COUNTIES MANUKAU

ORAL HEALTH PLAN

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Abbreviations

ACC	Accident Compensation Corporation
AUT	Auckland University of Technology
ARDS	Auckland Regional Dental Service
ARPHS	Auckland Regional Public Health Service
CMDHB	Counties Manukau District Health Board
CPHAC	Community and Public Health Advisory Committee
CME	Continuing Medical education
CMCOHG	Counties Manukau Child Oral Health Group
GDB	General Dental Benefit
NDSA	Northern DHB Support Agency
MHAC	Maori Health Advisory Committee
MoH	Ministry of Health
OHRG	Oral Health Reference Group
OHSA	Oral Health Services Agreement (sometimes also known as AOHSA Adolescent Oral Health Services Agreement)
PHO	Primary Health Organisations
PHAC	Pacific Health Advisory Committee
SDB	Special Dental Benefit
SIA	Services to Increase Access
WHO	World Health Organisation
WINZ	Work & Income New Zealand

Executive Summary

The oral health needs assessment process identified the three themes of reducing oral health inequalities, integrating oral health with other primary care services, and focusing on prevention as well as treatment. It also identified a number of priority areas upon which to concentrate CMDHB efforts to improve oral health. Notwithstanding the influence that the broader social and economic determinants of health have on oral health inequalities, the Oral Health Plan focuses on oral health services and the potential for prevention through behavioural risk factor modification and service orientation.

Therefore, the overall vision for oral health and oral health services in Counties Manukau comprises working towards:

- The integration of oral health and oral health services into primary care
- Integrated oral health services that are easy to negotiate and access
- The configuration of existing and new oral health services developed in partnership with primary care and the communities they serve, including the development of some strategically placed community clinics
- Oral health services orientated towards oral health promotion and prevention
- Oral health services designed and targeted foremost for those with the highest need and designed from the perspective of the patient and their family

Recommendations to achieve the above overall vision for oral health can be summarised by the following areas of activity:

- Increasing the integration of oral health and oral health services into primary care through primary care;
    - Undertaking to facilitate access to oral health services
    - Incorporating the consideration of oral health issues into day to day practice
    - Carrying out joint service delivery with oral health services
    - Contributing to oral health education and promotion
    - Funding oral health services
- Providing oral health services to local communities through a varying combination of school based clinics, mobile caravans, and community clinics
- Improving integration among the different oral health services
- Exploring and instigating potential new developments in oral health services of;
    - Strategically placed community clinics

    - Some general dental care for mothers-to-be
    - Some general dental care for low income adults
    - Outreach services
    - Whole family services
    - Facilitation services
- Developing partnerships for community clinics and options/opportunities for service development with Maori and Pacific communities and providers
- Increasing the utilisation of free oral health services for children and adolescents especially in Maori, Pacific, children and adolescents from areas of high deprivation and children and adolescents with high needs
- Increasing the use of clinical prevention procedures such as fissure sealants
- Integrating oral health promotion into the more general health promotion of breastfeeding, good nutrition, and tobacco control
- Improved information regarding oral health status and oral health service delivery
- Oral health service workforce development particularly in Maori and Pacific

Our Shared Vision and Values

Shared Vision

Counties Manukau DHB's shared vision is:

To work in partnership with its communities to improve the health status of all, with particular emphasis on Maori and Pacific peoples and other communities with health disparities

- We will do this by leading the development of an improved system of healthcare that is more accessible and better integrated
- We will dedicate ourselves to serving our patients and communities by ensuring the delivery of both quality focussed and cost effective healthcare, at the right place, right time and right setting
- Counties Manukau DHB's provider arm will be a leader in the delivery of successful secondary and tertiary health care, and supporting primary and community care.

Shared Values

Care & Respect	Treating people with respect and dignity; valuing individual and cultural differences and diversity
Teamwork	Achieving success by working together and valuing each other's skills and contributions
Professionalism	Acting with integrity and embracing the highest ethical standards
Innovation	Constantly seeking and striving for new ideas and solutions
Responsibility	Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions
Partnership	Working alongside and encouraging others in health and related sectors to ensure a common focus on, and strategies for achieving health gain and independence for our population

Our Commitment to the Treaty of Waitangi

The Treaty of Waitangi

The New Zealand Public Health and Disability Act 2000, Part 1, section 4 identifies that DHBs must work to improve Maori Health gain through the provision of:

"mechanisms to enable Maori to contribute to decision-making on and to participate in the delivery of, health and disability services"

CMDHB is therefore duly bound to action the Treaty of Waitangi through the principles of partnership, protection and participation.

