

C&C DHB Partner Update

8 December 2009

Capital & Coast DHB will regularly be providing information packs to stay in touch with our colleagues in primary health and to keep everyone up to date with what's going on.

Please help us by distributing this to other Primary Health Care Providers who you think might find this information useful.

Headlines in this edition:

- ***Message To Primary Care*** – A few words from CEO Ken Whelan
- ***New HealthPoint website*** – with C&C DHB clinical and referral information
- ***Access to General Adult Mental Health Services*** – Te Haika (The Anchor) launched
- ***Medical Assessment & Planning Unit Open for GP Referral*** – See referral guidelines attached
- ***New Specialist to GP phone advice service*** – Kenepuru & Kapiti area patients
- ***New Clinical Pathways Collaborative Initiative***
- ***Cancer Control Plan public engagement*** – Feedback period extended
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- ***Reminder of TIA clinic*** – See referral guidelines attached
- ***Care Coordination Centre*** – Update on Packages of Care
- ***Winners in Primary Care*** – Wellington Region Primary Health Care Nurses Reference Group awards showcase great initiatives
- ***Hospital Departments On The Move*** – See move details below
- ***Anticoagulation Working Group Update***

- ***Diabetes Hui held***
- ***Vacancies – PATHS Case Nurse Manager***

See below for further details on each of these issues. Documents attached to the newsletter are in bold and underlined.

Message from C&C DHB Chief Executive, Ken Whelan

This year has seen a few new challenges for health in our region – not least of which was the introduction and subsequent nationwide spread of the new H1N1 virus (Swine Flu) in the community.

Given the significant extent of the virus in our area, I believe all health professionals, in both primary and secondary settings, can be justifiably proud of the way they managed this pandemic.

It is a tribute to the hard work and dedication of not only doctors, but also practice nurses and lab staff, that there were few deaths and the outcome for most sufferers was full recovery.

The key to this success was outstanding management in difficult conditions in the community.

Wellington city officials recently awarded C&C DHB with a special Safety In The City Award for the work done during the outbreak. We share this with you all because we know that this was a combined primary-secondary effort. I think Mayor Kerry Prendergast covered it, when she said that "...from the besieged GPs, to the DHB staff who cared for patients, did tests, kept the hospitals safe and the managers who managed the crisis, Wellingtonians owe you all a great debt."

The work done towards greater cohesion in primary-secondary clinical governance is hugely important and a great step forward this year.

The Primary Secondary Clinical Governance Group has been strengthened to make it into a decision-making body. The group includes clinical representatives from both the primary and secondary services as well as key decision makers from the DHB including the Chief Executive. The aim of the group is to ensure patient outcomes are maximised by improving quality and reducing risk across the patient journey through Primary/Secondary/Tertiary systems.

As it evolves, it is now well placed to assist work in the coming year to support the shift of some services from hospital, to primary care settings. The key programme for delivering on this is the Clinical Pathways Collaborative which aims to deliver clinical and patient pathways for implementation to improve outcomes and quality of care.

I look forward to seeing this work develop and enhance relationships across the sector in our region.

Input from our primary care colleagues has played an important part of the development of new and existing services this year, including the orientation of the new hospital and the construction and opening of the new Medical Assessment and Planning Unit (MAPU).

The MAPU will be integral in improving not only the flow of patients through the Emergency Department, but also the actual experience of the patients themselves when admitted to hospital.

The appropriate utilisation of this service is the key to its success and once referral processes are properly bedded down, we expect this to make a significant difference to medical patient admissions and treatment times, and patient flows.

We have also been fortunate to have an excellent contribution from the primary sector when developing planning around our Palliative Care Programme and Cancer Control. Going forward, we are looking for further input from you all into the drafts of these documents and look forward to hearing your ideas and comments before these plans are put into action (see details of the public engagement process for both of these below).

Finally, I would like to wish you all the very best for the festive season and look forward to working closely with you in the new year.

New HealthPoint website with C&C DHB clinical and referral information

Healthpoint.co.nz is a new website which has the latest DHB referral and clinical guidelines, protocols and contacts.

We encourage all healthcare professionals to access this site to get the latest information from C&C DHB on:

- Referral criteria and priority
- Management protocols for common conditions
- New patient waiting times – updated monthly
- Monthly newsletters and DHB updates

You must register and sign in on www.healthpoint.co.nz to access the referral and clinical information about C&C DHB services.

