

Building on local strengths:

# Launceston's Northern Suburbs

Executive Summary

**ANTICIPATORY  
CARE PROJECT**



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

This project is funded by the Australian Government through the National Partnership Agreement on Improving Health Services in Tasmania.

The research reported here was produced by a collaboration between Our Community Our Care, 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.

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## In brief

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

The neighbourhood house model used by the Our Community Our Care team, built on a strengths-based community development approach, is an ideal place from which to work to enhance anticipatory care. The OCOC team is trusted, nimble and flexible, characteristics that are a good fit for this action learning project. The team is supported by its established role in relationship building across sectors, 'get in and do it attitude', and ability to hear from the community, to advocate, and to rapidly see the impacts of what they do and adjust accordingly.

This executive summary is formatted in four parts. For a high-level, short summary, read the **In brief** section.

The **Key Points** section is a brief overview of what we have learned.

The full summary is in the section, **Methods, Processes and Findings**.

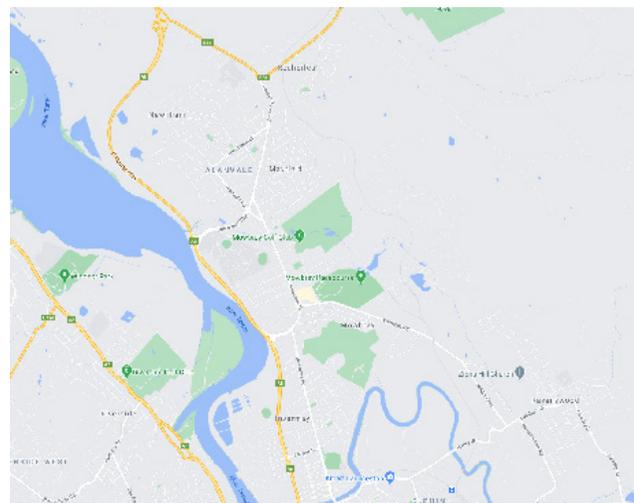
This document concludes with a series of **Recommendations**.

## 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.<sup>1 2</sup>

This summary documents the project's aims, processes, activities, and findings for the Our Community Our Care (OCOC) site in Launceston's northern suburbs. We gathered qualitative data from 204 community members and service providers in the OCOC site.



**Figure 1: Map showing the northern suburbs of Launceston** (source, Google)

## What was already known

People living in the OCOC 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.

There are financial, physical, psychological, and emotional barriers to safe health support in this community. People in this community are more likely to live with the negative effects of the social determinants of health. This includes insufficient affordable health and social support provision.

### Some AC project statistics for the OCOC site

As well as the approximately 2300 people involved each week in usual activities at SPNH and NSCC combined, a large number of people engaged specifically in OCOC activities:

Our data gathering and sharing activities	More than 200 people
Adventure Play sessions	50 young people 6 support staff (volunteers) and 4 PSOs Staff from 3 schools and 1 NGO
Adventure Play training	15 people
Community art activities	100 people
Metro Tasmanian Greencard sessions	15 community members 2 Metro Tasmania staff
TBRI training	27 people (community/services staff)
Clean up walking group	5 regular walkers
The LAG	40+ members

### What our research has added

Residents whom we talked with report experiencing demeaning or stigmatising encounters with many providers, which make them unwilling to return, or to try other similar services. Medical services (GPs) have historically been seen as central to AC, but in this community, access to GPs is restricted by lack of bulk-billing, and distance. We have found we have found that there are many other services that can play a part; examples include police, NGOs, pharmacies, allied health practitioners, local council, public transport, schools, local shops, community organisations (and particular individuals who lead programs or build links) and infrastructure planners. Expanding our understanding of who is part of the AC system supports increased collaboration and coordination, and the overall effectiveness of the system.