CMDHB has identified the following roles with which to enact these Treaty obligations:

- The appointment of Maori members to the Governance Board of the District Health Board
- The appointment of General Manager, Maori Health as a part of the Executive Management Team
- The establishment of a Maori Health, Funding and Planning team working in conjunction with Tainui MaPO
- The development of the Maori provider unit, Matapuna Rapuora

CMDHB has identified the following concepts to guide the enactment of its Treaty obligations:

- Maori health is everyone's responsibility
- Maori health gains will be addressed through sustainable solutions
- Maori will enjoy the same level of health as non-Maori
- Maori health gain is whanau health gain.

1 Introduction

Improving oral health is a strategic priority for Counties Manukau DHB. An objective of the Counties Manukau District Annual Plan 2003/04 was to develop an Oral Health Plan for the district, as Counties Manukau District Health Board (CMDHB) does not have a coherent framework from which to direct new and current activities related to oral health. This Plan provides a strategic direction for CMDHB in relation to oral health for the next 5 years.

1.1 Plan development process

The development of a Counties Manukau Oral Health Plan involved a two stage process. The first stage consisted of completing an oral health needs assessment for the district. This process highlighted numerous issues for oral health and identified several priority areas for the concentration of CMDHB efforts. This work forms a background document to the Plan and provides an ongoing resource for CMDHB.

The second stage of the Plan development involved a process of internal and external consultation and the generation of specific recommendations and actions for CMDHB. The background document was circulated widely as a discussion document, including to Community and Public Health Advisory Committee (CPHAC), Maori Health Advisory Committee (MHAC), Pacific Health Advisory Committee (PHAC), Maori team, Pacific team, and key informants in the oral health sector.

An Oral Health Reference Group (OHRG) was established for a fixed term to assist in the development of the plan (see Appendix 1 for members and meeting details). The OHRG provided expert opinion and feedback. This group met on several occasions, at which the group discussed the background document, adult oral health, and aspects of the draft Plan.

Exploratory meetings were held with various stakeholders and providers in order to align the Plan with their activities, identify opportunities for collaboration, and to test the initial acceptance and feasibility of aspects of the Plan. The draft version of the Plan was presented to OHRG, CPHAC, PHAC, and MHAC for comment.

1.2 Underlying themes

Three themes emerged from the oral health needs assessment process for Counties Manukau;

- The need to reduce oral health inequalities
- The need to integrate oral health with other primary care services
- The need to focus on prevention as well as treatment

1.2.1 Reducing oral health inequalities

Oral health is another example of where socioeconomic and ethnic inequalities in health exist. A clear picture of oral health inequalities is evident across the lifespan in terms of both oral health status and the utilisation of oral health services for general dental care. Poor oral health and low service utilisation is disproportionately seen in Maori, Pacific, and those of low socioeconomic status.

1.2.2 Integration of oral health with other primary care services

Oral health problems are common and regular contact with oral health services is recommended for the entire population. Therefore, oral health and oral health services are a fundamental constituent of primary care. However, historically, oral health and oral health services have been isolated from primary care.

1.2.3 Focusing on prevention as well as treatment

The major dental conditions of dental caries, periodontitis, and dental injury are all potentially preventable. Low sugar consumption, regular tooth brushing with fluoride toothpaste and smoking cessation can all help to prevent the onset of disease. Oral health services also have a role to play in the prevention of disease onset, as well as a role in the early detection of problems and halting of disease progression.

1.3 Priority areas

In addition to the aforementioned underlying themes, the oral health needs assessment process identified the following priority areas:

- Maori
- Pacific

- Pre-schoolers
- Maternal oral health
- General dental care for low income adults
- Rural areas and areas without fluoridated water
- Adolescent coverage and utilisation
- School dental service review and the provision of complex treatments and out-of-hours care for children
- Developing the role of primary care and Primary Health Organisations
- Increasing oral health promotion and prevention
- Improving the monitoring and reporting of oral health data

1.4 The Oral Health Plan in context

1.4.1 CMDHB priorities

Improving oral health services has relevance to several wider CMDHB service development priorities, such as child and youth health, Maori health services, Pacific health services, primary health care, public health and health promotion, and rural health. Reducing inequalities in health is a fundamental component of the CMDHB vision and a focus for all strategic plans, including the Oral Health Plan.

