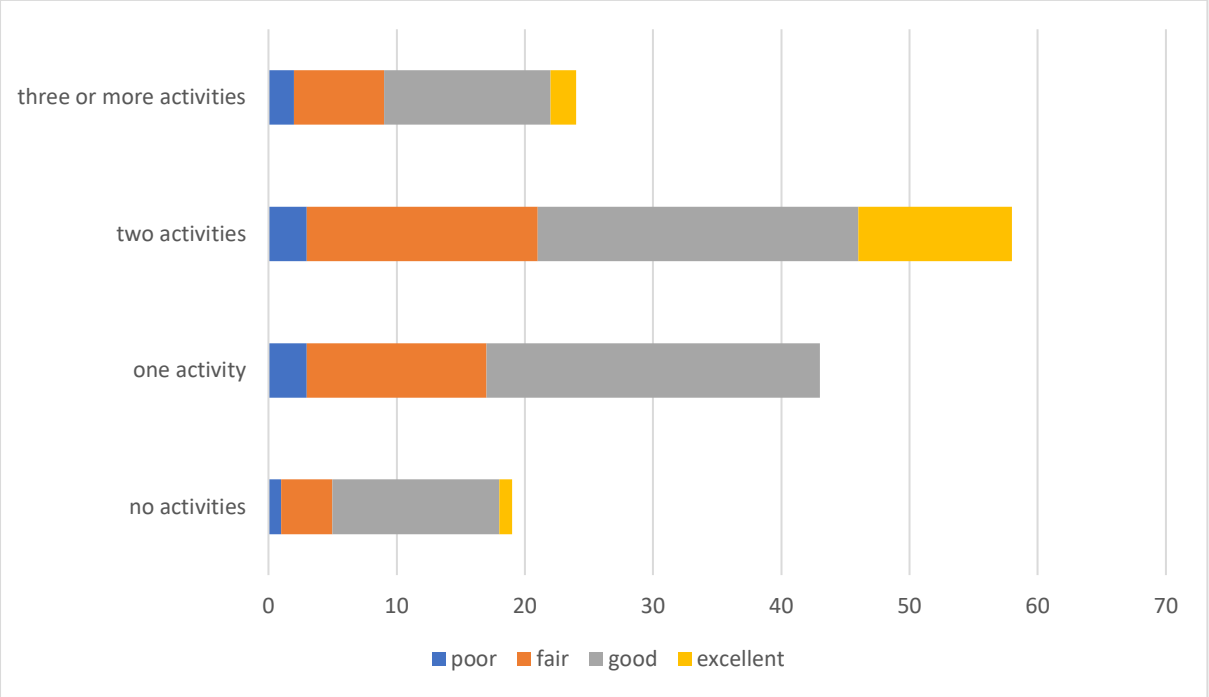

Figure A3: Number of social activities and self-reported health

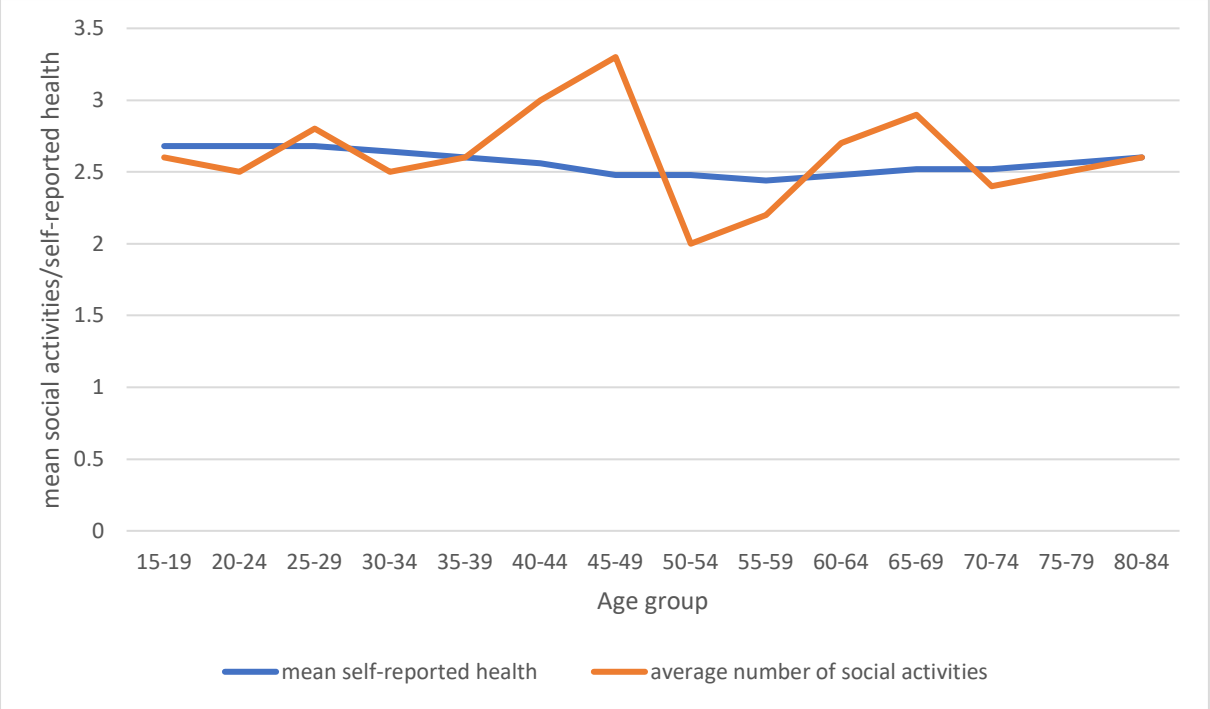

Figure A4: Average number of social activities and mean self-reported health

Physical activities

Physical activities were undertaken by 124 people (86.1%) of respondents to this question (n = 144). Far the most commonly mentioned activity was walking (including dog walking and bushwalking), which 96 people listed (77.4%), followed by going to the gym or a formal exercise class (53 people; 42.7%), following a personal routine (e.g., swimming, bike riding) (46 people; 37.1%) and playing a formal sport (football, soccer, netball, bowls) (n = 30; 24.2%). The other activities listed were working around the house or property (n = 10), and practices like yoga or meditation (n = 14; 9.7%). Only one person mentioned taking care of their diet as a physical action they took for their health.