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

Actions taken in the AC Action Learning Project have increased:

- Understanding that AC involves a wide range of people and services and their inter-connectedness, and built new collaborative relationships with shared goals, language, and ways of working for health advocacy
- Capacity in key players and organisations to work safely and effectively with community members
- Engagement of some groups (including previously hard to reach people) in health-promoting activities
- ‘Good news’ media stories about the OCOC community (with potential reductions in stigmatising of community and individuals)
- The effectiveness and authority of the lead agencies in health

While these benefits from the project activities are difficult to measure in terms of chronic health outcomes within the life of the project, they are important short to intermediate measures/markers within a system which indicate a more enabling environment. We have evidence of changed behaviours, awareness and relationships

(human capital) which, over time, we anticipate will lead to better health and wellbeing outcomes. A longitudinal study is needed to determine the full level of benefit from the changes to the local AC system.

The project identified barriers to AC. These include historical stigmatising attitudes to the community that reduce external and internal opportunities to change, and policy settings (e.g., for bulk-billing, welfare supports, and funding) that reduce options for taking a social determinants of health—including mental health—preventive approach.

This summary can be read alongside the full site report as well as the local report prepared by the OCOC team, and reports on the other three AC project sites: Clarence (Help to Health), Ulverstone and the 7315 postcode area (Connecting Care), and Flinders Island (Our Health Our Future). A final report, incorporating external evaluation, will be delivered in December 2020.

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 OCOC project in this site ran from February 2019 to June 2020.

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

### 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.

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).<sup>3 4</sup> This means that our mapping of the AC system was not limited to health services, resources, or infrastructure.

The four communities in the project have high rates of people being admitted to hospital for preventable conditions (in some suburbs, the rate is almost twice that for Tasmania overall), including chronic illnesses. They also each have different demographical, social, cultural, and geographical characteristics, some of which may be contributing to the

### 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.<sup>5</sup>

chronic illness load. These differences are helping us to learn what local AC systems have in common as well as what different agencies (services, groups, organisations) can do in the system to support better health outcomes. The Our Community Our Care site is in the northern suburbs of Launceston. The site's lead agencies are the Northern Suburbs Community Centre (NSCC) and the Starting Point Neighbourhood House (SPNH). SPNH and NSCC employed four project support officers (PSOs) to work with the community and the UTAS team. They also convened a

local advisory group (LAG) made up of local residents and representatives from services working in the area. The leads, PSOs, and LAG members are the OCOC team.

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 OCOC site. More than 200 people contributed to the qualitative data. We wanted to know how they understood health, about their experience of the health system, and what supports or gets in the way of better health outcomes for the residents of Launceston's northern suburbs.

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 OCOC 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 four major opportunities for change, by increasing:

Safety (quotes are from local participants):

| *I don't feel that comfortable at many places ...*

Access:

| *I feel like I have to tell my whole life story to convince them to bulk bill me*

Connection:

| *Sometimes it feels like I'm being handballed around the place—no one seems to want to fix things*

Resources:

| *Northern suburbs sucks when it comes to health care*

The focus of project activities in OCOC was on increasing safety. A proxy for lack of safety is stigma. Stigma was evident in the data as a major barrier to people accessing services or places that could support better health. We found that too many residents' fear of being judged affected how likely they were to attempt to use a service or visit a place.

Poverty put some services out of reach for some people, and fear of being judged plays a part, but the effects of personal poverty are made worse by lack of local services and infrastructure (e.g., sufficient GP services, low-cost sporting or fresh food options), and a lack of personal and public transport. These deficits may be a consequence of historical attitudes to this community, attitudes that make people reluctant to work here, contribute to a 'these people' marginalising discourse, and are reflected in political decisions about resourcing or upkeep of local infrastructure. The wider negative perception of the northern suburbs in stories about Launceston are also reinforced by some media. All these are impacts of stigma and make the AC system unsafe for too many people.