1.4.2 Important linkages

The Oral Health Plan has important links with the Primary Health Care Plan, Maori Health Plan, Pacific Health Plan (under review), Child and Youth Plan, and the Integrated Diabetes Strategy. Oral health is also affected by activities in other areas of health, for instance, breastfeeding promotion, improving nutrition and obesity prevention, smoking cessation, and injury prevention.

1.4.3 CMDHB Strategic intent

The Oral Health Plan addresses many aspects of the DHB strategic intent oral health and oral health services. Specifically this includes;

- A strong focus on PHO development in the area of oral health
- Attempting to decrease barriers to accessing oral health services
- Emphasising the important role of health promotion and prevention in improving oral health and identifying the contributions that CMDHB can make to this
- Involvement in dental workforce development
- Encouraging moves to improve the clinical information technology and compatibility used in the oral health services sector
- Facilities development is anticipated within the school dental service and there is also potential for further facilities development for other oral health services
- Improving the information available for parents regarding oral health and oral health services

- Better customer service through oral health service design that tries to take account of the patient's life
- Quality improvement through enhanced information for outcome measurements, and utilisation and service delivery monitoring

1.4.4 Current developments

1.4.4.1 The School Dental Service

A national review of the school dental service has been underway concurrent to the development of the Counties Manukau Oral Health Plan. The results of this review from a DHB perspective are due with the MoH in November 2004 and the MoH response is expected in 2005.

Notwithstanding the results of this review, the Auckland regional school dental service, namely Auckland Regional Dental Service (ARDS), also has four major projects underway covering information technology, facilities development, individualised risk assessment and treatment, and a pre-school project.

1.4.4.2 Counties Manukau Child Oral Health Group

The Counties Manukau Child Oral Health Group (CMCOHG) is a collaboration of oral health service providers, Primary Health Organisations (PHO), and community paediatrics (see Appendix 3 for membership), with a particular interest in the oral health of children.

During 2004, the group secured corporate sponsorship, which enabled the purchase of a mobile dental caravan and provided funding for a regional media campaign promoting oral health. In addition, an oral health educational package for primary care staff has been developed and delivered to several PHOs by CMCOHG. A number of further initiatives are underway that are designed to raise awareness about oral health and to see oral health incorporated into Wellchild and the routine care and assessment of children.

1.4.4.3 Health Practitioners Competence Assurance Act 2003

With the advent of this Act, dental therapists will now be registered within a 'scope of practice' that describes the services they can provide. This Act has also involved some changes to the scope of practice within which dental therapists may operate, in particular allowing them to work outside the school dental service and to provide services to all age groups. The full implications of this Act for the dental workforce

and oral health services are unknown. Whilst on the one hand, there is a risk that dental therapists may move into private practice; on the other hand there are opportunities to employ dental therapists in new ways and with new providers, and perhaps offer more attractive career pathways.

1.4.4.4 Dental therapy training at Auckland University of Technology

In conjunction with changes to the scope of practice, several changes are expected to take place to the dental therapy training course at Auckland University of Technology. Not only does the course now incorporate training in treating adolescent and adult patients, but graduates in dental therapy may also qualify with dental hygiene skills. This has the potential to produce a much more versatile dental therapy workforce that could be utilised across a range of different public oral health services.

1.4.4.5 Pilot using conscious oral and inhalational sedation

A pilot using conscious oral and inhalational sedation has been developed in conjunction with the regional hospital service and local Special Dental Benefit (SDB) providers in the community. This service development is designed to deliver dental treatments to children, many of whom are pre-schoolers, by conscious oral and inhalational sedation rather than by general anaesthetic and at sites within Counties Manukau rather than at Greenlane Hospital. With time, it is envisaged that this alternative will allow much better local access to these services and will allow some treatment to be provided without resorting to general anaesthesia.