Forty-eight people did only one activity (38.7%), 35 (28.2%) did two, and 33 (26.6%) did three or more. How does this link with age or with self-reported health? Physical activity and age are shown in Figure A6, and physical activity and self-reported health are shown in Figure v.

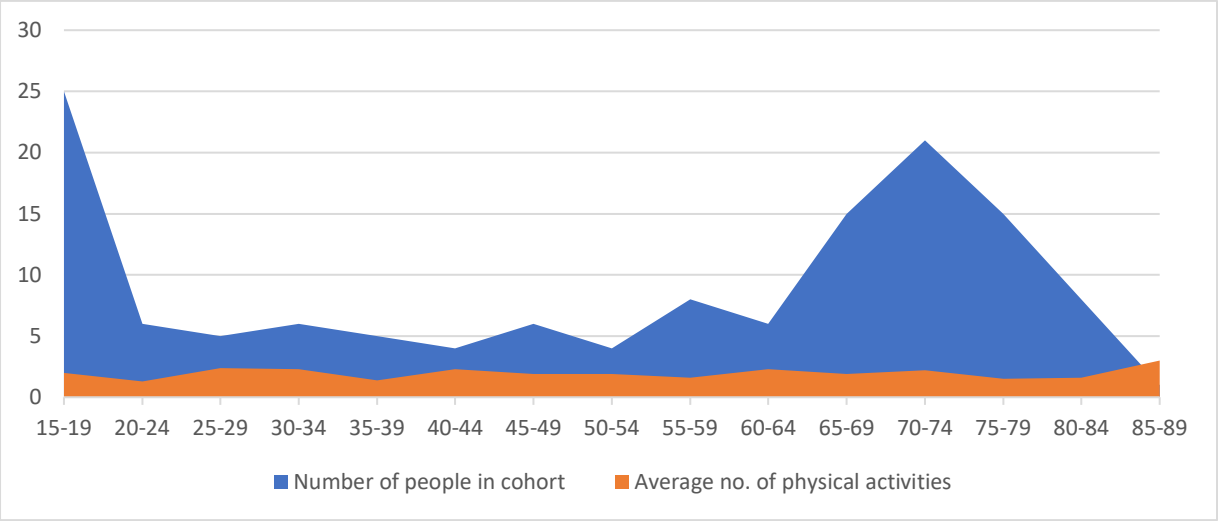

Figure A5: Number of physical activities and age

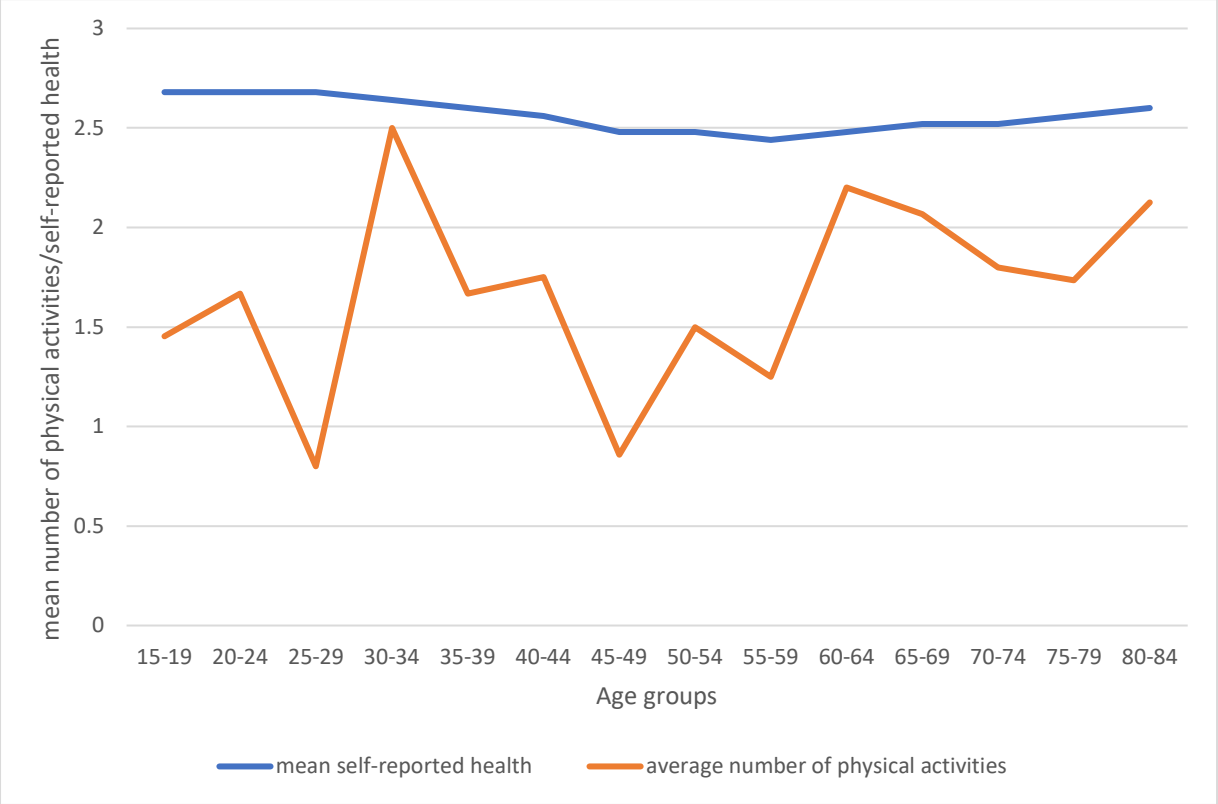

Figure A6: Average number of physical activities and mean self-reported health

Again, the relationship between self-reported health and physical activity is 'messy'; it is likely that for some people ill-health or a physical impairment may be preventing activity.