### 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, 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 safer system. The 'flag-ship' Our Community Our Care activity is Adventure Play, a physical activity program with a trauma-informed approach for people aged 10–16 who have experienced significant trauma. This was one of many actions; others include working to increase:

- transport access (physical/financial) (sub-project: bus services, Green Cards)
- access to GPs (sub-project: working with local clinic to increase information sharing)
- physical activity and social connection (sub-projects: Ravenswood Basketball Bins, Clean-up Walks)
- social connection and information sharing (sub-project: Facebook page, videos, LAG)
- safe responses to people experiencing trauma (sub-project: Trust Based Relational Intervention Professional Learning session)
- community pride, local positive identity, and engagement (sub-project: community arts projects)

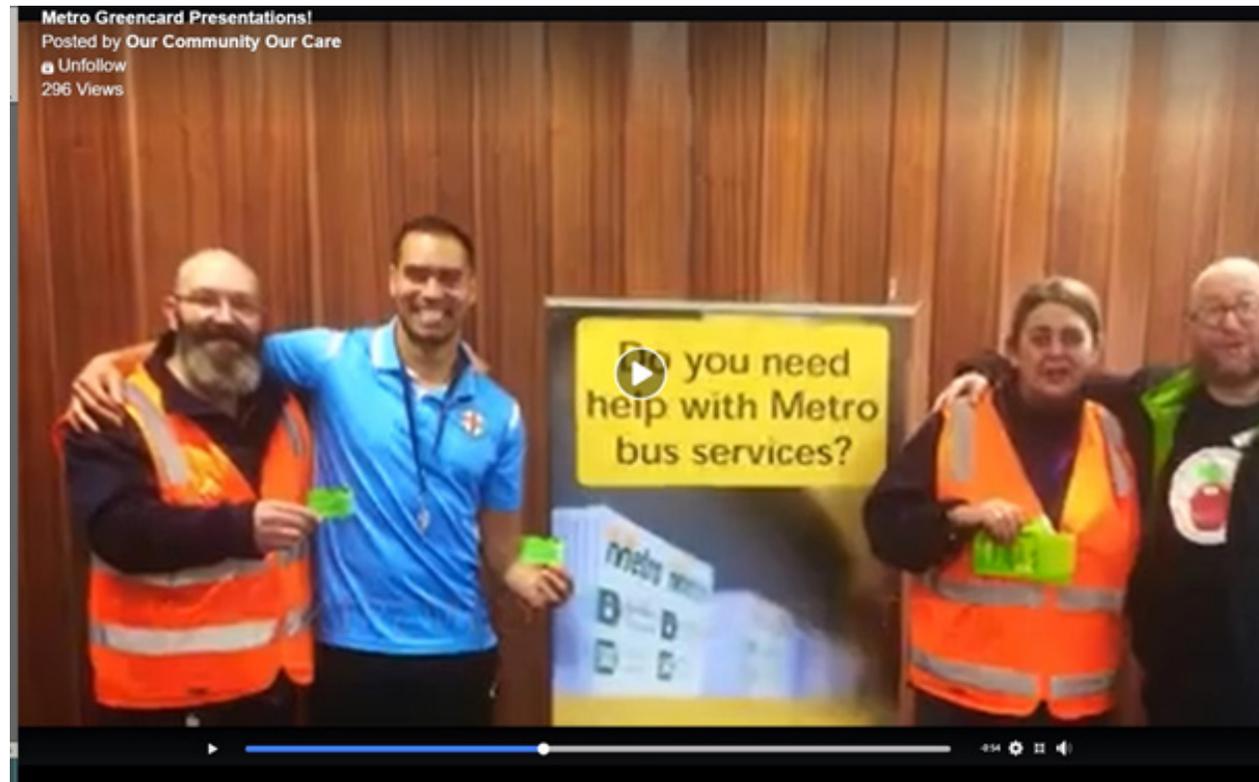
During the project, we have continued to gather data (more than 200 people contributed to our data) and to reflect on what we are learning with the OCOC team. New knowledge helps us to review and adjust activities. Causal loop analysis (or causal loop diagramming, CLD) has been an important tool for 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. This is part of the action learning approach.