For GPs and medical professionals, please register by clicking on the register at the top of the home page.

For all other health professionals we would encourage your practice or PHO to obtain a login from info@healthpoint.co.nz.

The services below are now live:

AT&R	Genetics	Ophthalmology	Renal
NASC	Primary Care	Orthopaedics	Respiratory
Cardiology	Gynaecology	Paediatric Surgery	Sexual Health
Dermatology	Infectious Disease	Chronic Pain	Urology
Diabetes	Internal Medicine	Palliative Care	Vascular Surgery
Emergency	ICU	Pharmacy	Whanau Care
Endocrinology	Maternal Fetal Medicine	Pregnancy Termination	Te Whare Marie
ENT	Neurology	Preparing for Surgery	Te Haika
Gastroenterology	Neurosurgery		

The information on the website is developed and reviewed by each service. The information is updated regularly and each page is dated.

Access to General Adult Mental Health Services – Te Haika (The Anchor) launched

Te Haika, a new central point for referrals to C&C DHB's General Adult Mental Health Services, has now been launched.

The service books appointments throughout the Wellington region – Kapiti, Porirua and Wellington – and aims to offer an appointment in a location that is most suitable to the consumer.

To contact Te Haika, call (04) 918 2267 or text 027 500 1569.

Referrals can be sent by:

Email to TeHaika@ccdhb.org.nz or by fax 04 9182284.

Our team process referrals between 8.30 and 5pm Monday - Friday and can be contacted on 04 9182267 during these hours.

Our mailing address is Te Haika, PO Box 50-215, Porirua.

Please see the attached referral form (called CPReferral). It is helpful to have the following information included in any referral (where applicable/possible):

- Whether the client consents to the referral.
- Purpose of referral (e.g. diagnosis, case management, medication review, psychology, advice).

- Information on clients previous mental health history.
- Any Alcohol and Drug issues. (e.g. History, what are the past and current issues/ treatments/ needs)
- Current Mental Health Concerns
- Level of Risk and Urgency of referral
- current Medication Regime (it is helpful to include previous medication trialed and efficacy of this.
- Physical Health Issues/ Diagnoses
- Other interventions currently being implemented or previously trialed.

Te Haika:

Referrals to community mental health teams, which meet access criteria, are booked into "Choice" appointments (initial appointment). Te Haika clinicians will arrange these appointments with GPs over the phone.

The focus of the Choice appointment will be to clarify the consumer's needs and decide what the most appropriate intervention/service is to meet those needs.

The Choice appointment is a one-off session, which may last 45-90 minutes, concluding with an initial shared formulation and agreed summary and plan, including things that the consumer, family and others can do to assist. It is not a comprehensive psychiatric assessment but may consider risk and diagnostic frameworks as required.

Choice appointments are not intended to replace requests for very urgent psychiatric or crisis assessments. These will continue to occur as at present with the Crisis Assessment & Treatment Team (CATT).

Following completion of the Choice appointment, the consumer may be offered further appointments with a Community Mental Health Team for ongoing assessment and treatment. This may include being assigned a Case Manager to provide for ongoing care and support in the community.

After a period of treatment under the CMHT, most consumers will be well enough to be discharged. The CMHT will discharge only after consultation with the consumer, family (whanau) or other significant persons (if involved in their care and treatment).

After discharge the consumer may be re-referred to the CMHT via Te Haika by a GP if this again becomes necessary.

If the consumer cannot attend the appointment, 24 hours notice is appreciated.

Feel free to advise the consumer to bring a support person(s) to their Choice appointment. If they are choosing to bring more than one person can you please let us know so that we can ensure the room we book is adequate.

For further information including inclusion and exclusion criteria see Te Haika on www.healthpoint.co.nz.

Further updates will be provided as Te Haika expands its function beyond the General Adult Mental Health Services.

Medical Assessment & Planning Unit (MAPU) Open for GP Referral

The Medical Assessment and Planning Unit (MAPU) at Wellington Hospital is now open.

This allows GP-referred patients who are not critically ill to bypass the Emergency Department after a brief triage assessment and proceed directly to the new unit which is on the same floor, next to the Short Stay Unit.

The process of referral remains unchanged with the General Practitioner calling the medical registrar (on **0274999465**) or sub-specialty medical registrar to discuss patients requiring assessment and/or admission. The registrar will determine whether the patient can be assessed in the MAPU or will need to be seen in ED.