Medical activities

One hundred and forty-two responded to the question about sources of health care, of whom one hundred and sixteen (81.8%) reported that they went to particular people or places for health care. The majority went to the GP/doctor (106 people; 91.4%). The next

largest group visited one or more specialists (n = 21; 18.1%), 21 people were engaged with condition-specific support groups or specialists and 12 people saw an allied health professional (e.g., physiotherapist). In responding to this question, five people mentioned a complementary or alternative practitioner, two people their counsellor, one person the pharmacist and two people the dentist. Seventy-one people (61.2%) of respondents listed only the GP/doctor, and thirty-four (32.1%) visited two or more health places or people.

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 A2).

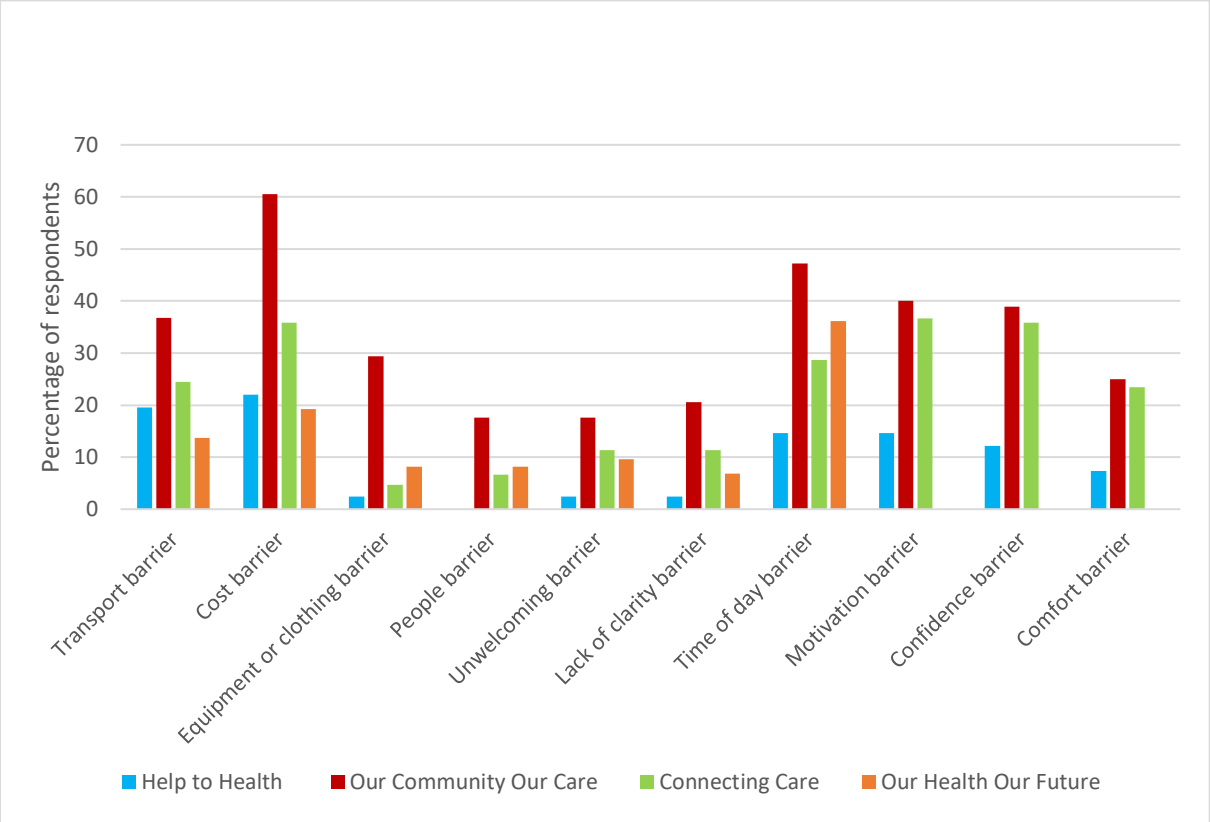

Figure A7: Survey data, all communities—barriers to accessing AC (%)

While cost and accessibility (transport) are prominent, the interesting finding is how important motivation and confidence are; this was true for all sites where this question was included.

There was an option for additional comments; a strong theme in this section was that people wanted to be more involved, but didn't feel able to go to activities alone, often because they felt socially isolated, and didn't have networks from which they would get information and company. These are the comments made about barriers people experience (spelling errors have been corrected, and identifying material removed):

Anxiety

Don't feel like I'd fit in

I have only just turned 18 and I get bulk billed where I attend at Victoria Street Clinic. But now I am 18 I think that makes a difference and I am not always bulk billed. When I had to see another doctor who wasn't my usual doctor (because I had a more urgent issue and was not able to get into my usual doctor for a couple of weeks) I did have to pay.

Not being able to get an appointment

More education around health and how to look after yourself. Current education system is outdated and teaches very minimal real world life. If people were more educated about health and preventative measures perhaps people would take more responsibility for their health. Information is out there for people willing to look.

Lack of time

There is no services for [disorder] on the North West coast. I have to go to Hobart for help.

Fatigue is a killer, I wake up tired. I am only 28, shouldn't be happening, so frustrating.

Time restraints for work

Youth mental health services are unavailable in our area. Young people struggle to access this due to a large range of barriers. Access to GP extremely difficult, large waiting times—too hard, it gets put off. Costs associated with these visits a barrier. People accessing hospitals instead of GP due to accessibility.

A lot of old people running groups and services. Need younger people. Get the crack dealers out of town. Need more funding for rehab to help more people help themselves. Community transport would be awesome. Schools need to teach better and updated education especially around life skills. There needs to be more advertisement about drug addiction, more hard hitting evidence and images.

Psychologists—waiting lists are huge—[…]. Exercise physiologists/PTs—more tailored programs so people can ensure they are doing the exercise correctly. Programs run in conjunction with child care—drop your child off, adjunct programs. Mindfulness programs. 0-5 y.o.—education on healthy eating, how to feed kids, how to minimise choking. More qualified breastfeeding/lactation counsellors—readily available.

I need to manage my fatigue better.

