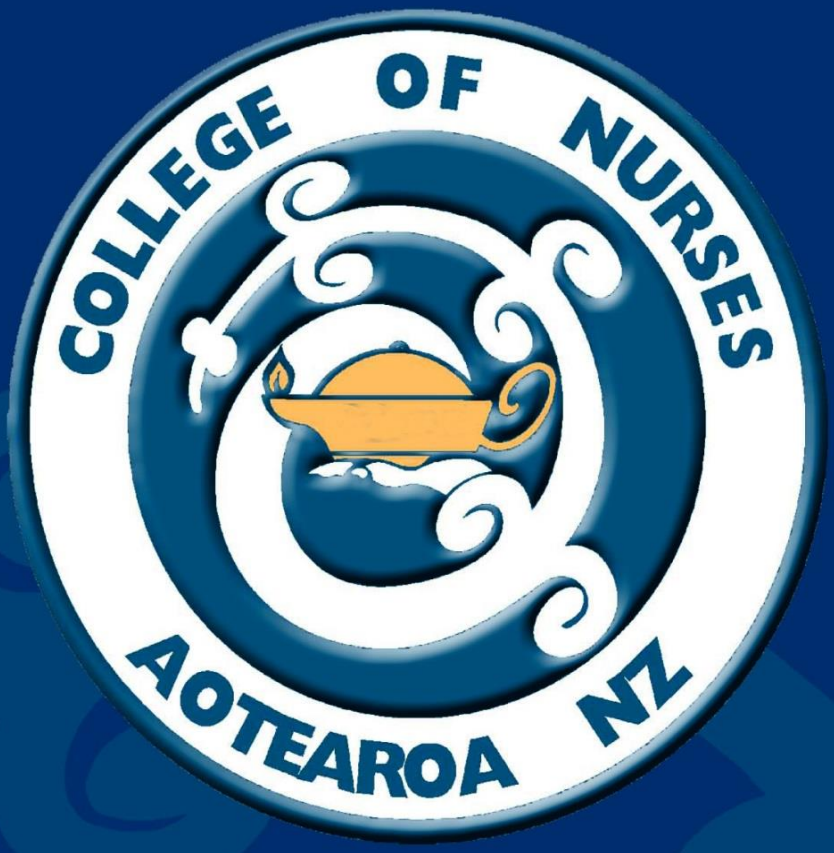
Te Puawai

The Blossoming



The Professional Update for Registered Nurses

December 2014

TE PUAWAI

The Blossoming

Whakatauki

Kia tiaho kia puawai te maramatanga

"The illumination and blossoming

of enlightenment"

This whakatauki highlights the endeavours of the College of Nurses as an Organisation which professionally seeks enlightenment and advancement.

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College of Nurses Aotearoa (NZ) Inc

PO Box 1258, Palmerston North 4440

www.nurse.org.nz

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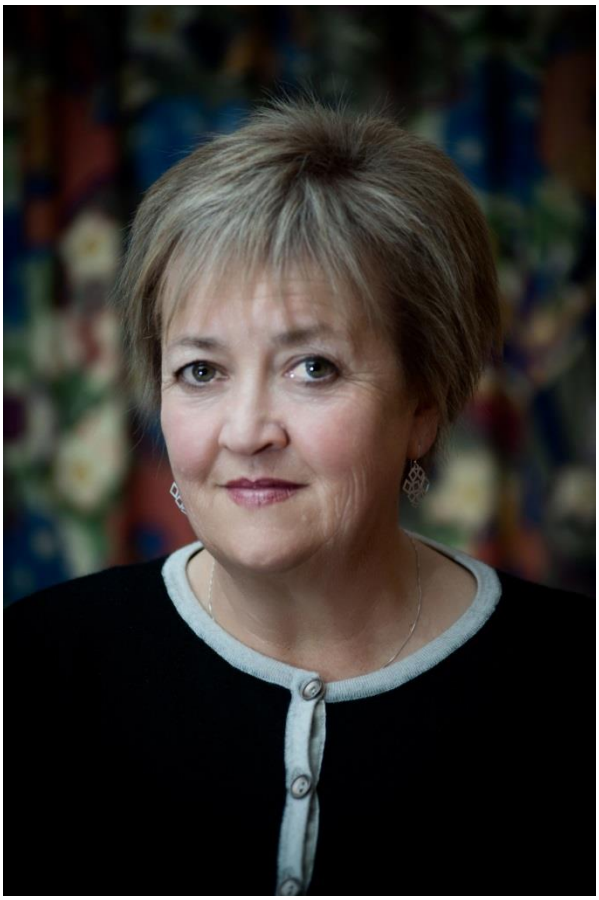
Editorial



Professor Jenny Carryer
RN, PhD, FCNA(NZ) MNZM
Executive Director

School Nurses are a significant, indeed critical, front line for primary and integrated care for young people. To have skilled health professionals on site where children and young people can opportunistically, or through necessity, access treatment, advice, care and support is a valuable resource not to be squandered. The opportunity for timely advice, guidance and early response for young people is unlimited and the mental and sexual health needs of young people are especially important. School nurses have a vital role in supporting the health of the youth of today, often in communities of several thousand.

A summary in the Youth 2000 Survey series 'The Health and Wellbeing of New Zealand Secondary School Students in 2012' Health Services in NZ Secondary Schools and the Associated Health Outcomes for Students, reported as follows

"Overall these results indicate that high quality school health services that have health professionals on site at the school, who have sufficient time to work with students, are well trained in youth health, and perform tasks like routine HEEADSSS assessments, do impact positively on student health and wellbeing outcomes such as depression, suicide risk, sexual health, alcohol misuse and school engagement. The results also indicate that high quality school health services lessen the use of hospital A & E by students. However, full school health services are not available in all secondary schools. Further investment and resourcing of school health services could have a positive impact on the health and wellbeing of secondary school students in New Zealand."

A study from New Zealand using data from the Youth '07 national survey of secondary school students found that there were fewer pregnancies among students at schools with health services, but only when they provided sufficient doctor and nursing time (Denny et al.2012)

Despite the obvious resource inherent in school nurses it seems that the New Zealand health sector is yet to take the role seriously across all schools in all regions. Currently there is no formal requirement to have a registered nurse in all schools or colleges.

Following a period of raised awareness of the role of school nurses a few years ago some low decile schools (decile 1-3) were provided with a school nursing service directly funded by the Ministry of Health through the District Health Boards. These RN school nurses are linked to a professional leadership structure and are more likely to be appropriately remunerated.