We will be aiming to see as many patients as possible in the MAPU but those with acute coronary syndrome, the possibility of a surgical problem and any who are very unwell will be directed to ED. For this reason patients who have not been discussed (even if carrying a referral letter) will also need an initial assessment in ED. We anticipate that this will result in a greatly improved experience for patients referred to the medical inpatient services and patients will therefore be significantly advantaged if they come to hospital via GP referral as opposed to self-referral. The MAPU has 24 beds and provides inpatient accommodation for people requiring a short inpatient stay (less than 36 hours) as well as for our sicker patients in the 6 High Dependency Bay beds. The MAPU is on level 2 of the new hospital and you are welcome to visit us and your patients.

Please see the **attached MAPU Admission Processes and Criteria for GPs**, and the **MAPU Entry Criteria for GPs** documents.

New Specialist to GP phone advice service (for adults in Kenepuru and Kapiti area)

A new telephone advice service is now available for GPs working with adult patients in the Kenepuru and Kapiti catchment.

This service provides telephone advice from Specialist Physicians and Geriatricians on specific medical issues, particularly in those with multiple comorbid medical conditions.

The service runs from 9am to 5pm on weekdays and is intended to provide urgent specialist advice to discuss appropriate medical management of those with complex medical conditions including direct admission if required.

The **on call consultant can be contacted on 027 2234647** or through the hospital switchboard.

New Clinical Pathway Collaborative (CPC) Initiative

The new Clinical Pathway Collaborative (CPC) initiative has now been endorsed by the Chief Executive and the Primary /Secondary Clinical Governance Group for the DHB.

The initiative forms a structured programme to engage Clinicians from across the health spectrum and professional groups to:

- explore issues and challenges
- identify priorities for improvement
- deliver clinical / service/ patient pathways for implementation aiming to improve outcomes and quality of care.

A main focus will be on improving Integrated Care across the Primary, Secondary and Tertiary Interface.

This will mean evidence-based planning in order to reduce unacceptable variation in the quality of care and timely access to integrated health services, which are conveniently situated. These services need to be owned, and led by Clinicians/health professionals.

Following the last meeting of the Primary/Secondary Governance Group the first wave for the CPC was agreed, based on collective information for suggested areas.

The information included:

- Level of clinical risk
- Sub-optimal performance
- Funding and cost implications

- Alignment with DHB strategic and annual planning
- Willingness to participate from clinicians

Based on this and a simple scoring tool, the following areas will commence in January 2010:

- Palliative Care
- Cancer
- Gastroenterology – Endoscopy
- Transition from Paediatric to Adult Services/ Care.

Time requirement for those involved will be 2 hours every 3 weeks for 5 meetings. Hospital clinicians and primary care GPs are invited to be part of the groups – in the first instance by those already working in some capacity in these areas or with an interest. There will be some financial recompense for the time involved for external providers.

If you should be interested in participating, or would like further information, please contact: Bridget Smith, Service Development Manager Primary – Integrated Care, by email: bridget.smith@ccdhb.org.nz

Or you can contact Dr Adrian Gilliland, Clinical Advisor for Primary / Integrated Care: Adrian.gilliland@ccdhb.org.nz or phone 04 803 1119; or Vicky Noble, Director of Nursing Primary Care: Vicky.noble@ccdhb.org.nz or phone 04 803 1128.

Cancer Control Plan – Public Engagement

We are also pleased to bring you the ***Cancer Control Plan 2010 – 2015***, which is now available for public engagement – you can view this document at: <http://www.ccdhb.org.nz/news/consultation/cancer%2Dcontrol/>

The DHB wishes to encourage anyone with an interest in this field to provide input into this important plan.

To provide feedback, you can use the following link to an online form:

http://www.surveymonkey.com/s.aspx?sm=PvjTpuis1b5VfR6sUsR9SQ_3d_3d

Alternatively, you can send your feedback by email to: viv.murray@ccdhb.org.nz

Feedback is required by **5pm, 5 February 2010**.

Background information:

The purpose of the Plan is to document service level improvements and public health initiatives that C&C DHB intends to undertake over the next five years. Our objective is to reduce the burden of cancer and reduce the disparities in survival rates within the communities we are accountable to.