Integrating services would be a good idea. That would be a lot easier and convenient.

Pain (I am unable to sit for more than 30 minutes at a time).

It is very hard to get into a doctor or even a specialist here. The waiting time for me to see a specialist in Tasmania was 8 months. Sometimes I have to wait weeks to get into see my GP. I find that the OPAL program I am doing at the moment is amazing and is an excellent program so I am grateful for that. I don't know much about what is available in terms of support groups or services/allied health services. I would like to know more but how ...

Nothing stops me!

I think that the MCH provided me with excellent service. I had to have my over 50 health check and the doctors there were great and it was good to have a health screening. Priceline pharmacy Ulverstone also provide a great service. Speaking from a service providers perspective: Underfunding is a huge issue, things are so outdated. There has not been an increase in wages for 3 years but all other costs and expenses have increased drastically. Sometimes programs work great and are successful and people enjoy them and love them but when the contract ends or funding is cut that takes us back to square one. There is no detox beds here on NW coast, only in Hobart. This means that patients have to travel to Hobart while they are detoxing which is unsafe for them and also unsafe for people on the public redline bus. There needs to be education for children who are disengaged from the education system, there is a huge gap there.

I cannot drive and the bus comes every hour

nothing external

Don't have the time with his job—time management

Had given up sport after a blood disorder but once that was resolved was not keen on going to gym. Friends suggested clinical pilates—I started 2 yrs ago and love it. Its beneficial to my health, lovely professional and caring teacher(s) and small group.

The info centre will be good. When diagnosed with diabetes, I walked out of doctors, I literally had no idea where to go.

Cannot find group for fitness to join

Lack of time

time factor working but now heading to retirement should be able to do more things. [need a] Hydrotherapy pool—only one available in Ulverstone at Mount St Vincent's nursing home

Constant pain. Lots of talk about how bad our health services are but still nothing happening.

There could be more social groups to cater for 50yrs—70 yrs who are on their own. Programs to get people out of their homes.

Great care given for all my health issues. Getting a doctors' appointment within a week is very difficult unless it is an emergency. More doctors on the north coast!

I feel I have a good balance at present. I feel engaged, motivated, and relaxed.

Lack of advertising. Water quality. More public transport like a hospital or health bus. Better hospitals and facilities. Most services are unaffordable though.

Can't walk as far as required

I do not have any problems with these

[Person] feels [they] love to socialise and interact with people. Wants to know about groups in the area. Would like to get [their] foot in the door somewhere as [they] wants a group to be part of or people to know. [Person] is relatively new to the area and doesn't know many people

in the area. [Person] would like: A connection to something out of the house with likeminded people. A social club with people the same age. Don't really know if there's something for [their] age group or needs already in the area??

Life is a lot better since we have had Jane

While I realise socialising and going to group activities are important for overall wellbeing for most, some of us need a lot of alone time and are happiest being solitary most of the time. I prefer short contacts with close friends and casual interactions with strangers—e.g., shop keepers, other dog walkers, rather than being 'imprisoned' in large social groups or community activities.

With all the support services available, today it's up to the people to access services. You can't make people access them. I think there is to much money waster on people doing surveys on mental health, depression and support services. We are being targeted with all the paraphernalia that is out there.

Not enough time!

The right vehicle to transport wheelchairs is difficult to get.

Parkinson's Warriors (physio) now at inconvenient times (both in middle of the day—no choices)

Disability when needing to walk lengthy distances from car parking area

Medical inability

Available podiatry in Ulverstone—[person] sometimes has to drive to Devonport for more intensive nail care (normally visits St Vincent's Nursing Home)

People that are unwell don't talk about their health. I enjoyed the doing the survey.

Getting older!

Elderly people living alone gets lonely, a lot of elderly people in Ulverstone suicide because they are alone and there is no social support services. There is no continuity of care with our home care package. There is also lack of choice and no freedom to hire our own support services desired with the home care package. The carers that come in should bring their own equipment (…), for example when you need to hire a painter or someone like that, they bring their own tools. I have had my [piece of equipment] broken by a carer with no reimbursement or replacement. The forms to complete for aged care assessment are 49 pages long and this is stupid, too much political bureaucratic paperwork and laws in this day and age. It's too difficult for me to fill out 49 pages. [Response includes example of worrying and costly process involving hospital discharge.] There needs to be education around how to deal with people with dementia and how to cope, etc. I think there is a drug problem in Ulverstone and I am scared for my safety sometimes.

Not readily available

Health is holding back

Different friend groups, anxiety

Nothing. I sometimes just don't choose to go.

Work and boyfriend. There needs to be more mental health services and availability of counsellors.

Feel like sometimes I get so overwhelmed with emotions that it doesn't help me improve my health

Often doesn't fit in with working shift work

Would like to partake in social tennis/squash etc. rather than competitive, during daylight hours.

Don't like going out in the dark and have to be at home at 8pm for meds

I go when necessary about 2 a year

Otherwise busy

I cannot afford to go to the doctor and I cannot get into a doctor for weeks.

Data from 2019 report

We presented analysis of the first tranche of data, in 2019. That analysis is presented in the tables below. The additional surveys conducted since then (11 people) are likely to have made little change to these findings.

Table A2: Initial quantitative analysis results (2019)