## Mapping the local AC system

The project has changed 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 of place and belonging (as a key system part) and the impact of policy and processes; these two parts of the system were missing from our understanding at the start of the project.

Through the project many 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 demonstrated at our final CLD session, in May 2020, where participants included people with community development, law enforcement, social work, faith-based, youth outreach, and health roles.



**Figure 2: Metro Tasmania Green Card presentation**

### What role do the local lead organisations play in AC and can their role be strengthened?

The lead organisations in the OCOC site, NSCC and SPNH, have a community development and strengths-based approach. The two neighbourhood house managers and their teams also have long histories in their communities, an established role in relationship building across sectors, and a 'get in and do it attitude'. Neighbourhood houses also deliver multiple programs that support health, despite not being 'health organisations'. The managers have the skills and experience to nurture, and embed the creativity and enthusiasm of, the PSOs. These factors mean that the lead organisations have the trust of large portions of the community and networks that increase their ability to hear from the community, to advocate, but also to rapidly see the impacts of what they do and adjust accordingly. The lead organisations here are trusted, nimble and flexible, characteristics that are a good fit for this action learning project.

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

We learnt that:

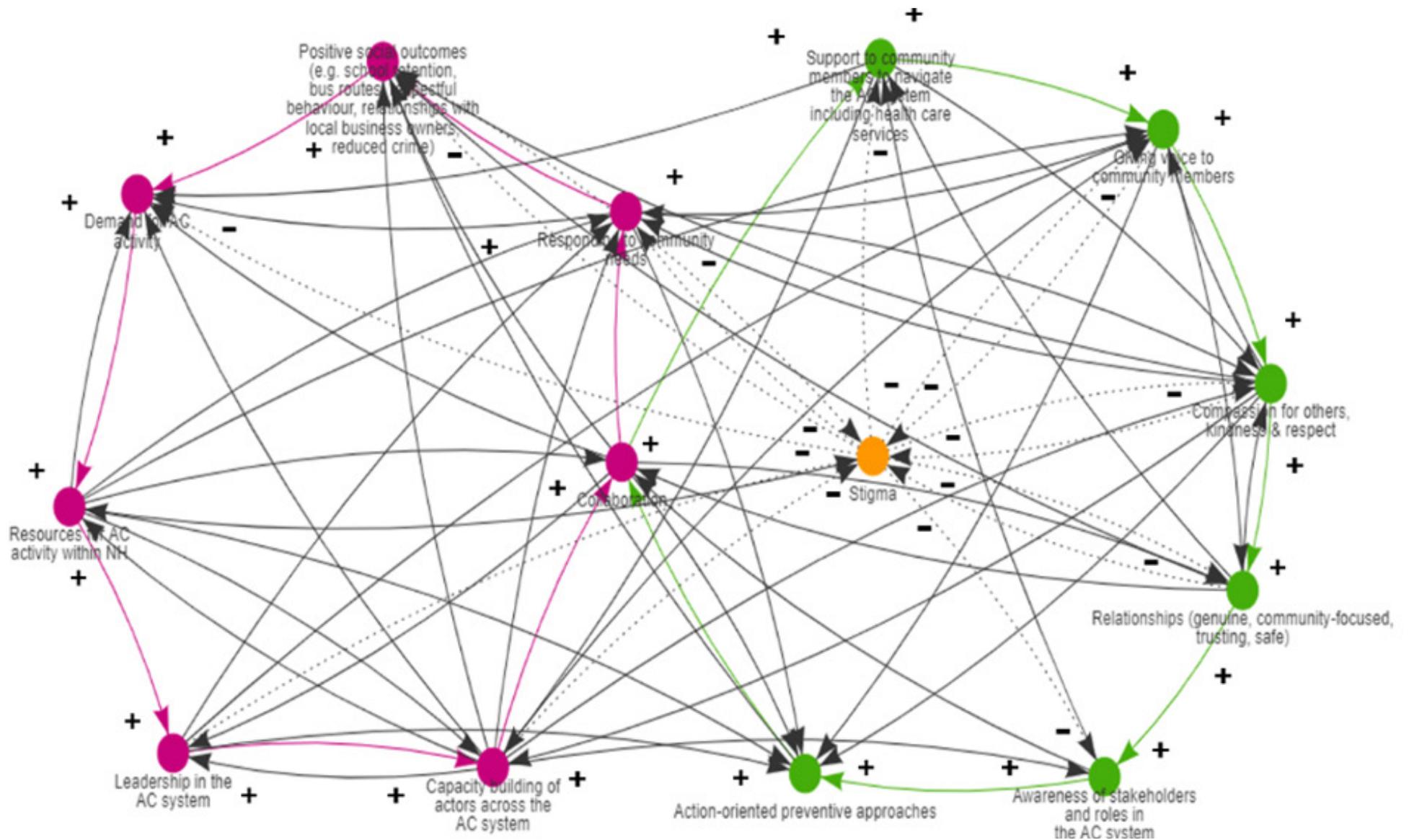
- AC is best viewed through a SDoH lens and neighbourhood houses work in this way; they are a vitally important stakeholder in the AC system. Although neighbourhood houses may not always identify 'health' as their core business, they work to address the SDoH and in doing so act on the 'causes of the causes' of poor health. This can help strengthen the AC system overall.
- Positive project outcomes were supported by:
  - the provision of dedicated, AC focused resources within the lead organisations (who take a strengths-based and community-focused approach)
  - careful listening to community members, and acting on what has been heard—including in very public ways (e.g., media stories)
  - a flexible approach that was responsive to local circumstances and the boundaries around their