Most commonly however, the Ministry of Education through Vote Education funds school nurses (via their school Operational Grant). This means, in effect, that they are employed directly by the school, and they are employed as a support worker in schools with a pay scale and conditions commensurate with support worker status. In some locations, Vote Health school nurses are also employed by the school and despite their remuneration being funded by the DHB, they also sit under the umbrella of support staff and the conditions that collectively affords. For the majority of Vote Education nurses, the salary is not equivalent to a registered nurse level and the nurses do not have access to nurse leaders or anyone who supports their professional development or oversees appropriate employment of appropriately qualified applicants. School nurses are not only abysmally paid but they are unpaid in school holidays. Despite holding the equivalent level of qualification of most of the school teachers they work alongside, they are treated entirely differently. A teacher working in a hospital would not expect to receive a teacher aide rate, so it is interesting that the education system considers it is acceptable to pay some RNs in schools a support worker's pay.

Nurses in schools funded through Vote Education, mostly do their professional development in their own time and self-fund this activity. Because they are disconnected from professional leadership structures there are many anomalies. In some instances the "school nurse" is a first aider with no formal qualifications.

It appears thus far that no one is able to challenge or change the status quo. The Ministry of Education and the Ministry of Health need to work together to transition away from such an anomalous situation. Over the years nursing has made various attempts to put this issue on the policy table but has been spectacularly unsuccessful in garnering any sustained or serious attention to the problem. The consequences of this failure are multiple but most of all they are important to the young people whose health is jeopardised.

Additionally if the school nursing workforce is not valued, resourced, properly remunerated, undertaking regular professional development and appropriately deployed then the service they deliver may, as a result be less cohesive and less effective. This means that a valuable and vital potential source of important primary health care is wasted. There is no evidence that young people in higher decile schools have less need for health care and no rationale for neglecting the school nursing service as a national strategy for delivering preventative health care at a critical point in life.

If school pupils are exposed to an under resourced and undervalued school nursing workforce this may directly reduce their likelihood of selecting nursing as a career. As other school teaching and guidance staff see that school nursing is just a support worker position they are unlikely to recommend nursing to appropriate students as a career opportunity. Given the predicted nursing shortage beginning to bite in 2017 this is problematic.

The school nursing service is unlikely to be sustained on this basis. Whilst a large number of dedicated and largely mature woman

continue to serve school populations, regardless of such unfair conditions, this will not last. It is highly unlikely that new graduates will seek out such anomalous employment.

Finally and perhaps most importantly of all the drive in health service delivery currently is towards integration and seamlessness of services.

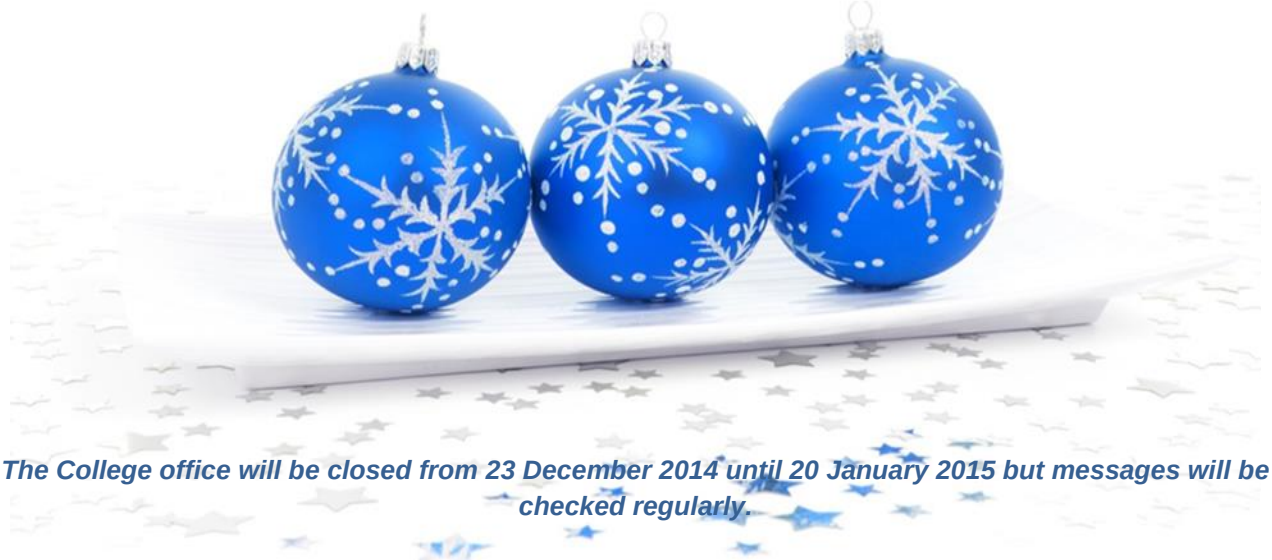
Where school nurses continue to work in isolation from the health sector they are not only professionally isolated but opportunities for an integrated primary health care service are lost. District Health Boards need to address their population health objective and ensure that school nurses are deployed as a key component of the regions' primary health care service as a matter of course. Young people deserve no less.

Denny, S., Robinson, E., Lawler, C., Bagshaw, S., Farrant, B., Bell, F., Dawson, D., Nicholson, D., Hart, M., Fleming, T., Ameratunga, S., Clark, T., Kekus, M. & Utter, J. (2012). Association between availability and quality of health services in schools and reproductive health outcomes among students: a multilevel observational study. American Journal of Public Health, 102, e14-e29.

Youth 2000 Survey series 'The Health and Wellbeing of New Zealand Secondary School Students in 2012' Health Services in NZ Secondary Schools and the Associated Health Outcomes for Students

With acknowledgement and thanks to Karen Howe (School Nurse)

The College Board and Staff
wish all College members
a very happy and safe
Christmas and New Year!



The College office will be closed from 23 December 2014 until 20 January 2015 but messages will be checked regularly.

Changes under the Misuse of Drugs Amendment Regulations 2014

Article by: Dr Jill Wilkinson, RN PhD

Changes to the regulations concerning the prescription of controlled drugs were made in July of this year under the Misuse of Drugs Amendment Regulations 2014. Under these regulations nurse practitioners (NPs), who are now in the *'authorised'* class of prescribers, may prescribe Class A, B or C controlled drug that is within their area of practice. Importantly, the maximum period of supply now aligns with medical practitioners and is one month for Class A and B drugs, and three months for Class C. The requirement to prescribe only in cases of emergency no longer applies.

Another change to the Misuse of Drugs Regulations in July allows for controlled drug prescriptions to be generated electronically and printed out rather than handwritten on the triplicate controlled drugs form (H572). Prescribers will still need to sign the prescription. The change is part of the New Zealand electronic Prescription System (NZePS) which is expected to be rolled out by the end of 2014.[1] While the system is still under development, handwritten controlled drug prescriptions will continue to be used.