Participants	58 men (43%)	76 women (56.3%)	1 not binary identifying (0.7%)	Total = 135	
Age	Mean = 51.83	Oldest = 88	Youngest = 16	Median = 59	The median age for the 7315 population (Census 2016) was 47.
Self-reported health	Excellent = 15 (11.45%)	Good = 69 (52.67%)	Fair = 37 (28.24%)	Poor = 10 (7.63%)	Total responding = 131
Mean age of self-reported health status respondents in each category	Mean age for 'excellent'— 55.93	Mean age for 'good' = 51.20	Mean age for 'fair' = 50.73	Mean age for 'poor' = 54.5	
Does self-reported health have an association with desire to change health? (There were 98 respondents who answered both these questions.)	4 (26.7%) of the people who rated their health as excellent wanted to make changes	50 (72.5%) of the people who rated their health as good wanted to make changes	31 (83.8%) of the people who rated their health as fair wanted to make changes	10 (100%) of the people who rated their health as poor wanted to make changes	So there appears to be an association between self-reported health and desire to make changes to health.
Looked at another way:	People who said they did want to make changes to their health had a mean score of 2.495 for self-reported health (where 1 = excellent and 4 = poor)		People who did *not* want to make changes to their health had a mean score of 1.862 for self-reported health.		That is, people who did not want to make changes to their health were more likely to have rated their health as excellent or good.
Sex/gender and self-reported health	15 people overall reported 'excellent' health. 7 were men (46.6%)	69 people overall reported 'good' health. 28 were men (40.58%)	37 people overall reported 'fair' health. 17 were men (45.9%)	10 people overall reported 'poor' health. 6 were men (60%).	Of the 131 people who responded to these questions, 58 (44.3%) were men. Men were well and truly over-represented in the self-reported 'poor' health status. Numbers are small, however.

Table A3: Numbers of social activities and self-reported health (2019)

	Number of activities involved in			
Rated health as	No activities (n = 19)	One activity (n = 32)	Two activities (n = 37)	Three or more activities (n = 46)
excellent	0	2	5	8
good	10	17	18	26
fair	6	11	12	10
poor	3	4	2	2
	19	32	37	46

Table A4: Age cohorts and inclusion of mental wellbeing or health in definition of health (2019)

Age cohort	Number in cohort	Number mentioning mental health	%
15-19	25	19	76.0
20-24	6	4	66.7
25-29	5	2	40.0
30-34	6	4	66.7
35-39	5	3	60.0
40-44	4	2	50.0
45-49	6	2	33.3
50-54	4	3	75.0
55-59	8	5	62.5
60-64	6	1	16.7
65-69	15	5	33.3
70-74	21	2	9.5
75-79	14	6	42.9
80-84	9	1	11.1
85-90	1	0	0.0

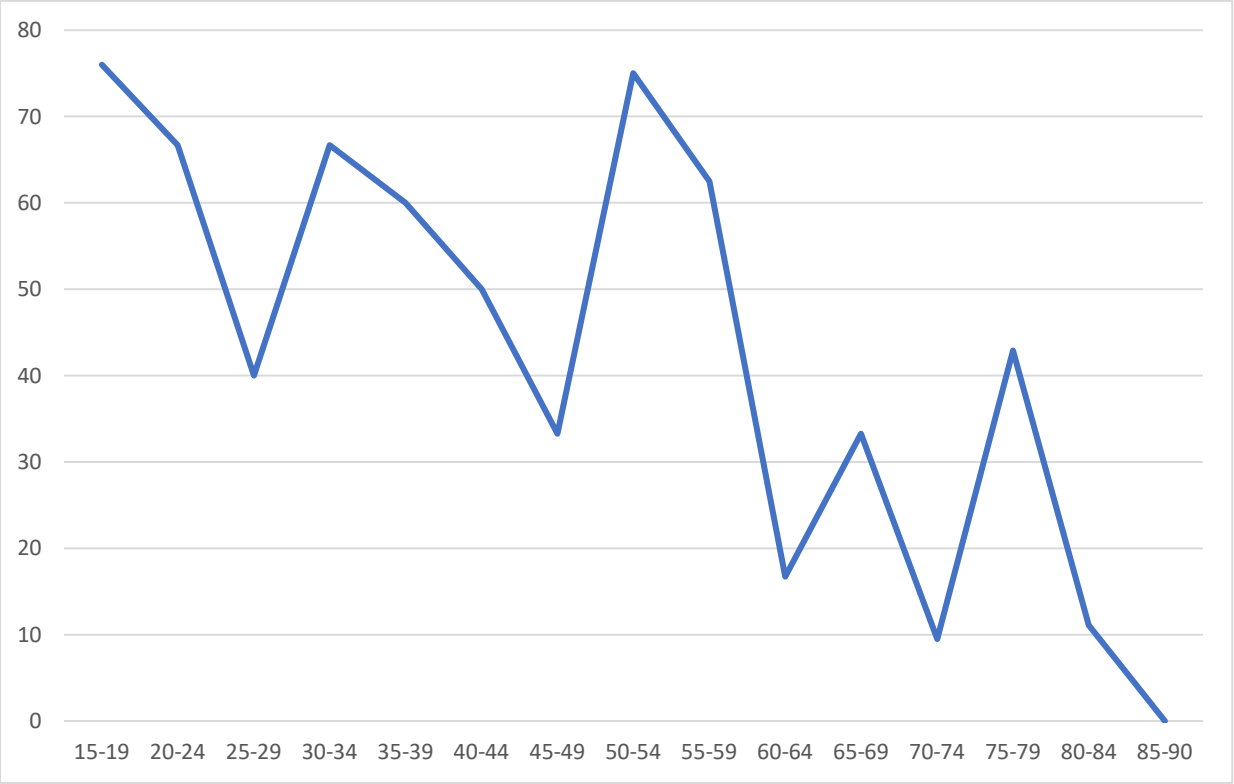

Figure A8: Age and mention of mental health (2019)