own and other organisations

- very active outreach to services and residents, through the PSOs
- offering system participants practical ways of working to reduce stigma and increase safety.

Barriers to improvement of the system include:

- Historical stigmatising attitudes to the community that reduce external and internal opportunities to change
- Policy settings that reduce options for taking a SDoH preventive approach. This is evident in:
  - Competitive funding models that reduce connection and collaboration between parts of the AC system
  - Lack of resources to support outreach
  - Continuing poor distribution of necessary services (e.g., the continuing lack of adequate, local bulk-billing GP services)



**Figure 3: Some parts of the system, 2020, post-activities**

Causal loop diagram showing the factors and links between them in the local AC system at the end of the project.

## Summary

The AC Action Learning Project in this site 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
- Networks, with shared AC goals, language, and opportunities for health advocacy
- 'Good news' stories about the Our Community Our Care community, potentially changing preconceived stigmatising attitudes
- The effectiveness and health authority of the lead organisations

The changes that have been made to the AC system in the OCOC site are significant. 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.

### *Trauma-informed ways of working*

Build on the individual and community benefits from the Adventure Play program and extend it to many more children, and embed the trauma-informed approach more widely:

- Extending and expanding the Adventure Play program, with appropriate evaluation measures
- Providing additional Trust Based Relational Intervention Professional Learning for local services and community members

This will expand the measurable benefits for the families and support networks (including

for teachers and community members) of participants and provide the opportunity to assess the approach's impact on risk of chronic illness.

### *Increased access*

Build on the potentially increased access to public transport gained through working with Metro Tasmania:

- Continue to monitor the changes to local bus services made by Metro Tasmania in early 2020 and continue to work with Metro Tasmania, the Department of State Growth and other key stakeholders to further improve local transport services.
- Continue to hold local Green Card information sessions at SPNH and NSCC venues.

