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Improving Community Healthcare: A Qualitative Evaluation Of The Neighborhood Team Model In West Essex

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Improving Community Healthcare: A Qualitative Evaluation of the Neighbourhood Team Model in West Essex

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Abstract

A qualitative study was conducted to evaluate the Neighbourhood Team Model of the National Health Service in West Essex. The West Essex Clinical Commissioning Group (CCG) initiated the community healthcare-based neighbourhood teams in West Essex in October 2015. A neighbourhood team consists of all levels of health and social care providers but is concentrated on a smaller, local population. The proposed Neighbourhood Team Model was developed to allow providers to better deliver efficient patient-centred healthcare. For the past six months, the West Essex CCG encountered challenges in implementing the model to seven local areas within West Essex. To evaluate the progress of this initiative, 24 participants were purposely selected for interviews to assess the challenges and potential for the Neighbourhood Team Model. Participants consisted of key stakeholders from the West Essex CCG, primary care, the voluntary sector, social care, and one of the main health centres in West Essex, Princess Alexandra Hospital. Ten major themes, 30 sub-themes, and over 30 practical suggestions for the implementation of the model were identified through the interview transcripts.

Introduction

The quality of care a patient receives is not solely determined by physicians but by multiple actors, including nurses, administrative personnel, patients and their families. When a medical case becomes complex, decision-making will necessarily involve a number of health professionals. However, in many cases, having multiple decision-makers creates complications and suggests that a unified decision-making process may be preferable (Elhauge 2010). Healthcare fragmentation, or the lack of coordinated healthcare, has long posed immense challenges to the National Health Service (NHS) and has resultantly been increasing healthcare expenditures and damaging the quality of care a patient receives. At the community level, the lack of coordinated care becomes even more unmanageable because a barrier to sharing information exists. Additionally, health providers and primary care personnel do not share the same incentives for providing treatment.

The impacts of healthcare fragmentation can be separated into two categories: a low quality of care and an inefficacy of care. As a result, many patients, especially those with age-related chronic and complex medical conditions, within the NHS suffer from uncoordinated health services. Nick Goodwin explained that patients with complex health conditions often receive very fragmented

health services (Goodwin, Sonola et al. 2013). A randomized controlled trial revealed that patients over the age of 65, who receive integrated care and case management, had improved physical function and less of a decline in their cognitive ability (Bernabei, Landi et al. 1998). The disconnect between primary care and secondary care is a major form of healthcare fragmentation in the NHS that results in inefficient health care and a diminished quality of care.

The NHS has had a longstanding ambition to promote the use of primary care services. Shifting care from secondary providers to primary care not only reduces the financial burden on the NHS but also prevents a largely at-risk population from becoming high-risk and costlier patients (Edwards 2014). As such, the NHS has multiple programs in place to integrate primary care and secondary care, such as reducing care complexity, creating a single system with one budget, building multidisciplinary care teams (MDTs), and providing services that offer an alternative to hospitals (Thistlethwaite 2011). Through these programs, The King's Fund has found that the integration of care could be more beneficial at a community, or neighbourhood level, which aligns stakeholders more easily (Goodwin, Sonola et al. 2013).

Wigan Borough Clinical Commissioning Group (CCG) recently initiated Integrated Neighbourhood Teams (INT), which aim to mobilize General Practitioners (GPs) to identify high-risk populations within their communities (Edwards 2014). Each neighbourhood consists of primary care, community matrons, district nurses, social care and mental health services. These teams provide patient-centred health services and outline a coordinated plan for treatment. As a result, INTs have been found to reduce Acute & Emergency attendances by 33 percent and unplanned admissions by 37 percent (Edwards 2014).

Furthermore, integrated care programs have been found to have a positive impact on chronically ill patients, especially those with cardiovascular disease, diabetes, or musculoskeletal related conditions. (Ouwens, Wollersheim et al. 2005). Chronic conditions are thus believed to be much more manageable when care is organized at the community level. A randomized controlled trial revealed that with a more collaborative primary care sector, the 10-year absolute risk of developing cardiovascular diseases was reduced by 1.75% and total cholesterol levels were significantly reduced (El Fakiri, Bruijnzeels et al. 2008). Besides improving the quality of care, the integration

of care also has a critical financial impact. Families who access primary care more often are expected to experience fewer hospitalizations, operations and patient visits (Jones 1992). Another study showed that using a case management system for a senior population reduces total health care expenditures in hospitals by 13.6 percent (Eggert, Zimmer et al. 1991).