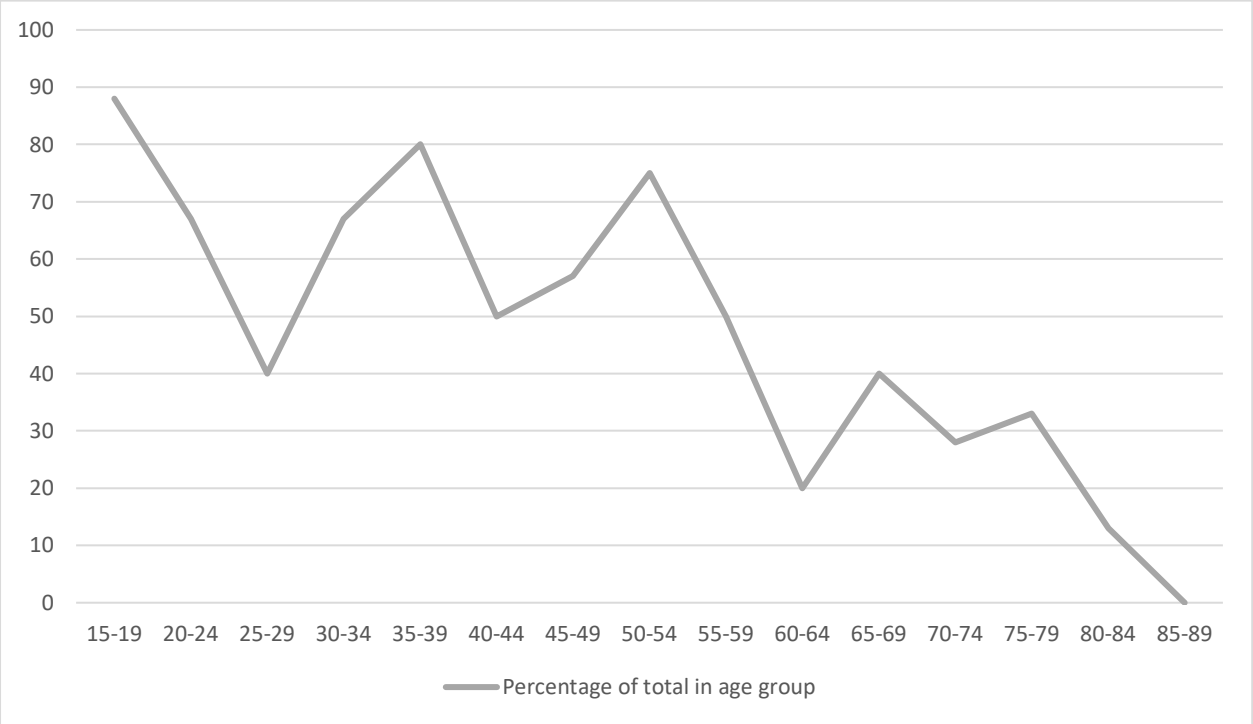

Figure A9: Age and mention of mental health (full sample)

Table A6: Age cohorts and average number of physical activities (2019)

ABS cohorts	Number in cohort	Average no. of physical activities
15-19	25	2
20-24	6	1.3
25-29	5	2.4
30-34	6	2.3
35-39	5	1.4
40-44	4	2.3
45-49	6	1.9
50-54	4	1.9
55-59	8	1.6
60-64	6	2.3
65-69	15	1.9
70-74	21	2.2
75-79	15	1.5
80-84	8	1.6
85-89	1	3

Appendix 7: Connecting Care action planning

Full plans are included in the Connecting Care final report (ACP 7315_Final Report V1.0.pdf)

Phase 4: Report of Activities against Target Outcomes

Success measures achieved	
Success measures still to be achieved	
Success measures not achieved	

Appendix 8: Some definitions of variables in the causal loop analysis

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
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

Ulverstone

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 we also hope they will be stimulated to 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 the set of posters for Ulverstone.

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

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Systems Parts Posters

Overview of project

Connecting Care: a GP led health initiative for Ulverstone

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Ulverstone—7315 postcode

The postcode area 7315 consists of the regional town of Ulverstone and West Ulverstone and rural farming communities including Abbotsham, Castra, Gawler, Guns Plains, Leith, Loongana, Nietta, North Motton, Preston, South Nietta, South Preston, Spalford, Sprent, Turners Beach and Upper Castra .

Add 7315 map

Theme—people and health

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

What we are learning

- The 7315 postcode area has a population of14,658 with 48.4% male, 51.6% female and a median age of 47 (state average is 42)
- Ulverstone and West Ulverstone are Level 2 Statistical Areas (SA2s) with Extreme Risk ie high geographical and social disadvantage. (SA2s are calculated on SEIFA, ISRAD and MMM).

- Central Coast Municipality as a whole has a slightly older population with most indicators of risk factors, morbidity and mortality that are close to the Tasmanian average
- Ulverstone residents are older than the State median—with a higher percentage of residents in the over 60 age range
- There is a strong Aboriginal presence in the community (Aboriginal people make up 6.9% of residents compared with state average of 4.6%) West Ulverstone has 8.5% of the municipality's Aboriginal population
- The community is less multicultural than Tasmania as a whole (92.4% of community speak English at home)
- 7315 postcode residents have higher rates of diabetes, obesity and overweight, high blood pressure, smoking, and inactivity than the State average (and it's worse where there is more socioeconomic disadvantage). Cardiovascular (heart) disease is the cause of death for a greater proportion of people in those disadvantaged areas, and there are higher rates of mental ill-health than for the state as a whole
- Potentially preventable hospitalization (PPHs) rates for Ulverstone / West Ulverstone are particularly high and are of particular concern to GPs and the nursing homes
- Access to economic resources is mixed—the town has pockets of advantage and pockets of disadvantage
- The top industries of employment are fruit and vegetable processing, aged care services and education (there is a greater proportion of people working in primary and secondary education in Ulverstone than in the state overall)
- The town's setting—with coastal stretches and agricultural hinterland—provides opportunities for physical activity and there are many sports and social clubs

What is emerging/still being explored

- There are positive trends particularly to help with social isolation among older generations such as great cross-sectoral initiatives between government and non-government organisations.
- Some evidence that care coordination has improved the management of chronic illness here, but cessation of previous care coordination funded program in general practice is a grave concern

Questions:

- To what extent are Ulverstone's demographics and health status the product of an ageing population or of people not accessing health services?
- How can we identify potentially preventable hospital admissions?