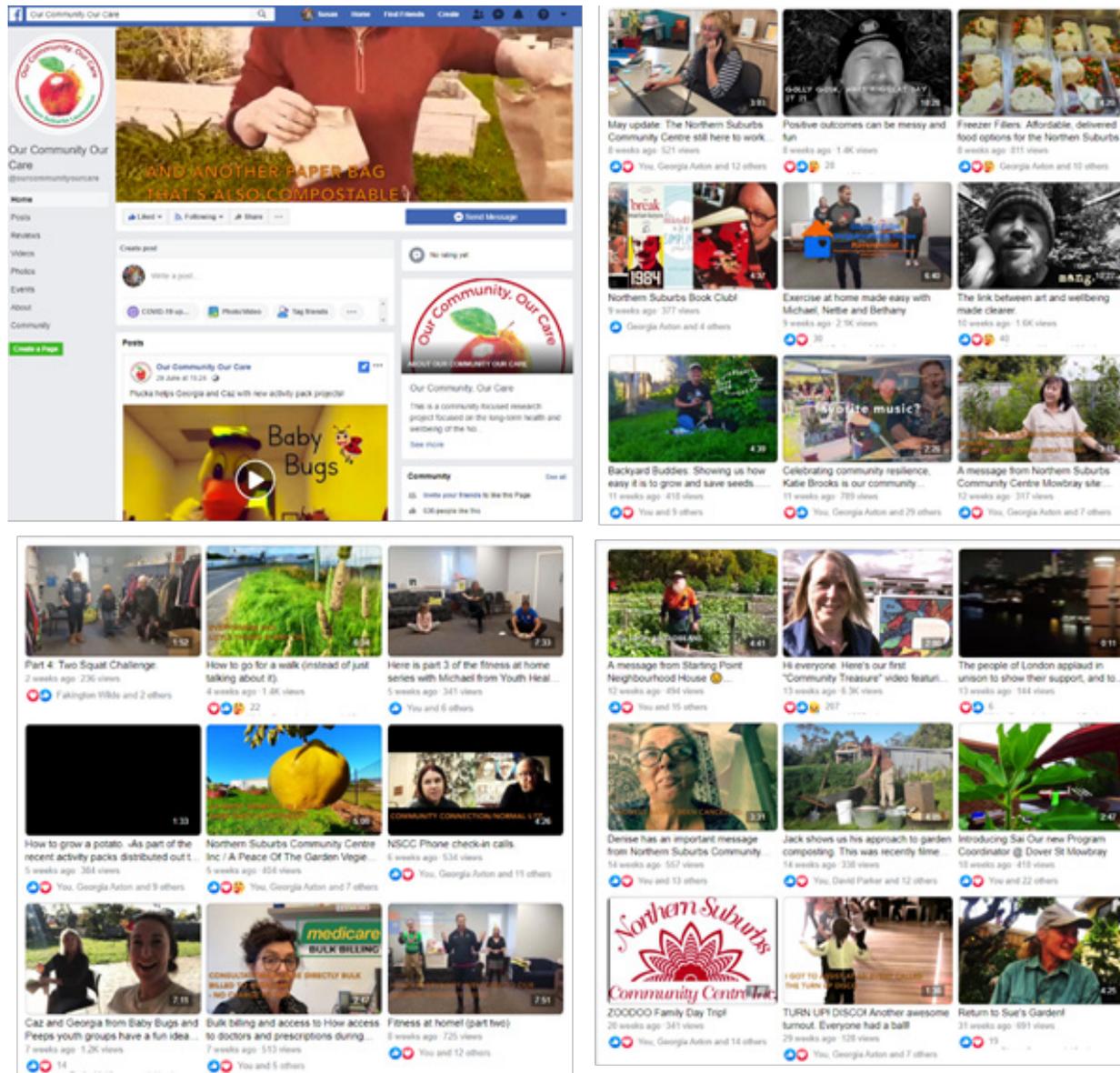
Build on increased safe access to GP services:

- Continue to work in partnership with local GP clinics to increase information sharing and to identify and pursue actions to improve safe access to GP services for the local community.