The Plan has been aligned directly to the six goals of the New Zealand Cancer Control Strategy (March 2005) and incorporates current and future initiatives from a local, regional and national perspective. The Plan is compiled into three sections:

- **The first section** highlights C&C DHB's service improvement and public health initiatives that are planned over the next five years.
- **The second section** sets out the current services delivered by C&C DHB that directly and indirectly relate to the provision of cancer services.
- **The third section** provides evidential information, both statistical data and research material that informed the development of the Plan.

Through our plan development process and by conducting a stocktake of services currently available, we believe that the communities and people we serve can take comfort in the knowledge that the number, nature and range of cancer services we provide are extensive. However, we have recognised that there are some areas that we can do better and there are others that we have yet to develop. Our Plan is aimed

at addressing those service improvements or shortfalls. It also identifies some new initiatives that have yet to be implemented either nationally or locally and additional services that could potentially be offered at C&C DHB.

C&C DHB accepts the challenge to deliver its services according to the preferences of people who are affected by cancer. Putting our Cancer Control Plan into place will provide the proof for how well we meet that challenge.

Palliative Care Programme Plan – Public Engagement

C&C DHB presents the ***Palliative Care Programme Plan 2010-2015*** for your review and feedback – you can view this document at:

<http://www.ccdhb.org.nz/news/consultation/palliative%2Dcare/>

This draft document contains C&C DHB's five year plan to address service improvements and shortfalls in the delivery of palliative care services to people in the region who could benefit from those services.

Meeting the challenges of changing disease and demographic profiles (see Strategic Context in appendix one), including people living longer with long term and life limiting illnesses, coupled with limited health care resources, requires that we step back and refocus on how we are providing palliative care services in the region.

Palliative care is appropriate not only for people with cancer, but also includes services, support and care for people of all ages who have a life limiting illness and whose needs change over time as the illness progresses.

People with age-related functional changes or with chronic diseases such as diabetes, heart and respiratory disease, and motor neuron diseases may all benefit from palliative care services provided according to the individual's specific needs.

Your feedback on this plan is important to us. You can make comments by using the attached feedback form, or online by clicking on the following link:

http://www.surveymonkey.com/s.aspx?sm=5EHg7sle06PIL3Wfh_2fUV7Q_3d_3d

You can also contact the Palliative Care Team directly, via email to Nancy.Harp@ccdhb.org.nz or by phone (04) 806 1153.

Please note the **closing date for feedback is 5pm, 5 February 2010.**

Reminder of TIA clinic

(Referral form attached – called TIA Referral Form)

The new stroke TIA (Transient Ischaemic Attack) service based at Wellington Hospital is now up and running.

Referral forms as MedTech Outbox document will be available from PHO Managers or from the Compass website for Compass practices.

TIA is a MEDICAL EMERGENCY – people with TIA are at high risk of early stroke. This risk is higher than that for chest pain and TIA therefore warrants urgent attention (NZ TIA Guideline, Stroke Foundation 2008).

The new clinic is based in outpatients and provides an acute telephone advice service from the Stroke Team for suspected TIAs via a **dedicated mobile number during opening hours of Monday – Friday, 8am – 4pm; this number is 027 555 4712.**

A next working day urgent clinic service referred by fax or email for probable TIAs, in accordance with the Stroke Foundation guidelines is also offered.

High risk patients are to be referred directly to the on-call Medical Registrar.

You can use the recommended pre-populating Medtech32 Outbox document referral form. This form includes an ABCD2 score to identify high risk patients.

The new service will provide next day specialist Stroke Physician assessment, priority access to CT and Doppler USS assessment where appropriate and vascular surgery when required.

The inpatient stroke service aims to have six beds in Ward 7 S (neurosciences ward) and 12 stroke rehabilitation beds. Currently two beds are available on Ward 7S.

Care Coordination Centre (Packages of Care) – Update

Acknowledgement of referrals sent to the Care Coordination Centre (CCC)

When referrals are received, they are screened by the CCC. The CCC screening process involves the completion of a form which indicates the outcome of the screening process and the services involved as a result of the referral. This is currently in hard copy, and is shared with the receiving service, usually via fax.

The CCC is currently working on its IT system (“Care Co”) to allow for generation and distribution of the Screening Form electronically, at which time it will be made available to GPs as the format for referral acknowledgements. A timeframe for this is still to be agreed and notified to the DHB.