In an attempt to provide improved preventative community health care and to address the rising rates of non-elective and A&E visits, the West Essex CCG piloted a change to its organizational and professional working relationships among health and social care providers, creating neighbourhood teams. Per the direction of the West Essex CCG, neighbourhood teams were to integrate health and social care within defined populations. Within West Essex, England (Epping, Uttlesford, and Harlow), a population of about 295,000 was segmented into seven neighbourhoods based on demographics and geography. The seven regions include Loughton, Epping and Ongar, Buckhurst Hill and Chigwell, Waltham Abbey, North Uttlesford, South Uttlesford, and Harlow.

To test the ability of neighbourhoods to operate effectively and the ability of separate organizations to work together in an integrated manner, the West Essex CCG launched the "100-Day Challenge." During a period of 100 days, each neighbourhood team convened, including hospital staff and leaders within health and social care. Following these 100 days, the West Essex CCG found that the teams were able to demonstrate significant reductions in A&E attendances. As a result, West Essex is currently in the early stages of scaling up the implementation of the Neighbourhood Team Model. However, the lack of defined structure and coordination in creating and establishing teams has limited the extent to which neighbourhood teams have been able to improve the quality of care. Six months since its initiation, no practical changes in care had been delivered to respective target populations. Given the results from the 100-Day Challenge, there are multiple means by which neighbourhood teams can organize to deliver care. As a result, there is a need to establish a structural framework by which neighbourhood teams can deliver patient-centred health services.

Given the fragmentation of the healthcare system in West Essex, the purpose of this study was to evaluate the implementation of the Neighbourhood Team Model – an initiative aimed to provide patient-centred community healthcare by integrating health and social care based on population risk stratification in West Essex.

Methodology

Study design

A customized, descriptive survey was designed to determine the current progress, challenges, expectations and understanding of the Neighbourhood Team Model (see Appendix). We asked a series of open-ended questions intended to elucidate the challenges to implementing the Neighbourhood Team Model and to gather suggestions for its development and improvement. Each participant was purposely selected and interviewed once. Each interview ranged from 20 to 45 minutes.

The survey included a cover letter introducing the interviewers, the purpose of the study and the format of the survey study. The survey packet also included background material explaining the concept of the Neighbourhood Team Model, the breakdown of the West Essex population into regional teams, and examples of the potential implementation and coordination of care using neighbourhood teams. The inclusion of background materials was intended to standardize the level of reference and knowledge regarding neighbourhood teams and their implementation.

Sampling and Recruiting

Participants were purposively selected from West Essex's healthcare providers and staff. Each participant had a stake in the implementation of the neighbourhood teams. In total, 24 participants were interviewed. Participants included administrative directors, managers, neighbourhood team leaders and organizational leaders. The participants consisted of seven health providers from the West Essex CCG, six primary care physicians, four employees from Princess Alexandra Hospital (PAH), three health professionals from the West Essex Mental Health Unit, two providers from the voluntary sector, and two participants from the social sector.

The Interview Process

Each participant agreed to allow their respective interview to be recorded, and each participant was given a brief introduction to the Neighbourhood Team Model. Then, 11 open-ended questions were asked. Participants were prompted to think about each of these questions before responding; if more information was requested by the participant, some information was given to the participant with careful consideration not to bias or mislead the participant's opinion.

Data Analysis

The recordings of each interview were transcribed using IBM's audio-to-text tool. Meaningful and suggestive responses were extracted in a spreadsheet and then coded using a defined code book (see Appendix). The codes were customized to effectively represent the breadth of responses. Non-code responses were categorized as *other*. Subsequently, the spreadsheets were reviewed, and both major themes and sub-themes were identified and evaluated.