A close look at the Schedules contained in the Misuse of Drugs Act 1975 and the instruction at regulation 22 in the Misuse of Drugs Regulations 1977, shows that Ministerial approval is required to prescribe Class A, B1 and B2 (excluding morphine), and Class C1 controlled drugs. These drugs are shaded grey in Table 1. In the normal course of events these drugs have limited therapeutic value, but have high value for illicit use. Indeed the Schedules are ranked (or classified) according to risk of harm (but commonly seen as street-value desirability), including the potential harm (high value) of precursor substances. The approval process is in place as a means to manage inappropriate prescribing and drug seeking activity, yet still provide a mechanism for access where there is reason to expect a patient will experience therapeutic gain.

Although Ministerial approval is needed for anyone to prescribe Class B1 and B2 drugs, delegated approval in fact allows vocationally registered ('Specialist') doctors in paediatrics, psychiatry, internal medicine and palliative medicine to prescribe dexamphetamine and methylphenidate.[2] Prescriptions written by other doctors for these drugs must be done on the written recommendation of the Specialist. There are restrictions too on the prescription of ephedrine and pseudoephedrine which can only be written by a medical practitioner. At this time NPs are therefore unable to prescribe dexamphetamine, methylphenidate, ephedrine and pseudoephedrine. However, an application to the Ministry for a similar type of approval as doctors could be made by NPs whose practice is affected by these restrictions.

In real terms, the Misuse of Drugs Amendment Regulations 2014 enable NPs to prescribe from a list of controlled drugs that is

[1] National Health IT Board. (2014). NZ ePrescription service. Retrieved from http://ithealthboard.health.nz/our-programmes/medicines/nz-eprescription-service

[2] Medsafe. (2014). Restrictions on the supply, prescribing or administration of medicines under the Medicines Act 1981 and Misuse of Drugs Regulations 1977. Retrieved from http://www.medsafe.govt.nz/profs/riss/restrict.asp

more or less the same as the designated prescriber Schedule (1A of the Misuse of Drugs Regulations 1977); ketamine and phentermine are the main additions. The increase in maximum period of supply is the more significant change for NPs, particularly those whose area of practice is pain or palliative care.

The layers of complexity surrounding the regulation of medicines in New Zealand make understanding what prescribers are able or unable to do difficult. On the one hand the legislation appears to award prescribing privileges, and on the other, it seems those privileges are withdrawn. While restrictions can be a barrier to access, they also act as a safeguard for a practitioner from those seeking drugs. As always, NPs need to remain alert for drug seeking behaviour and have strategies in place to manage those who present.

Table 1: Schedule 1, 2 & 3 Controlled drugs with the requirement for Ministerial approval to prescribe highlighted

Schedule	Class		Controlled drug #	Period of supply
1	Class A*		Cocaine Heroine Methamphetamine	One month maximum
2	Class B*	**Part 1***	Amphetamine Cannabis (resin or oil) Opium MDMA (Ecstasy) GHB (Fantasy)	One month maximum
			Morphine	
		Part 2*	Ephedrine Pseudoephedrine Methylphenidate	
		Part 3	Alfentanil Remifentanil Fentanyl Hydrocodone Methadone Oxycodone Pethidine	
3	Class C	**Part 1***	Cannabis (plant, fruit or seed) BZP	Three months maximum
		Part 2	Codeine Dihydrocodeine Propoxyphene	
		Part 3	Pholcodine	
		Part 4	Amobarbital Buprenorphine Ketamine	
		Part 5	Benzodiazepines Phenobarbital Phentermine Triazolam	

*Ministerial approval is required to prescribe Class A, Class B1 &B2 (excluding morphine) and class C1 controlled drugs

Note that not all the substances listed in the Schedules of the Misuse of Drugs Act 1975 are listed in this table

Pleasant Point Practice - Now Under Nurse Ownership

Article Provided by Tania Kemp NP

Tania Kemp NP & Chris Chamberlain, Practice Nurse

Background:

Pleasant Point: situated 20 minutes inland from Timaru on State Highway 4. The local population of the immediate town is about 1278 (Stats NZ, 2012)

The Pleasant Point Practice was bought by GP Dr Anton van den Bergh (Dr A) who wanted to ensure that the practice stayed open for the local semi-rural community in May 2013. Already owning a busy urban practice Dr A required someone to run the small practice of about 1000 registered patients. As a newly qualified NP I was in a situation where my future work prospects were "up in the air" and I was open to exploring new work opportunities.

My vision was to work in a General Practice that was rural to semi-rural with a supportive team that would allow me the opportunity to practice autonomously in a safe environment. I wanted to work WITH a GP (not for) who knew what the role of a NP was or at least was open to see what the role offered to the patient community. I wanted to be able to learn and exercise my knowledge and skills that I had spent the previous six years developing and fine tuning.

The model of care:

In August 2013 Dr A offered me the job working in a small semi-rural practice with Practice Nurse Chris (an esteemed colleague I had known for 5 years) and a receptionist. This role would include access to the GP (Dr A) off site but available any time by phone. He would provide a clinic half a day a week and we would have a weekly clinical case review meeting. This was both appealing and terrifying, because I would primarily be responsible for the overall patient care. Knowing PN Chris was a huge draw card as I knew she had an amazing range of skills and we would work well together and have a bit of fun! I agreed to work three days a week initially to see how this felt and if it was possible to run the clinic in this way. After six weeks I gave up the other locum job and started working full time at the Practice. The clinics were busy enough but not hectic initially. I contacted Dr A in his urban practice

as needed throughout the day or would ask him to phone in as he was able, to discuss patients. He would call in to the practice on his way home as was necessary to sign scripts etc that I was unable to sign. (eg: controlled drugs, methylphenidate and champix)

Dr A and I met once a week for 1-2 hours to do case reviews. We would discuss patients that were complex, and decide on certain investigations, treatments, how I was going to manage them or refer to secondary care or other providers. Patients with complex cases that I had worked up and then needed further input on would be booked in with Dr A on his weekly half day session at the practice, or he would see them on the day in town if this was warranted. This enabled the patient access to more expert opinion in a timely manner. I would discuss these patients with Dr A prior to them being seen. I would then review the notes to see what had been decided for the patient or follow up myself as required.

There were appointments available on a weekly basis for patients to book if they specifically wanted to see the Dr rather than myself as NP. This was interesting as for some months these appointments were booked up until the patients got to see me and became familiar with what I could or couldn't do and then they were happy to see me. Over time this changed and my appointments became fully booked and the Dr's less, apart from those that I requested be seen by Dr A. I do a half day clinic at Dr A's practice which allows his patients' access to a female practitioner. This is an urban practice and operates differently from the semi-rural practice. Services are more accessible which makes a difference to patient care (eg: access to laboratory services, radiology services and other primary care services).