## **For local processes**

Partnerships and collaboration across the system are essential. The LAG is instrumental in building and sustaining collaboration across this site, and in shifting attitudes to support AC. The LAG and the PSOs also play an important role in shifting historical attitudes to the community.

- Maintain the LAG and links with other northern suburbs initiatives (e.g., Launceston City Council's My Place My Future work).
- Continue to encourage local service providers to incorporate outreach and collaboration as key tasks for all service providers working in the northern suburbs.
- LAG and neighbourhood houses continue to advocate for funding arrangements that support and promote collaboration and long-term relationships.
- Governments/health policy and decision makers need to recognise, resource, and support the invaluable role played by local neighbourhood houses in supporting and improving health and wellbeing of their communities.



PSOs have supported the lead organisations and LAG, reached out to community and to services, been involved in the research, and introduced new ways of working. They have developed capacity in action learning and systems thinking, and for gathering and interpreting evidence. Their links with the research team have been essential for our work, and for connecting the research with the reality and implementation.

- Maintain a dedicated function/role within neighbourhood houses to support and enhance the AC system including through:
  - o physical activity, social connection and information sharing initiatives (e.g., Ravenswood Basketball Bins, Clean-up Walks, art projects, Facebook page and videos)
  - o relationships with existing and new service providers and researchers to strengthen coordinated approaches to improve health and wellbeing across the northern suburbs
  - o innovation to address AC needs.

**Figure 4: OCO social media supporting health in the pandemic**

### For local, state and national policy action

All levels of government have a role to play in efforts to alleviate chronic illness.<sup>3</sup> 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 neighbourhood houses play a central role in local AC systems, and provide flexible funding to support this role state-wide, to take locally designed and led actions to improve community health and wellbeing using an AC approach.
- Factor the importance of place and belonging into policy decisions at all levels of government, including (but not limited to) infrastructure, service provision and social housing.

Existing 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 should consider the adoption of 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)
- Trusting local communities to identify their own priorities and strategies to address those priorities

The role of GPs in the AC system needs to be better supported by policy:

- GPs' potential role in the AC system can be supported if they adopt clear, transparent information and easily understandable guidelines explaining their bulk-billing policy and practices.
- Continue bulk billed telehealth services, with evaluation of whether it is improving access to GPs for marginalised communities.
- Review national and state regulation of GP services to counter supply shortages and control over who has 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). 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.

- 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

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

There are clear mutual learning benefits for the University, the DoH and the OCOC team in the approach taken here to working to enhance anticipatory care. 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:

- <sup>1</sup> Baker, A., Leak, P., Ritchie, L. D., Lee, A. J., & Fielding, S. (2012). Anticipatory care planning and integration: A primary care pilot study aimed at reducing unplanned hospitalisation. *British Journal of General Practice*, 62(595), e113-e120. doi:10.3399/ bjgp12X625175
- <sup>2</sup> Tapsfield, J., Hall, C., Lunan, C., McCutcheon, H., McLoughlin, P., Rhee, J., Murray, S. A. (2016). Many people in Scotland now benefit from anticipatory care before they die: An after death analysis and interviews with general practitioners. *BMJ Supportive Palliative Care*. doi:10.1136/ bmjpcare-2015-001014
- <sup>3</sup> Marmot, M. (2005). Social determinants of health inequalities. *The Lancet*, 365(March 19), 1099-1104.
- <sup>4</sup> Marmot, M., & Allen, J. J. (2014). Social determinants of health equity. *American Journal of Public Health*, 104 Suppl 4(Suppl 4), S517-S519. doi:10.2105/ AJPH.2014.302200
- <sup>5</sup> World Health Organization (WHO). (n.d.). Social determinants of health. Retrieved from <https://www.who.int/gender-equity-rights/understanding/sdh-definition/en/#:~:text=Social%20determinants%20of%20health%E2%80%93The,global%2C%20national%20and%20local%20levels>