Results

Themes and Sub-Themes

- *Patient information sharing* – IT system issues, Electronic Health Record (EHR) sharing
- *Professional communication* – updated communication, communication accuracy, misunderstandings and unclear professional terms or jargon
- *Collaboration* – respect, responsibility, openness to change, benign and organic relationships, a shared goal
- *Patient Education* – the level of patients' knowledge about how to access healthcare services properly
- *Professional education* – the level of health professionals' knowledge regarding the delivery of healthcare services
- *Neighbourhood team concept education* – the level of key stakeholders' understanding of the Neighbourhood Team Model
- *Demographic variation* – age, race, gender, health condition, size of population in the seven neighbourhoods of West Essex
- *Delivery of care variation* – quality of care, inequality among the seven neighbourhoods
- *Financial incentives* – the extent to which a financial reward incentivizes the formation of neighbourhood teams
- *Quality of care incentive* – the extent to which a better quality of care is the incentive to form neighbourhood teams
- *Workload incentive* – the extent to which existing/future workload is the incentive NOT to form neighbourhood teams
- *Behaviour change* – the extent to which sentiment against behaviour change is the incentive NOT to form neighbourhood teams

- *Clinical priority* - the priority of the organization of the participant to address medical complications
- *Service reorganization* - the priority of the organization of the participant to relocate the financial/labour resources
- *Model 1/2* – choice of Neighbourhood Team Model 1 or Neighbourhood Team Model 2 presented in brief interview introduction
- *Role of coordinator* – given Neighbourhood Team Model 2, what responsibilities should the neighbourhood care coordinator take on
- *Size of neighbourhood* – uncertainty about a workable size of the neighbourhood
- *Primary/self-referral access* – the two ways patients access care in each neighbourhood team
- *Risk segmentation* – assessing the target population that the neighbourhood teams should focus on: high-risk, rising risk/at risk, healthy, or the entire population
- *Fragmentation* – a lack of coordination among health providers is the reason the overall health system does not work well
- *Politics* – health policies and politics are the reason the overall health system does not work well
- Financial – a lack of financial capacity is the reason the overall health system does not work well
- *Capacity* – a lack of institutional and infrastructural capacity is the reason the overall health system does not work well

Table 1 shows the frequency of each theme and sub-theme mentioned during the interviews. Issues including collaboration, patient information sharing, the role of a coordinator, system fragmentation and capacity were mentioned most frequently. Matters of collaboration were mentioned the most. Neighbourhood Team Model 1 and Neighbourhood Team Model 2 (see Appendix) were mentioned in high frequency because each participant was asked to choose between the two. Some participants declined to respond because they thought neither model worked well. For the risk segmentation theme, the frequency of responses did not sum to 24 because some participants thought more than one population should be targeted.

Table 2 shows the response rate for each sub-theme. Table 2 and Table 1 reveal similar results; issues including patient information, collaboration and system fragmentation/capacity were all mentioned by over 70% of the participants. In addition, issues such as project education, the role of a coordinator, a rising-risk population, professional communication and behaviour change were mentioned in high frequencies.

Table 3 breaks down Table 2 in more detail. The columns are organized by the respective organization of the participant, and the rows show the response rate of each sub-theme. For example, participants from hospitals and from primary care have similar response rates in all sub-themes. They consider communication, collaboration and the care coordinator to be the most critical issues, and both suggest that neighbourhood teams should address at-risk populations rather than others. Participants from Clinical Commissioning Groups considered the size of the neighbourhood to be an especially important issue.

Table 4 provides a summary of the question, *'What is missing, or what support do you need the most?'* Participants from primary care suggest that hospital and social care services are missing in their network. Voluntary sector participants suggested that they need the institutional support of other organizations. Also, nearly all participants claimed that social care was integral to neighbourhood models and an element that was currently missing.

Table 5 presents the variance in responses based on the organization the participant represents. GPs and PAH are categorized as providers; and, the Voluntary Sector, Community Services and the Mental Health Unit are categorized as community service organizations. The variance depicts whether the three types of organizations have divergent responses and incentives. The results show that providers believe the real population target of neighbourhood teams to be rising risk/at risk populations, but fewer professionals from the West Essex CCG and Community Services agreed. Professionals from Community Services did not mention Patient Education as an issue, whereas the other two did.