I spent some time in the first few months defining and putting some boundaries around my role. For example there were presentations I felt completely comfortable with and then those that I took a lot of time to work up and work out and then there were those that were very complicated and outside of my comfort zone. I worked out a process where at any point that I felt the presentation was outside of my level of knowledge, I had to decide if the patient was safe waiting to see the GP or if I needed to send them through to the Dr A's urban practice for an opinion immediately. I would phone and discuss the case with Dr A and he would decide if he felt there was benefit in him seeing the patient or in fact if they needed to be seen in the emergency department (ED) instead.

The theory I worked on was based on the fact that the simple acute cases and the stable chronic presentations are the vast majority of the patients I would see. Then, there are the acute-on-chronic and urgent presentations that are more complex and potentially require Dr collaboration. Because the practice is situated only twenty minutes from the base hospital it does not fit the criteria for 'rural' but it does mean we are closely affiliated with the rural community. This means when there is a patient with an acute problem they often present to us first as the closest point of care. For this reason we see a number of acute cases that are not registered patients. It also means we have had a number of serious acute presentations including seriously ill children. This requires an ability to manage the acutely sick patient in the clinic whilst waiting for ambulance services to arrive. This can take up to an hour if they are busy. Being PRIME trained has proved to be of significant value.

The practice role has continued to increase and the feedback from patients is positive. Those who don't feel comfortable with the service will transfer to other GPs. The general feedback from secondary care services has changed over the course of a year

significantly. As a NP I referred patients to secondary care specialists and some wrote back to me but the majority wrote back to Dr A as the patients "GP" even though I had sent the referral. The Practice owner was a GP and I worked for him - the patients were registered with him and so this was fairly standard. Now the vast majority of them address their correspondence to me. This is a good indication that they actually see me as the primary provider of care and not "Dr A's Nurse. "

Our NP peer review group have had education sessions with different specialists, allowing the opportunity to ask questions about particular conditions, investigations and treatment options and it also allowed them to ask questions of how we worked. This proved to be immensely helpful in promoting positive collaboration.

The decision to buy:

One day after about 10 months of working in this way Chris (PN), suggested that we try and buy the business as we had in effect been 'running' it for the past year. Initially I felt this was too big a responsibility and sounded a bit daunting to say the least, however it did appeal to me enough that I discussed it with my husband and continued to explore the idea with my colleague. Not knowing how to approach this idea with Dr A; we decided to let the idea go and bide our time until the opportunity arose to ask the question. Then two months after our discussion Dr A asked me if I wanted to buy into the business and when I declined he then asked if I wanted to buy it outright, to which I immediately said yes. (...and immediately rang Chris) From there on the discussions continued and we planned a model that would work. This was not difficult; we needed to continue as we had been for the past year successfully – BUT with the ownership changing from the GP to the nurses!

We spoke to a practice manager and asked for help to buy the practice and set up the contracts with the DHB and other contract providers. We spoke to our colleagues and again I had the sound input from an NP colleague and another Practice Nurse who is a practice owner with a GP. The feedback from these people was positive and supportive. The DHB's Primary and Community Services division were also very supportive of the concept. They outlined what would need to be provided in order to meet the DHB/MoH contractual obligations. This included access to medical services and a commitment to the local After-Hours (AH) roster. Both of these criteria could be met through Dr A continuing to provide medical care on a weekly basis and I needed to put a submission to the AH committee requesting that I be able to join the roster to provide the Pleasant Point Practice share of the after-hours cover. (This was declined and we have had to get GP cover as the AH committee decided against having a NP on the AH roster)

NURSE Ownership:

On 1st October Chris and I (and our husbands) took over the Pleasant Point Practice and the 1500 patients are now registered with me as a NP. We have had enormous support from the community and continue to operate as we have for the past year.

We have had student nurses attached to the practice, and we have had two registered nurses from secondary care come and sit in with us, in their free time, to see how the clinic works and what General Practice – Primary Health Care can look like with a different model of care.

A physio continues to use a room half a day a week, and we have a range of health care providers such as smoking cessation, Brief Intervention Service counsellors who use the

rooms as needed. Med-lab takes bloods two mornings a week. As there is no local pharmacy, prescriptions can be taken by patients or faxed to two pharmacies and one delivers to the practice while the other has their depot at the local dairy.

Our plan is to be a multi-purpose centre where our patients can access a range of services along-side general practice. Our vision is to provide expert care that is non-judgemental and is holistic in its approach to total well-being.

Personal statement:

I am a 6th generation Pitt Islander (Chatham Islands). My whakapapa is *Te Atiawa*, *Ngā Mahanga O Tairi*.

I am a South Island Rep on the NZ Rural General Practice Network board. I am on the Major Trauma National Clinical Network and the Canterbury -West Coast ECCT board (Emergency Care Communications Team)

Departing College Board Members

A very big *"Thank You"* to our two departing Board Members

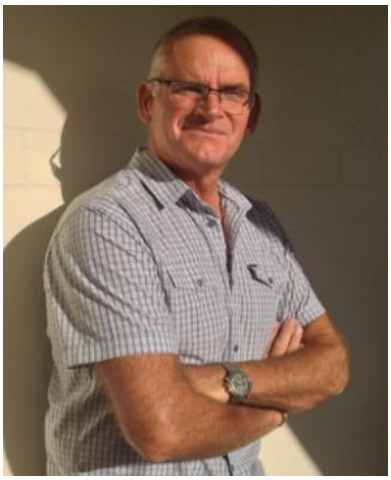
Judy Yarwood has been a College of Nurses Board Member since December 2006 and was appointed Co Chair in 2010. We thank Judy for her time, significant contribution, commitment and valuable leadership she has given to the College Board and College Membership. In recognition of Judy's significant service to the College, Judy has been awarded Life Membership with the College of Nurses. Congratulations Judy and we look forward to your continued support and contribution.

Nicola Russell has been a College of Nurses Board Member since December 2011. We thank Nicola for her time and contributions given as a College Board member. We wish you well with your PhD and also look forward to your continued support and contribution to the College.

Welcome To New College Board Members

The College of Nurses is pleased to welcome two new Board Members

Dr Mark Jones and Liz Manning



Dr Mark Jones, FCNA(NZ), FACN

Mark Jones is CEO of Iosis Family Support, a not for profit agency based in South Auckland providing a range of services to parents in vulnerable situations, including social work, counselling, foster care, social workers in schools, and a range of additional support programmes such as parent support, men's development, a family learning centre and a young father's programme. Iosis also runs a therapeutic residential community for mothers who have experienced violence and addiction, seeking to build their resilience and parenting skills in a safe environment.

Previously Mark was Director of the Global Health Alliance, Western Australian Department of Health and Professor for Transcultural Health Improvement at Curtin University, Perth. In these positions Mark led an educational and research programme aimed at improving maternal and child health in East Africa.