The CCC is working with Healthpoint to make the referral form and service information available. Implementation is expected in December.

Meetings with GP practices by CCC Service Manager

These meetings are continuing, with the focus on those practices that have large numbers of patients receiving home-based support POC. Care Managers have been assigned to GP practices on a geographical basis so all practices should now have a clear link/communication process with their identified Care Manager. The CCC reports that Care Managers are spending considerable time on the phone and liaising with GP practices, which is resulting in improved communication and understanding of clients’ needs and POC processes.

Reassessment of 700 ‘low needs’ clients

This project was commenced in August in line with the revised POC Allocation Guidelines, which were developed as a result of ongoing refinements of the POC model and processes.

A group of clients was identified as receiving long-term household management services whose needs were not associated with any long-term health condition or disability. It was agreed that these clients should be reassessed to ensure that the services being delivered were based on a client’s assessed needs for support related to a long-term health condition or disability.

Although a communication process regarding this project was initiated, it appears that the process has not been well understood. Clients received a letter informing them of the process and were then contacted by telephone for the reassessment. The results of the reassessment were communicated to the client GP.

The DHB have received a number of queries and complaints about the process. We have agreed to put the process on hold until we have reviewed the POC Allocation Guidelines and the processes for this.

In the meantime, if GPs have any queries or wish to raise any issues regarding individual clients they would be best to contact their nominated Care Manager.

Note that GPs will NOT be notified as a standard for all reassessments for all their clients at this point as per the previous Primary Care Newsletter communication – such a process cannot be implemented immediately, but we are working with CCC to find ways to improve this process.

Winners in Primary Care

This year's Wellington Region Primary Health Care Nurses Reference Group awards have showcased some great initiatives from our colleagues in the primary sector. The judges noted that all this year's applicants were "of a very high standard showing real commitment to improving primary health care."

The two winners of the **Award for Innovation in Quality Improvement** were:

- **Palcare Project – Elizabeth Paske/Paul Holmes, Mary Potter Hospice**
The judges noted that this was an:
"Excellent example of using an IT tool to connect information between hospice and general practice. Effective implementation with a personalised approach. Visiting practices on an individual basis, answering questions and demonstrating the tool. Allowed for 2 way interactive communication."
- **The Primary Care Nursing Team, Waikanae Health Centre**
The judges noted that this was an:
"Excellent example of identifying leaders and using skills effectively. Innovative role development - mobile nurse and clinical support nurse. This Medical Centre is a good example of high performance nursing teams working together and perusing professional development."

The other applicants were:

- **Island Bay Medical Centre, Raewyn Cook and Margo Martin:** Systematic support for Breastfeed in Primary Care
- **Newlands Medical Centre, Cathy Nichols:** Eczema
- **Newlands Medical Centre, Norma Maclachlan and Robina Wickman:** Cervical Smear Uptake Newlands
- **Newlands Medical Centre, Wendy Horo-Gregory:** Breast screening
- **Newlands Medical Centre, Wendy Horo-Gregory:** Cornerstone
- **Work & Income/Regional Public Health/CCDHB:** Lucy Gunn
- **SECPHO, Fiona Osten and team:** Immunisation Coverage
- **Lou Haddock and Nic McCartan:** Healthy Homes/Health People
- **Regional Public Health, Bronwyn Gammie:** "Seasons for Growth" Mental well-being workshops
- **Kapiti PHO, Vikki Cooper:** Why Immunise Brochures

The judges said the other applicants were: "All of high standard, demonstrating strong commitment to innovation within nurse-led initiatives to improve health services to patients."

Congratulations to the winners and all those who entered.

Hospital Departments On The Move

Over the next few months, a number of departments and offices will be moving to refurbished floors within the old buildings of Wellington Hospital. All patients affected by these changes will receive maps and directions to new patient areas with their appointment letters.

If you need directions to any new areas, please contact the individual departments.

Please see the departments which move in December below:

Department	Moving From	Moving To	Date of Move
Endocrine Outpatients & Diabetes Research	NZ Blood Building, Diabetes Centre	Level 5 Grace Neill Block	16.12.09

Planning & Funding Directorate	Lotteries Commission Building, Cambridge Terrace	Level 12 Grace Neill Block	14.12.09
Children's Outpatients	Children's Ward	Level 5 Grace Neill Block	16.12.09

Please note:

From 14 – 16 December while Paediatric Outpatients move to their new premises on Level 5 of the Grace Neill Block, **all paediatric medical clinics will be held in the CMU**, located on level 2 of the new hospital. The intention is to have no down time for Clinics.