Table 1 Frequencies of major themes and sub-themes

Theme	Frequency
Communication	
Patient information sharing	61[1]
Professional communication	59
Collaboration	124
Education	
Patient	9
Professional	11
Neighbourhood team concept education	39
Variation	
Demographic	11
Delivery of care	10
Incentives	
Financial	15
Quality of care	41
Workload	44
Behaviour change	40
Priorities	
Clinical	24
Service reorganization	26
Model	
Model 1	5
Model 2	14
Role of coordinator	60
Size of Neighbourhood	9
Primary care access	12
Self-referral access	7
Both	9
Risk Segmentation	
High risk	8
Rising risk/At risk	17
Healthy	6
All of the levels	5
System Issue	
Fragmentation/Inefficiency	84
Politics	28
Financial	19
Capacity	68
Suggestions	325
Other	86

[1] The IT-system theme is categorized in patient information sharing; IT-systems were mentioned 14 times.

Table 2 Response rate by sub-themes

Theme	Frequency (n=22)	Percentage %
Communication		
Patient information sharing	21	95.5
Professional communication	19	86.4
Collaboration	21	95.5
Education		
Patient	7	31.8
Professional	8	36.4
Neighbourhood team concept education	16	72.7
Variation		
Population	8	36.4
Delivery of care	7	31.8
Incentives		
Financial	12	54.5
Quality of care	11	50.0
Workload	10	44.5
Behaviour change	16	72.7
Priorities		
Clinical	12	54.5
Service reorganization	14	63.6
Model		
Model 1	4	18.2
Model 2	14	63.6
Role of coordinator	18	81.8
Size of Neighbourhood	5	22.7
Primary care access	5	22.7
Self-referral access	7	31.8
Both	4	18.2
Risk Segmentation		
High risk	6	18.2
Rising risk/At risk	14	54.5
Healthy	4	18.2
All of the levels	4	27.3
System Issue		
Fragmentation/Inefficiency	19	86.4
Politics	13	59.1
Financial	13	59.1
Capacity	16	72.7

Table 3 Response rate by organizations and sub-themes

Theme	PAH (n=4)	West Essex CCG (n=8)	GP Practice (n=4)	Mental Health Unit (n=3)	Voluntary Sector (n=3)	Social Sector (n=2)
Communication	-	-	-	-	-	-
Patient information sharing	4	7	4	2	2	2
Professional communication	2	2	1	1	0	0
Collaboration	4	7	4	2	2	2
Education	-	-	-	-	-	-
Patient	1	4	2	0	0	0
Professional	2	3	1	0	1	1
Neighbourhood team concept education	4	4	3	1	2	2
Variation	-	-	-	-	-	-
Population	2	2	1	2	0	1
Delivery of care	1	3	1	1	1	0
Incentives	-	-	-	-	-	-
Financial	3	4	2	1	1	1
Quality of care	2	4	3	2	0	0
Workload	2	5	2	1	0	0
Behaviour change	4	5	3	2	1	1
Priorities	-	-	-	-	-	-
Clinical	3	5	2	2	0	0
Service reorganization	0	6	3	2	2	1
Model	-	-	-	-	-	-
Model 1	1	2	1	0	0	0
Model 2	3	4	3	2	1	1
Role of coordinator	4	7	3	1	2	1
Size of Neighbourhood	0	2	1	1	1	0
Primary care access	0	3	1	1	0	0
Self-referral access	1	1	0	2	0	0
Both	1	1	0	2	0	0
Risk Segmentation	-	-	-	-	-	-
High risk	2	3	1	0	0	0
Rising risk/At risk	4	4	4	1	0	1
Healthy	1	2	0	1	0	0
All of the levels	2	1	1	0	0	0
System Issue	-	-	-	-	-	-
Fragmentation/Inefficiency	4	7	3	2	2	1
Politics	3	4	2	0	2	2
Financial	2	5	3	1	1	1
Capacity	3	7	3	0	2	1

Table 4 'What is missing, or what support do you need the most?'