Before moving to work with the Western Australian Government, Dr Jones served as Chief Nurse for New Zealand based within the Ministry of Health. Mark was recruited to this position largely as a result of his background and experience in primary health care organisations in the UK; as Director and CEO of the Community Practitioners and Health Visitors Association and senior policy adviser with the Royal College of Nursing.

Mark has a Bachelor of Nursing (Hons) degree and Higher Diploma in Health Visiting from the University of the South Bank, London, and Masters and Doctoral degrees from the University of Bristol. He is currently studying for a Graduate Diploma in Theology with Laidlaw College, Auckland.

Mark is a Fellow of the College of Nurses Aotearoa and as a Board member has a specific interest in primary health care policy and furthering the nursing role in this field of practice. Mark is also a Fellow of the Australian College of Nursing.

Outside of health and social care, although underpinning that also, Mark is a committed Christian and member of C3 church North Shore. Instructing new and experienced motorcycle riders and flying light aircraft also provides some interesting diversions in a pretty busy but exciting life!

Liz Manning, RN, BN, PG Cert (Leadership in Health Practice), MPhil (Nursing)

I have been a registered nurse for 27 years and have worked in England, Saudi Arabia and New Zealand.

My clinical background is cardiac and medical nursing. More recently I held designated senior nursing positions at Waitemata DHB including; Clinical Nurse Educator and Associate Director of Nursing. I worked for 4 years at District Health Boards New Zealand as a Future Workforce project manager, coordinating national nursing workforce projects, including the Nurse Practitioner Facilitation programme.

I set up my own business, Kynance Consulting Ltd in 2011, where I work as a Health Workforce and Professional Development Consultant. I have undertaken a number of national nursing projects working with; DHB Shared Services, Nga Manukura o Āpōpō, Nurse Executives NZ and the Nursing Council of New Zealand.

My areas of expertise and experience include: nursing leadership, project management, professional development, ePortfolio, nursing regulation, work/role transition, portfolio auditing, networking and collaboration.

Moving House or Changing Job

Please remember to update your contact details with the College office.

Email: admin@nurse.org.nz

NZ Population Health Congress October 2014

Report by Jo Peterson NP

I was fortunate to receive a scholarship from the College of Nurses to attend and present at the first New Zealand Population Health Congress.

The congress is collaboration between the New Zealand College of Public Health Medicine (NZCPHM), the Public Health Association of New Zealand (PHANZ), and the Health Promotion Forum of New Zealand (HPF). While each Partner Organisation has its own purpose and membership, they share many values and practices, as well as a commitment to improving public health in Aotearoa. This collaboration created the potential to engage with more challenging and influential speakers, greater diversity of participants in greater numbers, and a programme that exposed participants to new ideas, research and experience in the varied fields of population health. It was the largest gathering of population health practitioners and researchers New Zealand has seen, with more than 600 delegates attending the congress over 3 days at the Aotea Centre. The theme of this event was, 'Connecting Communities, Policy and Science'.

As a Nurse Practitioner for Children and Young People, working in the community in this role and in many others in the community I am often bogged down easily in the case by case frustrations and challenges of constantly dealing with public health issues such as obesity, poor dental hygiene, rheumatic fever, chronic skin and respiratory illness, poor housing and poverty related disease. This conference allowed me to take a more helicopter over view of how policy and science were being fused together by some great minds in New Zealand and abroad and to take heart that change was on the agenda.

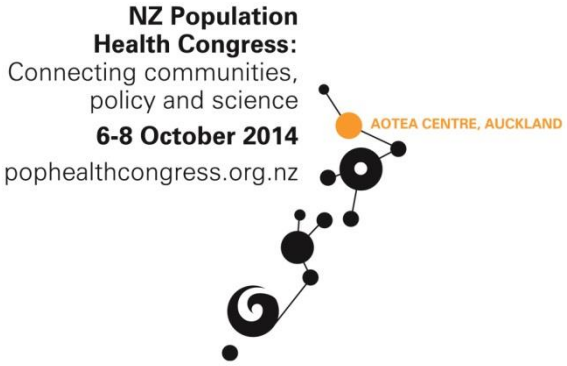
The passion and kaupapa of improving public health outcomes for all New Zealanders especially Tangata Whenua and vulnerable communities was evident in all of the speakers. It was encouraging to be able to hear of the other initiatives that are occurring in communities all over the country.

I particularly enjoyed the sessions on tackling child obesity, one debate in particular that had representatives from McDonalds, advertising NZ, a number of population health specialists and the chef Nadia Lim. They debated whose responsibility it was to address the issues and ways to move forwards. The ethicist in the group reminded us that to address child obesity we may need to see adult liberties such as free choice being limited as it is often the adults making the choices for the children. Each participant while having their own agenda shared a common understanding that

while the issues were complex they required a sustained collaborative community commitment.

I was selected to present the findings of a two year retrospective audit of the service I lead called Toi Tu Kids. We are a collaboration between local Hauora Te Hononga o Tamaki me Hoturoa and Starship General Paediatrics. This model demonstrates partnership with the Nurse Practitioner, Starship Paediatricians and Whānau Support Worker. The service targets Maori, Pacific and high needs families who may be struggling with attending appointments, managing a child's health or behavioural condition, navigating the health system and requiring other social supports. The audit revealed that many of the Maori and Pacific children we worked with had high numbers of avoidable hospitalisations and also many did not attend (DNA) booked appointments, some up to 10 per child. After being involved with our service only 4 of the 111 did not attend a booked appointment and only 5 were seen again in the emergency department for a related illness. The reasons for these successes were noted to be the Whanau Ora approach the service takes, ensuring a broad view of the family's health and other needs is taken. The preventative and timely treatment approach as well as having strong links with primary and secondary care providers, has also led to its success.

Lastly at the end of the congress the partner organisations were able to agree on a declaration or statement of commitment in moving forwards. In summary this declaration commits to actively grow and develop our population health workforce, pursuing excellence in all aspects of their work. Develop and maintain relationships with stakeholders across sectors, with communities and fellow citizens, working to understand our common challenges and to identify and implement solutions. Create a robust evidence base for population health so that health status and health threats are made visible along with valid evidence about the effectiveness of policies and programmes; Promote and lead healthy public policies and programmes. Confront social, political and economic forces that lead to: inequities and breaching of human rights, particularly in indigenous communities; and increasing environmental degradation. Also to work to make healthy choices the easy choices wherever people live, work, worship, learn, travel or play. I applaud them for this commitment and look forward to the improved public health outcomes that will occur when we all work together.



Report by Dr Grace Wong FCNA

The Congress was jointly run by three organisations, the Public Health Association of NZ, the Health Promotion Forum and the NZ College of Public Health Medicine. It attracted a wide range of like-minded people who work to reduce inequities to improve the health of communities and populations. Over 800 people attended. One delegate said it was "like coming home".