Theme—Local infrastructure

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

What we are learning

- There are 2 general practice clinics in the town, with a total of 8.8 FTE GPs—ratio of 1 GP to 795 people (plus temporary registrars and trainees) and 7 FTE practice nurses
- The GP clinics both offer limited bulk billing
- There is THS community health centre (offering clinics, community and visiting services, including palliative care, continence advice, family and child health clinics and dementia care support)
- Community Nursing Services have recently been relocated to Burnie and Devonport
- Patrick Street Clinic is collocated with other services (PhysioTas, Australian Hearing, Sleep Study Services, Cardiology, Respiratory medicine, Cosmetic medicine, Orthotics and prostheses, and Neurosurgeons) and Victoria Street Clinic also has an audiology service
- Two Aged care facilities in the community provide beds for 211 people; access to aged care services has been identified as an area of continuing need
- There are dedicated psychology/mental health services in the community and GPs report a very significant rise in patients with anxiety and depression and subsequent referrals to psychology services
- A number of community programs operating to support health —suicide prevention, Rotary's work with football clubs, men's shed, Lions Club, Dementia Café, Neighbourhood House, the "Opt-in Wellbeing" program (featuring a range of sporting, recreation and lifestyle activities)
- In particular is Rotary's Beyond Blue work, and an annual Health and Wellbeing Expo.
- Anecdotal evidence suggests that parts of the town are "a fresh food desert" despite proximity to food production
- Housing infrastructure, family violence, better early-responding to illegal drug use, and the need for parenting support have been identified as issues in the community
- Most specialist services are in Launceston, Hobart or Melbourne; access is therefore not straightforward
- Lack of transport options is an issue for many, particularly since an increasing number of support services are delivered from either Burnie and/or Devonport, but no longer Ulverstone

What is emerging?

- There is interest in increasing volunteering in the area (Central Coast Council has a volunteering policy) and it would be beneficial to explore the number of people actively volunteering (23.1%) considering that there are 5 active service clubs as well as Vinnies, Salvos, Red Cross, Meals on Wheels, volunteers in sporting clubs, etc.
- GPs, health professionals, the nursing homes and local government are keen to create and strengthen links; connecting people to community; a one-stop shop, with information in one place about health supports/services in local area; one stop website; better co-ordination (connecting the dots).
- There is a perception that some potentially health-supporting infrastructure is 'locked up' (e.g., school sporting facilities, heated swimming pools), and some are inaccessible to people who do not drive
- Some people/families are being helped by a multitude of different services, but they don't necessarily communicate to ensure integration of the services

Questions

- Are residents aware of what services exist in the community (both health and health-related)
- Do consumers understand why they are sometimes bulk-billed and sometimes not?
- What are innovative ways of using under-utilised spaces to support anticipatory care eg Pop-Up health related spaces?
- Do support agencies / services meet to share what they offer and how can they collaborate to reduce service duplication?

Theme Local health and service data and information

Definition This refers to data and information regarding health of the community and health and community services. What exists and how is it shared

What we are learning

- Reporting on programs and services seems 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
- Health data are difficult to access and to understand and are not routinely used for planning
- 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?
- Some community members feel there are too many sometimes conflicting messages in the media about how to be healthy
- Different services may not be sharing important information that would support preventive care or management of conditions
- Privacy issues are a problem for data sharing
- Central data banks will have advantages so that personal records are easy to access wherever one is (eg My Health Record)
- Telehealth may have some merit for some people. Both GP Practices offer Telehealth services with specialists

- Central Coast Council has a comprehensive Community Directory but it is difficult to maintain accuracy and Patrick Street Clinic has developed a Resource Book for GPs to use. Could these be merged in some sort of electronic resource database that is easier to maintain?

What is emerging?

- Patrick Street Clinic is undertaking an audit of anticipatory care and chronic disease management using Pencat and Best Practice data to determine change in patient profiles over the past 10 years, review of management and systems within the Practice to improve consistency and quality of CDM.
- People may be unaware of what services are available and who they are for (e.g., the NDIS)
- Some development of community services information to share; Health Pathways (online information sharing system for GPs and other medical practitioners) system is available
- There is good coordination between the two GP clinics—after hours roster; access to patient records; monthly education sessions
- How accessible (Easy English, culturally safe, etc.) is the health information that is being shared with the community?
- Some people have low levels of health literacy (often related to other forms of low literacy, including computer literacy), so find for example dealing with NDIS and My Aged Care difficult
- Newsletters are a good means of distributing information, but currently are not used enough
- Many older people do not access the internet for information and if they do, they get confused with huge amounts of information

What we are trying to explore/looking at:

- We need to know who is **not** having positive experiences of the health system as well as who is
- How to better understand residents' reports of receiving conflicting information from GPs and specialists
- How social media or the internet is being used for health information and support, by community members and by clinicians
- Does the existing collaboration between GP clinics extend to other services (e.g., aged care facilities, dementia services, disability providers, chronic illness services, school nurses, school social workers, chaplains—especially re mental health and sexual health)
- Are GPs using Health Pathways? If so, how does this impact on patients' health outcomes?
- When government funding of services is withdrawn (eg coordinated care) how can the gaps best be filled?
- What are the best ways to evaluate programs/initiatives so we know what's worth investing in?

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?

- Community members dislike rushed and inattentive consultations

- There is some unhappiness amongst health professionals and consumers about the existing funding and availability of supports for people with chronic conditions in the public and private health systems
- Drug abuse (legal and illegal) is impacting upon some community members' health directly, and indirectly (e.g., reducing motivation or capacity to self-care, …]
- There is evidence from the aged care sector that people (older people and their carers/families) are unsure about how to develop Advanced Care Directives. Compared with other states Tasmania falls behind in this area

What is emerging

- Are the higher rates of chronic conditions in the Ulverstone area due to people not accessing health services? If so, what is affecting access?
- 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]
- Some residents may be reluctant (or not equipped) to take more control over their health
- Uncertainty as to how receptive GPs are to 'social prescribing' but are increasing conversations and initiatives relating to the aspects of health which may be best complemented in non-medical settings.

What we are trying to explore/looking at:

- How do medical and other health practitioners understand the community and its information needs?
- Need to know more about how community members think about and act on health concerns
- Are there still stigmas and judgemental attitudes around some health issues and people's willingness to discuss and seek help?

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 some networking between the health services—what does this enable?
- Patients value long-term relationships with their health practitioners
- There is a sense that there needs to be a lot more collaboration, eg sharing of information, and more cross-referrals
- Very good relationship between Patrick Street Clinic and the 2 nursing homes—one is a UTAS clinical teaching site and both take students on placements

What is emerging

- Is there a lack of coordination across health services and health supports in the community? And is there a need for inclusion of bodies not normally linked with health (schools, churches, police, emergency services)?