Need Support/Communication	GP practice	Voluntary Sector	Hospital (PAH)	CCG	SEPT (Mental Health)	Care Home	Social Care
GP practice	-	●●	●●	●	-	-	-
Voluntary sector	-	●	●	-	-	-	-
Hospital (PAH)	●●●	●	-	-	-	-	-
CCG	●	-	-	-	-	-	-
SEPT (Mental Health)	-	●●	-	-	-	-	-
Care Home	-	●	●	-	-	-	●
Social Care	●●●	●	●	●	●	-	-

Refer to top row first and then look down the column; for example, GPs (first row) claim to need the most support from Hospitals & Social Care (Column).
The dots indicate the frequency of needed support an organization mentioned during the interviews; for example, almost all participants mentioned that social care support is needed or missing.

Table 5 Responses segmented by providers, West Essex CCG, and Community Services

Theme	Providers (n=8)	West Essex CCG (n=8)	Community Services (n=7)	Variance
Patient information sharing	8	7	6	1.00
Professional communication	3	2	1	1.00
Collaboration	8	7	6	1.00
Patient	3	4	0	4.33
Professional	3	3	2	0.33
Neighbourhood team concept education	7	4	5	2.33
Population	3	2	3	0.33
Delivery of care	2	3	2	0.33
Financial	5	4	3	1.00
Quality of care	5	4	2	2.33
Workload	4	5	1	4.33
Behaviour change	7	5	4	2.33
Clinical	5	5	2	3.00
Service reorganization	3	6	5	2.33
Model 1	2	2	0	1.33
Model 2	6	4	4	1.33
Role of coordinator	7	7	4	3.00
Size of Neighbourhood	1	2	2	0.33
Primary care access	1	3	1	1.33
Self-referral access	1	1	2	0.33
Both	1	1	2	0.33
High risk	3	3	0	3.00
Rising risk/At risk	8	4	2	9.33
Healthy	1	2	1	0.33
All of the levels	3	1	0	2.33
Fragmentation/Inefficiency	7	7	5	1.33
Politics	5	4	4	0.33
Financial	5	5	3	1.33
Capacity	6	7	3	4.33

Discussion

Many studies have addressed the potential benefits of moving toward community healthcare within the NHS, but this study is one of the first that explores the Neighbourhood Team Model. Similar to the responses of our participants and the results of this study, other studies have found that moving care from hospitals toward the community has the potential to reduce duplication, reduce physician workload, reduce the activity and cost within A&E, and to improve the quality of patient care. In many of the interviews, participants worried about the difficulty of implementation given the current system's fragmentation and inefficiency. However, because community healthcare resembles the Neighbourhood Team Model in many ways, teams should consult past attempts at implementation to better establish realistic expectations, to inform patients and team members, and to set forth a plan of action.

Higher frequency responses do not completely align with the severity of the subject matter, whether it be a problem, concern, or goal. Instead, the frequency data provides direction for policy makers and neighbourhood teams. By interviewing professionals involved in a variety of health sectors that make up neighbourhood teams, this study was able to gather information to assess the sentiments surrounding the early stages of the development of neighbourhood teams. Participants in the study identified many potential benefits of working in neighbourhoods. These included: better quality of patient care, reduction in A&E admissions, reduction in workload, increased job satisfaction, and increased collaboration and information sharing within the community, among other benefits. However, there were many concerns about the organization of neighbourhood teams, the timeline of implementation, potential confusion among patients and team members, a lack of information sharing about neighbourhood teams, and incentives for involvement.

Generally, participants acknowledged the potential positive impact of neighbourhood teams and emphasized the necessity for change within the current system to ensure sustainability. Participants saw neighbourhoods as a means to providing much needed communication and collaboration among healthcare sectors. In addition, perhaps because an operable IT system (information sharing system) has yet to be established in many areas of West Essex, participants looked favourably upon the neighbourhoods to galvanize the development of an efficient IT system. Conversely, we heard fewer than expected concerns regarding the variation in patient populations and delivery of

care between neighbourhood teams. Perhaps, this is because there was little to no communication between the teams at the time of the study.