There was an exciting buzz throughout and so many sessions to choose from I could happily have stayed twice as long. Delegates were asked to give every speaker a "standing ovation" so there was a lot of bobbing up and down. This counteracted the adverse effects of sitting down for long periods, and eating too much of the wholly vegetarian food. We were seated for our daily mindfulness session with the Mental Health Foundation.

I will report on three sessions that I found especially interesting. The first was called **"Hypothetical".** It was a chaired panel discussion about the following proposition:

The most effective and sustainable way to ultimately end childhood obesity, is to change our obesity-promoting environment so that children can make healthier choices.

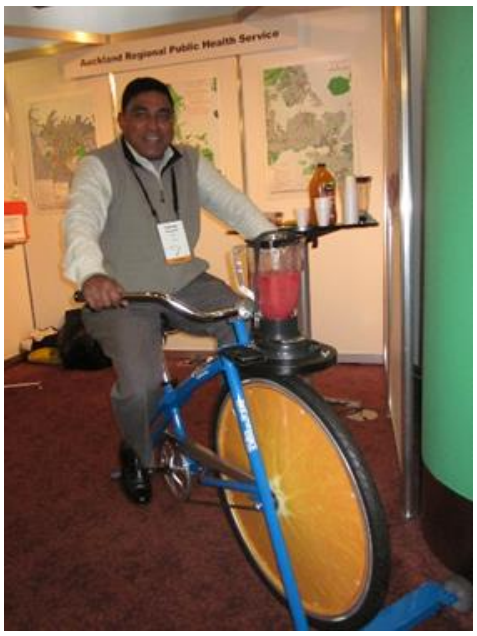
Panel members included Patrick Wilson (Managing Director of McDonalds), Martin Wilkinson (ethicist), Nadia Lim ("food celebrity" and nutritionist), Lindsay Mouat (NZ Association of Advertising), Robyn Toomath (diabetologist and founder of FOE), Nick Wilson (tax/pricing expert), Colin Tukuitonga and Boyd Swinburne.

There was a lively debate ranging through policy, cooking from scratch, the injustice of singling out McDonalds vs other fast food outlets (!), reformulation of foods to be both "healthier" and responsive to consumer demand and sales, and whose responsibility the issue of childhood obesity is (parents? children? government?).

The second session was called **"Good government and public health".** Michael Moore, CEO of the Public Health Association of Australia talked about individual freedom and responsibility and concept of the **"nanny state".** Michael neatly turned the concept on its head by showing how big corporations function as nannies themselves (for example, "Nanny Big Tobacco"), using the very techniques they protest about.

Finally I will touch on a plenary called **"Climate Change in the Afterlife"**. In this, Kirk R. Smith employed a gamut of philosophical, scientific and other erudite sources to argue that the future does matter to us and to humankind generally. A life without a future, without children, where life as we know it no longer exists, makes our lives meaningless. And yet economic approaches to issues such as climate change discount the future in favour of short term gain. He provided global warning projections under different conditions to support his argument.

Grateful thanks to the College of Nurses for sponsoring my attendance at the NZ Population Health Congress held in Auckland from Oct 6-8, 2014.



A Congress stand showing how to simultaneously make a smoothie and burn the calories you will gain by drinking it. The smoothie was delicious.

Health Quality & Safety Commission 2013/14 Serious Adverse Events Report

The work and resources the health sector has put into getting better at reporting incidents of patient harm are reflected in the Health Quality & Safety Commission's latest annual report into serious adverse events (SAEs).

Commission Chair Professor Alan Merry says the improved reporting is encouraging: 'Patients who are harmed during health care have a right to understand what happened and to expect that everything possible will be done to prevent the same thing from happening to someone else in the future.'

The 2013/14 report shows a four percent increase in events reported by district health boards (DHBs), with 454 SAEs, up from 437 in 2012/13.

The rise is a consequence of steadily improving reporting systems and DHBs' commitment to learning from events, the Commission believes.

There is also a growing range of non-DHB providers reporting their SAEs, with 104 from private surgical hospitals, aged residential care facilities, disability services, the National Screening Unit and hospices.

Falls were the most frequent cause of harm reported by DHBs, making up 55 percent of all cases. Clinical management incidents were next, with 158 cases, including delays in treatment, assessment, diagnosis and observation. Thirty cases involved medication prescribing, dispensing or administration.

Prof Merry says the high number of broken hips following falls in hospital is of continuing concern.

"Ninety-eight people suffered a broken hip in hospital. This rate of harm is far too high, and equates to almost two patients every week suffering such an injury. This is very disappointing given the considerable effort going into reducing harm from falls, and shows this must continue to be an area of high priority for the Commission and the sector."

The Commission will be working with the sector over the next year to increase expertise in learning from adverse events, including providing training in the review of events, and to strengthen the network of experienced reviewers able to offer advice when an event occurs.

One opportunity for health professionals to increase their review skills will be next week's inaugural national Patient Safety Week, during which there will be four workshops led by world-renowned patient safety expert Dr James Bagian.

For the full 2013/14 SAE report, summary report and FAQs, visit http://www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/1832/

Progress Among Women Towards The Smokefree 2025 Goal

Reprinted with the kind permission of the Auckland Women's Health Council Newsletter

Two years ago I reported on New Zealand's smokefree status and progress towards reaching our Smokefree 2025 goal i.e. less than 5% of the population smoking. At that time around 21% of women were current smokers. That figure has now dropped to 16.4%.

However, smoking rates are still much higher for Māori women (41.8%), and somewhat higher for Pacific women (22.6%) than for NZ European/Other (14.3%) and Asian women (3%). Māori women are 2.9 times more likely to smoke than non-Māori women. In 2011 9% of NZ European women smoked during pregnancy compared to 37% of Māori women and 34.2% of under 20 year old pregnant women. Usually women who smoke during pregnancy have a partner who smokes and/or they come from a low socioeconomic area.

Rates for teenage girls (14-15 years) dropped from 17.1% in 1999 to 3.5% in 2013 but 18.4% of girls in low decile schools are regular smokers.

So the good news is Asian women and teenage girls are already largely smokefree and NZ European/Other women are probably on track to almost reach the 2025 smokefree goal. Smoking prevalence rates are on a general steady decline on the way to the planned 10% at around 2017 and under 5% by 2025, but the bad news is it is unrealistic to believe that Māori and Pacific people, Māori pregnant women and mental health consumers will achieve the goal. So what will the new government do to get us ***all*** there?

The problem with the Smokefree 2025 goal is it is aspirational and there is no government plan to achieve it. There has been no government tobacco control strategy in New Zealand since 2009. So how do we get there without a plan?