From Wednesday 16 December, clinics will take place at the new location in the Grace Neill Block.

The **new Outpatient number is ext 82130 or 04 8062130** and the fax number will remain the same 04 3855841.

Normal December closure dates are from Wednesday 23 December at 4.30pm, to Monday 11 January, 2010.

Anticoagulation Working Group Update

The C&C DHB Anticoagulation Working Group is working to develop a model of care to support the safe and effective use of anticoagulation. The group includes representation from Primary Care, Secondary Care and Planning & Funding.

The working group has developed an integrated model for warfarin and enoxaparin management across primary care and secondary care. The key components of the model include provider education, patient education, patient information on discharge, programme audit, review of model, protocols and the co-operative management of people across the interface.

To enable the development of the model, for each component the group has identified particulars including content of material, delivery methods, identification of responsibility and frequency of activities.

Following the completion of remaining aspects of the model, a proposal for the integrated model will be completed in the first quarter of 2010.

The Primary Secondary Clinical Governance Group has been updated with the Anticoagulation Working Groups' progress.

The Primary Secondary Clinical Governance Group is supportive of the integrated model of care that is being developed and has agreed that the anticoagulation work is suitable to be form one of the work streams that feed into the Primary Secondary Clinical Governance Group in line with the Clinical Pathway Collaborative process.

Diabetes Hui

The C&C DHB Local Diabetes Team held their annual hui in November and a key focus was to identify ways to improve the health of people with diabetes through increasing the uptake of Annual Diabetes Checks (Get Checked) and achieving improvements in HbA1c measures.

Some of the suggestions by the LDT included:

- Ensuring that the annual checks are meaningful for people with diabetes through establishing realistic goals in a supportive and collaborative approach
- Promoting the annual checks through recalls, letters, leaflets, opportunistic reminders during other consults and persistence

- Establishing good relationships with people with diabetes and discussing the importance of having their annual check
- Utilising the support of other people with diabetes to tell their stories through a variety of events and utilising them as buddies or champions
- Having a designated person in the practice to review the uptake of annual checks in the practice and working out plans to make improvements
- Utilising consistent guidelines and for diabetes management to ensure that patients are getting consistent health messages
- Linking with other support resources such as PHO Diabetes Nurses, the Hospital Diabetes Team, PHO Outreach Nurses, transport and translation programmes.

Diabetes is a key focus for C&C DHB – of those in the population expected to have diabetes, the DHB is aiming to have 45% of Maori, 54% of Pacific and 52% of the total population complete a Diabetes Annual Check.

C&C DHB is also aiming for 64% of Maori, 54% of Pacific and 74% of those who have had a Diabetes Annual Check also have an HbA1c <8%.

This can only be achieved through the collaborative efforts across the DHB – so thank you for your efforts so far.

Vacancies

PATHS Nurse Case Manager

(32 hrs per week for 5 months maternity leave commencing 18 January 2010.

Based at Planning and Funding, PATHS, Newtown)

PATHS - Providing Access to Health Solutions

PATHS is a partnership programme between the Ministry of Social Development (Work and Income) and Capital & Coast District Health Board.

The Health Case Manager will, in collaboration with the intersectoral team, provide enhanced opportunities for sickness and invalid beneficiaries to experience improved health to return to employment. The voluntary programme aims to remove barriers to employment in the presence of health issues.

We are looking for a Registered Nurse with at least 3 years experience who has:

- intensive case management of clients with complex health needs
- excellent communication and relationship skills
- knowledge of health and community sectors
- ability to work autonomously within a small intersectoral team environment
- post graduate qualification is desirable.

For further information on this role please contact Sharon Mackie 04 380 2470,

sharon.mackie@ccdhb.org.nz

Applications close Friday 11 December 2009.

If you have any feedback, suggestions or questions regarding these communications please do not hesitate to contact us.

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 Email: raylene.bateman@ccdhb.org.nz
Or

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Or

Vicky Noble
Director Primary Nursing and Integrated Care
Capital & Coast District Health Board
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For C&C DHB information for the general public about Primary Care, visit:
http://www.ccdhb.org.nz/planning/Primary_Care/Primary_Care.htm

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