- There is a need for better networking between Nursing Homes and psychological/counselling services

What we are trying to explore/looking at:

- How do we ensure/build a more collaborative approach between all agencies?
- Building a comprehensive and available electronic data source of health and related services available in the community that is easily maintained
- How can the GP clinics, Nursing Homes and the NWRH partner to reduce potentially preventable hospital admissions?

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?

- Health leadership is spread and includes formal health practitioners, as well as schools, and other community bodies
- There is police leadership to change norms within social and sporting groups (e.g., reducing drink-driving)
- Schools have some great recent initiatives particularly in relation to mental health Service clubs e.g., both Rotary Clubs providing health leadership especially in mental health
- Local Government instituted a Health Round Table a few years ago but this was not sustained

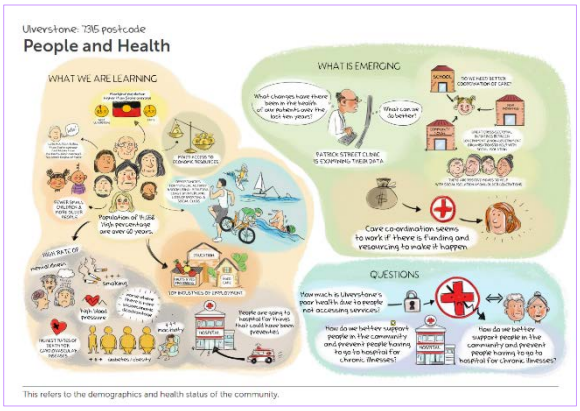
What is emerging?

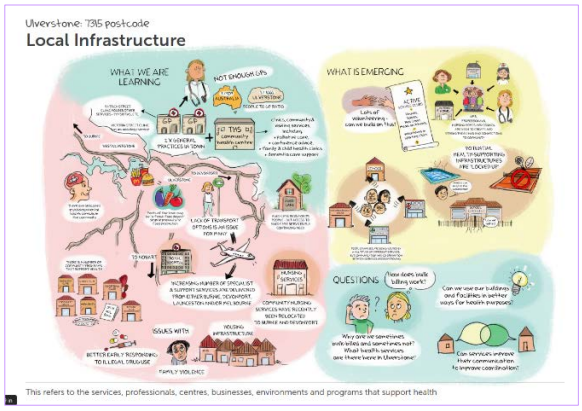
- Question—Who is influential in improving the health of the community? This poster could include a large question mark with a range of people represented—GP clinics, schools, Police, Service organisations??
- Are there other leaders, or key health information and support people, like the hairdresser, neighbours, publicans?

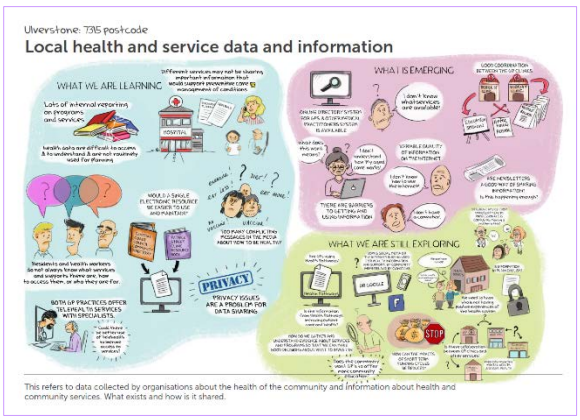
Where we are trying to explore/looking at:

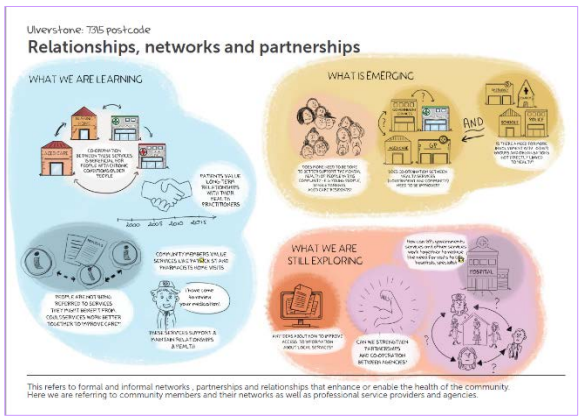
- The role of local government as a leader in local leadership for health and the need for a broad health and social care policy framework

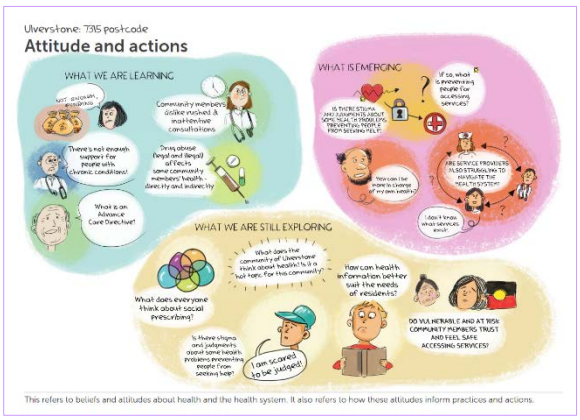
Appendix 10: Community workshop posters

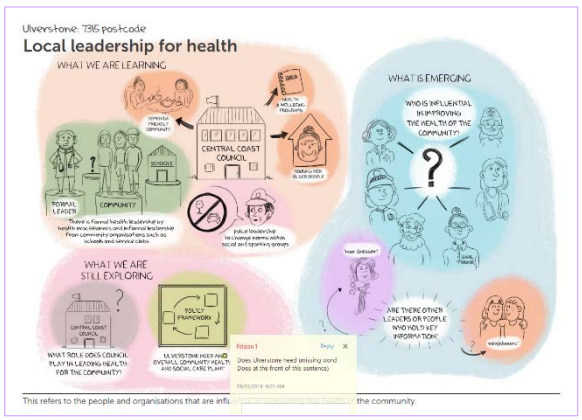












Appendix 11: Presentations and papers

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. (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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