What is helping us on our way?

In July 2012 the display of cigarettes was banned with none of the very strange anticipated problems by the tobacco industry such as impeding competition, imposing significant costs and other burdens on retailers, encouraging price competition and fostering illicit trade. Banning the display of cigarettes was introduced to contribute to reducing the uptake of smoking among young people and to provide a more supportive environment for smokers to quit smoking. There is no reason to believe this has not happened.

The Government health target 'Better help for smokers to quit' now requires 95% of hospitalised smokers and 90% of smokers who are seen by a health practitioner in primary care to be given advice and help to quit. Most of the DHBs are achieving this target but the primary sector is lagging in its efforts. As with the banned display of tobacco products, these targets provide a supportive environment for smokers to quit smoking.

The Smoke-free Environments (Tobacco Plain Packaging) Amendment Bill passed its first

reading by 118 votes to one. The Bill is being considered by the Health Select Committee. It was our great hope that the report on plain packs would be tabled in Parliament before the final sitting pre-election. However, this was not to be and even if it was, the Government is currently not prepared to follow Australia's gutsy lead implementing plain packaging. Instead it is waiting until all challenges to the Australian Government have been overcome. This could take 20 years.

In Australia, there was a 78% increase in the number of calls to the Quitline associated with the introduction of plain packaging and it now has the lowest smoking rate in the world at 12%, with the highest rate of decline happening since plain packaging was introduced in 2010. Plain packaging is apparently a priority for the Government, but one that they are giving more lip service to than any real commitment. Meanwhile other countries such as Ireland, the UK, the Netherlands, and most recently France are committing to plain packaging and leaving New Zealand in their wake.

The price of cigarettes has increased 10% in January every year since 2008 and the final increase is planned for 2016. There have also been small inflationary price increases annually as tobacco is included in the Consumer Price Index. These price increases are helping to drive more smokers to try and quit but are not high enough to make a significant difference. In 2012 the tobacco control sector recommended a 40% tax increase for 2013 followed by 20% increases for the next 3 years. Unfortunately Government chose to ignore this recommendation.

The Health Research Council and the Ministry of Health have funded research through the University of Auckland to halve the prevalence rate of smoking by 2020. This has resulted in investigations into nicotine e-cigarettes, very low nicotine cigarettes, WERO a team based stop smoking competition targeting Māori and Pacific smokers, and other innovative studies to inform rapid smoking prevalence reduction. The research funding comes to an end in 2016.

In the 2012 Budget the Government allocated $5 million per annum to establish the Pathway to Smokefree New Zealand 2025 Innovation Fund to support innovative approaches to reduce smoking prevalence among Māori, Pacific people, pregnant women and young people. The fund has subsequently provided funding for evidence-based programmes such as WERO, Stoptober, a Quit Bus in South Auckland, incentives for pregnant women.

Tobacco representation in Parliament

With only 11 years until 2025, the Government needs to get serious about achieving its smokefree goal. The biggest worry with the new Government is it has lost two very strong tobacco control advocates and gained, for the first time in the history of New Zealand politics, not one but two ex-Philip Morris Corporate Affairs Managers, Chris Bishop and Todd Barclay. Both these MPs lobbied against plain packaging on behalf of Philip Morris and Chris Bishop against taxation increases. .As the *Dominion Post* reported 'One tobacco lobbyist in the National caucus might be an accident. Two begins to make National look like a party whose anti-tobacco stance is hollow and hypocritical.'

Trish Fraser

Global Public Health

APAC 2014 - Asia Pacific Forum, Leading Healthcare Transformation

Report by Julia Ebbett RGON BN MPHC FCNA

Without a doubt, this would have to be one of the most valuable conference experiences I have ever attended. All credit must go to Ko Awatea and Counties Manukau DHB for their huge effort. I also acknowledge partial funders for my attendance: HBDHB Nursing Award, HHB PHO and Te Taiwhenua o Heretaunga.

With 1500 delegates from 14 countries, there were surely some solutions to be found from among the conference line-up, given the burgeoning complexity we experience globally in health every day.

To do sufficient justice to the very wide and varied conference proceedings I have prepared a full paper, available on request from HHB PHO, with related links, vignettes and articles gathered during the three days.

However, I will mention here two of the most inspiring speakers.

Dr Dafydd Rhys "Dave" Williams, President and CEO, Southlake Health Centre, Canada. A physician and retired Canadian Space Agency Astronaut. He was also a former mission specialist on two space shuttle missions. Well, I don't know about you all, but this resonated well from my desk. At times we navigate our roles in health care. From time to time it feels enormous, as though indeed we might be designing and scoping a mission to outer space. Sometimes we get there, sometimes we are there but can't navigate the way out of the dark, and sometimes we simply don't have the navigational aids to get us off the ground. Either way, we seek to keep safe and whole and do the right thing or what is right. I jest. The most impressive take-home message was the importance of team purpose and attitude. Importantly to Dave, when on a mission, it is those critical conversations that MUST be had to ensure Mission Success.

The second impressive speaker was Dr Doug Eby, Vice President of Medical Services, Southcentral Foundation, Alaska, USA. Doug has played a key role in the development of an innovative primary care system for Alaskan indigenous populations. This system redesign achieved a 50% reduction in Emergency Room attendances. Key messages included:

- Replace blaming with understanding;
- Control does not equal compliance;
- Give the customer options, not orders;
- Make it simple;
- What processes can you put in place to innovate using customer feedback?
- How does story affect whole-system transformation?
- Provider as the supporter supplying resources.

Themes that threaded across all speakers have been already eloquently summarised (taken from Geraint Martin, CEO CMDHB blog, accessed on 16th September 2014 and modified):

- "We must scale up the focus on improvement. There is already great work taking place across our region, but we can't afford to be complacent. If we know something works, we must ensure it is scaled up as quickly as possible;

- We must be transformational leaders. This message is for everyone. We know the increasing pressures and challenges on our health systems, and we need to bring about the transformation in our services that's needed;

- We must make the frontline our focus. Frontline staff need to be supported and enabled to deliver the best services possible. We also need great managers who support our staff to do this.

- We must continue to work together. Work to support one another as we support our communities."

Maureen Bisognano, CEO Institute of Health Care Improvement provided many take-home messages. She spoke of "joy" in our workforce and addressed five priorities of leadership:

1) Start with the young (they are easier to change);

2) Build learning plans and personal asset maps with staff. The four Es: What do you want to explore? What do you want to experience? What exposure will be helpful? What education do you need? The Manager guides, and the organisation enables;

3) Teach clinicians how to see and hear. Demonstrate the burden of disease as well as plan for treatment. For example, NY Times website – patient voices; IHI patient experience tool;

4) Foster multi-professional teams. Morning huddles -- what might go wrong today? Collaborate about care from entry to exit; map of care with patient in the centre;

5) Nurture the culture;

Finally, to quote Dr Dafydd Rhys, we are all "difference makers" as we contribute to our many varied roles. Good luck out there as we plan and execute successful missions!