Key considerations:

1. Healthcare personnel do not share the same understanding of neighbourhood teams.

Participants from each health or social care sector had slightly different yet noticeable differences in opinion about the Neighbourhood Team Model. For instance, participants from hospitals were pessimistic about the neighbourhood teams because although they were interested in relieving urgent care centres and meeting a 4-hour waiting standard for patients, the implementation of neighbourhood teams would expectedly take a long time for benefits to manifest. Conversely, participants from the social care sector were optimistic, suggesting that the implementation would go smoothly and that the piloting of the program was going very well. Future studies should investigate the variation in responses based on healthcare sector.

2. Few practical cases/examples of how neighbourhood teams should operate exist.

Although participants agreed that they understood the Neighbourhood Team Model once presented with information, their responses suggested that case studies and case discussions would be an effective tool to educate health providers on the purpose and organizational structure of neighbourhood teams.

3. Care homes were not adequately represented.

Care homes appeared extremely over-worked and unable to participate in the study due to a lack of capacity at the time. Greater integration between health providers at the West Essex CCG and care homes would help facilitate more engagement and involvement.

4. A care coordinator is heavily preferred within the current system.

Participants were presented with two access models during each interview. More than half of the participants chose the model with a care coordinator. However, based on the specific responses, participants preferred a combination of both models, where the coordinator would be added to a model similar to that of the current system. Participants suggested that a new model would cause

confusion and reluctance to participate. The coordinator would help facilitate communication where it is most needed.

5. The voluntary sector is largely misunderstood and disconnected.

Participants from the voluntary sector voiced two ideas that were especially noteworthy. First, they suggested that creating contracts with voluntary sector organizations does not work. Oftentimes, the West Essex CCG contracts the voluntary sector, which places limits and restrictions on their capacity for change. A voluntary sector organization has different work practices and recruitment procedures, so it is difficult for them to deliver constant support because volunteers are not always available. Second, participants insisted that the voluntary sector could play a greater role in providing basic medical services to patients.

6. The target population should be those with at the lowest risk for complication.

Currently, neighbourhood teams focus on the population with the greatest risk for complications. However, more than half of the respondents suggested that the lowest risk populations should be of primary focus. Participants argued that neighbourhood teams could integrate care to prevent an at-risk population from deteriorating into high risk patients. Future studies should evaluate the capacity for neighbourhood teams and community healthcare systems to provide care for low risk populations considering their substantially larger size compared to that of high risk populations.

Limitations

A limitation of this study was its sample size. Given the relatively small sample size, statistical analyses were limited. Additionally, participants from care homes were not included in this study, though they are considered important stakeholders in the development of community health systems. Ultimately, this study focused primarily on senior managers and executives within respective organizations, and as a result, these findings do not illustrate the general sentiment of patients or immediate practitioners who interact with patients daily.

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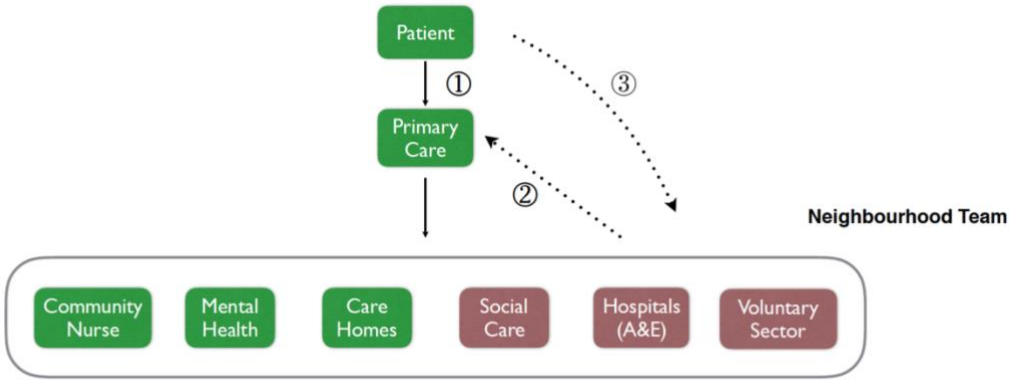
Appendix 1 Suggestion Table