To download presentations:

http://apacforum.com/download-the-presentations/

Preventing Overdiagnosis

Reprinted with the kind permission of the Auckland Women's Health Council Newsletter

In September 2014 Oxford University hosted the second international conference on Preventing Over-diagnosis. The conference was attended by a number of New Zealanders, including three women from three women's health consumer groups, and two health professionals who gave presentations. Ben Hudson's cautionary tale was about screening for prostate cancer in New Zealand, and Erik Monasterio discussed the behaviour of the pharmaceutical industry in relation to the TPPA (Trans Pacific Partnership Agreement).

Crossing the border

The conference began with a keynote speech by Iona Heath, former president of the UK Royal College of GPs which set the scene for the following three days. Her presentation focused on overdiagnosis and the individual patient. The abstract for her talk states: "Susan Sontag's kingdom of the well is being absorbed into the kingdom of the sick, and clinicians and health services are busy ushering people across this important border in ever increasing numbers. The costs, personal, social and economic, are enormous. Working face to face with individual patients, what can clinicians do to stem the tide? Many feel helpless in the face of the increasing stampede but patients need clinicians courageous enough to reassert the border between the well and the sick so that people only make the journey across when medical care is appropriate and will produce more benefit than harm."

As with last year's Preventing Overdiagnosis at the Dartmouth Institute in Hanover, USA, one of the major issues to come under the spotlight at this year's conference were the harms caused by screening programmes. Breast cancer, prostate cancer and colorectal cancer screening programmes were the subject of many of the presentations.

Cancer screening

One of the many excellent workshops on offer at the conference focused on the need for a rational approach to cancer screening. "Cancer screening generates substantial overdiagnosis and overtreatment. The benefits of cancer screening are less than people believe, while its harms are greater than people think. Drivers of excessive cancer screening include consumer advocates, payers (who use cancer screening rates as quality metrics), and professional special interests, including clinicians and researchers. Promotion of screening is often based on the mistaken concept – and conventional wisdom – that early diagnosis is always beneficial," said Ronald Adler from the University of Massachusetts Medical School. His workshop demonstrated innovative communication strategies and techniques for re-educating and empowering clinicians and patients to engage in rational approaches to cancer screening that will reduce overdiagnosis.

Pre-diabetes

Another health issue of international concern is the overdiagnosis of diabetes and the

epidemic of pre-diabetes. John Yudkin, Emeritus Professor of Medicine at University College, London, and author of "*Pure, White and Deadly*," gave a keynote address at the beginning of the second day of the conference. He described attempts to tackle the increasing prevalence of diabetes which have focused on identifying and treating people with marginally elevated measures of glycaemia. "The definition of intermediate hyperglycaemia has expanded from impaired glucose tolerance to include people with raised fasting glucose or glycated haemoglobin (HbA1c) concentrations, and cut-off points have been lowered. While people in all the above categories have a raised diabetes risk, prediction is poorer for fasting glucose and HbA1c than for impaired glucose tolerance. Moreover the expanded categories dramatically increase the prevalence of intermediate hyperglycaemia by twofold to threefold, with over half of all Chinese adults so defined.

There is no evidence that treatment of people in these newly-defined categories with lifestyle advice or with drugs, will improve mortality and morbidity. A label of "pre-diabetes" as recommended by the American Diabetes Association brings problems with self-image, insurance, healthcare costs, and drug side effects. Diabetes prevention requires changes to societies and a concerted global public health approach. Diagnoses and thresholds for clinical application may unrealistically burden societies in exchange for limited value."

Anti-depressants

Overdiagnosis in mental health was also the subject of a number of work-shops and presentations at the conference. A workshop on the medicalisation of sadness in old age by Stefan Hjorleifsson described how among 40,000 patient living in nursing homes in Norway, around 15,000 were taking anti-depressants.

Gisle Roksund's workshop focused on the increase in psychiatric diagnoses in children and young adults in Norway which often serves to subsequently exclude them from contributing to society and sustaining themselves through work.

Dangerous caring

Dee Mangin's workshop on dangerous caring dealt with how the medicalization, overdiagnosis and overtreatment with multiple drugs can steal away healthy old age with the drugs frequently causing more death and illness than the diseases they're supposed to treat. On average the number of medications older people are on is seven. More people die from adverse drug reactions than from breast, lung and colon cancer combined.

There are a number of drivers behind this horrific statistic and they include the therapeutic imperative to do something, the distortion of evidence-based research, polypharmacy, and the problems surrounding complex co-morbidities and multiple medications. Many of the drugs involved in poly-pharmacy are for prevention and not cure, and there is now good evidence for discontinuing diuretic drugs and cholesterol drugs (statins).

Defining overdiagnosis

Other workshops dealt with the need to come up with a commonly agreed definition of overdiagnosis. While an article in the *British Medical Journal* in 2012 used two: "when

people without symptoms are diagnosed with a disease that ultimately will not cause them to experience symptoms or early death" and "over-medicalisation and subsequent overtreatment, diagnostic creep, shifting thresholds, and disease-mongering, all processes helping to reclassify healthy people with mild problems or at low risk as sick," there is a need to develop an understanding of the definition of overdiagnosis and the various types of overdiagnosis

One of the standout presentations on the final day was a summary by Helene Irvine, consultant in public health of the National Health Service in greater Glasgow and Clyde, of a study she undertook on the national allocation formula in Scotland. Contrary to her expectations she found that "in a health board that is famous for concentrated social deprivation, the rising activity and costs were increasingly disproportionately attributed to elective activity in the most privileged which included screening-related overdiagnosis and overtreatment for the worried well."

The conference ended with a number of excellent keynote presentations. Alexandra Barratt outlined the 45 year history of overdiagnosis in screening. It has taken decades for this shadowy idea of overdiagnosis to be accepted in the mainstream of medical awareness, she said. Along the way it's been the subject of vitriolic debate, professional division and public confusion, misunderstanding and disbelief. As a researcher working in the field for 20 years, she reflected on the long journey of overdiagnosis from an outlandish idea to an acknowledged reality.

Many of the keynote presentations will be placed on the Preventing Overdiagnosis website in due course: www.preventingoverdiagnosis.net/

Preventing Overdiagnosis 2015

1. Next year's Preventing Overdiagnosis conference will be held on 1st – 3rd of September 2015 in Washington, DC USA http://ethics.health.govt.nz/

College of Nurses Aotearoa (NZ) Inc
Life Members

Name	Date Awarded
Judy Yarwood	October 2014