Theme	Suggestions
Communication	• Standardize communication and avoid duplicated contacts • Make sure people have a clear and designated contact • Joint-patient care record and IT system
Collaboration	• Get the right people on the table and make sure each voice is equally heard • Build relationships/trust in an organic way • Encourage people to take ownership/responsibility; can-do mind-set • Have a shared goal • Know the available services and capacity
Education	• Develop clear expectations (e.g. time, benefits, etc.) • Be realistic about the project and capacity • Speak understandable language; keep participants on the same page
Model	• Decide the patient role in the model • Need a central managerial part • Care Coordinator - responsibility, skill, working hours, co-location • Find a good size for neighbourhoods; Harlow is too big • Personnel consistency • Flexibility - model peoples' ability to adapt to changes in the system • Have a full-time project manager who drives and follows people
Risk Segmentation	• Cannot ignore top-risk patients; prevent rising-risk to high risk • All patients approach is extremely difficult given resources
System Issue	• Overarching infrastructure support rather than isolating neighbourhood team • Empower junior level staff to make decisions • Long-term financial support • Remove potential perverse incentives from the policy • Prioritize initiatives
Other/Innovative	• Stop endless discussion • Incorporate news sectors, such as SEPT • Promote job satisfaction as an incentive • Clarify that neighbourhood teams are not the same as small hospitals
Next Step	• Identify the area that can make a difference in care • Learn from what works • Implement best model immediately • Focus on smaller projects that provide a better way forward

Appendix 2 Terms for Clarification

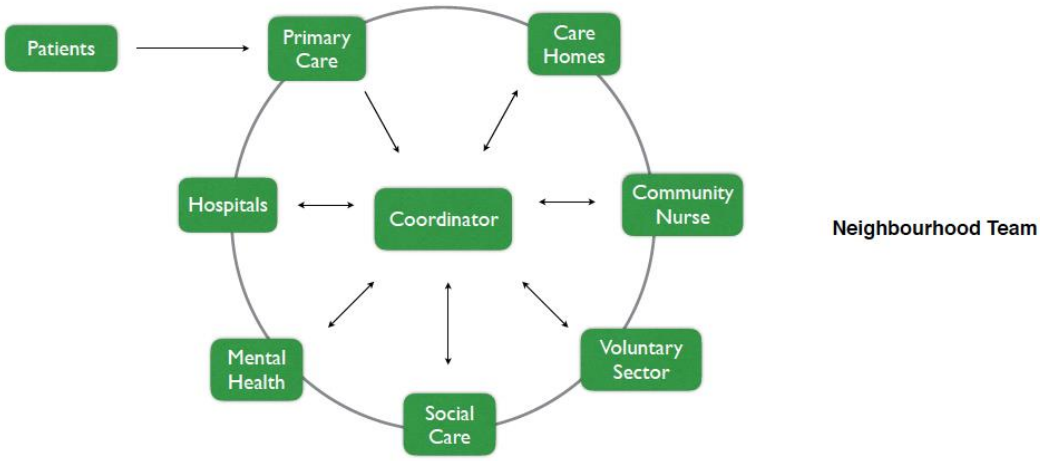
Name	Definition
Clinical Commission Group	NHS bodies responsible for the planning and commissioning of health care services for their local area.
National Health Service	The National Health Service (NHS) is the publicly funded national healthcare system for England and one of the four National Health Services of the United Kingdom.
General Practice	GPs usually work in practices as part of a team, which includes nurses, healthcare assistants, practice managers, receptionists and other staff. GPs work closely with other healthcare professionals, such as health visitors, midwives, mental health services and social care services.
Voluntary Sector	Volunteer organizations, such as Rainbow Services in Harlow
Social Sector	West Essex County Counsel provide social care services including *looking after someone, staying safe, going out, working and learning, protecting vulnerable children, etc.* to West Essex local residences.

Appendix 3 – Neighbourhood Team Model 1



In this model, patients are referred to the Neighbourhood Team. A patient can access different sectors of the Neighbourhood Team via (1) Direct GP referral (2) Members of the Neighbourhood Team contacting the patient's GP for further referral (3) Self-referral

Appendix 4 – Neighbourhood Team Model 2



In this model, patients are directed toward different sectors of the Neighbourhood Team through a care coordinator. The coordinator will have necessary patient information readily accessible.

Similar to Single-Point of Access