1.5 Approach to planning

In developing the Counties Manukau Oral Health Plan, the following approach has been used. Firstly, the Ministry of Health (2002) offers a framework for interventions to improve health and reduce inequalities. Interventions can be targeted at;

- The underlying social and economic determinants of health *(structural)*
- Factors that are intermediate between socioeconomic determinants and health, such as behaviour, environment, and material resources *(intermediary pathways)*
- Health and disability support services *(health and disability services)*
- The impact of disability and illness on socioeconomic position *(impact)*

The answer to oral health inequalities does not lie with CMDHB alone. However, as a District Health Board, CMDHB has a major contribution to make to reducing

inequalities through the health and disability services it funds and provides, particularly in ensuring accessible and acceptable services to those most in need. It also has a role to play in activities aimed at intermediary pathways, with a much smaller role at the 'structural' or 'impact' levels. Consequently, notwithstanding the influence that the broad social and economic determinants of health have on oral health inequalities, the Oral Health Plan focuses on oral health services and the potential for prevention through work along 'intermediary pathways'.

Secondly, oral health and oral health services are considered to be a fundamental part of primary care. The Oral Health Plan has therefore sought to identify as many opportunities as possible for an increasing role by the primary care sector in oral health.

Thirdly, collaboration, alignment, and consistency have been attempted with the developments and activities of the regional school dental service, the regional adolescent coordinator, the Counties Manukau Child Oral Health Group, and other regional or national initiatives for oral health.

Finally, the proposed recommendations and actions have drawn on previous work and recommendations, along with suggestions from key informants, including the Oral Health Reference Group.

1.6 Assumptions and constraints

The Counties Manukau Oral Health Plan was also developed with certain assumptions and constraints in mind. These constraints included the uncertain potential for new funding, in particular for adults, and the fact that many decisions are made regarding oral health services outside the DHB, at a regional or national level. Such decisions include the overall funding levels for oral health, the content of the oral health service contracts, price setting, and the degree of flexibility to adapt national and regional services to local circumstances.

A major assumption applied to the development of this Plan and its recommendations is the continuation of CMDHB's support for the regional oral health services provided for Counties Manukau children and youth by Waitemata and Auckland District Health Boards. Counties Manukau DHB currently provides no oral health services itself.

However, as will be clear from this Plan and the accompanying needs assessment, Counties Manukau children and youth are not yet receiving an optimal level of service, and their oral health outcomes are worse than for the general metro Auckland population as a whole. CMDHB is working with Waitemata DHB and ARDS on a service level agreement (SLA) which will accompany the regional inter-district flow agreements. This SLA will outline what is expected from ARDS in order to improve the oral health of the children in our district.

CMDHB's preferred approach is to maintain support for ARDS as the provider of the regional service. However, if the SLA does not deliver the cooperative planning relationship and improvement in processes and outcomes the DHB expects, then CMDHB will need to reconsider the regional arrangements.

The assumption was also made that there is likely to continue to be a mixture of models of service delivery for the foreseeable future and a mixed workforce. Furthermore, reliance on private dentists and on schools to provide or allow permanent facilities is deemed unrealistic. Workforce shortages are an ongoing issue. The Oral Health Plan also recognises that the changes to the dental therapy scope of practice are both a risk and an opportunity.

1.7 The organisation of the document

Firstly, an overall vision and direction for oral health services and oral health is described. This is followed by a discussion and specific recommendations for each priority area identified from the oral health needs assessment process.

2 An overall vision for oral health services and oral health

Currently, publicly funded oral health services are fragmented, oral health service providers are isolated from other health services and primary care, and no single provider has overall care of a person's oral health. There is inconsistent access and utilisation of services by the population, and several barriers to care exist, particular for those most in need. There is a general lack of awareness about oral health and oral health service availability, both within primary care and amongst the public.

CMDHB is in a position to act as a coordinator and facilitator of links between oral health and primary care, as well as links to other activities that support oral health. Therefore, bearing in mind the previously outlined approach, constraints, and assumptions, an overall vision for oral health and oral health services consists of attempting to achieve:

- **Integration of oral health and oral health services into primary care**
- **Integrated oral health services that are easy to negotiate and access**
- **Existing and new oral health services configured in partnership with primary care and the communities they serve, including the development of some strategically placed community clinics**
- **Oral health services orientated towards oral health promotion and prevention**
- **Oral health services designed and targeted towards those with the highest need in mind and designed from the perspective of the patient and their family**

The following proposals are not intended to replace or detract from the oral health services and relationships currently in place, but rather to enhance and support them. Fortunately, there is a sense of general alignment in the directions that many services and groups are wishing to work towards and a desire to address similar issues in relation to oral health and oral health services.

One overall aim is for oral health services themselves to be more integrated and thus easier to negotiate and access. Given the different service delivery models and

providers involved, one way of achieving integration is through the development of local oral health service networks, utilising primary care and the district overview CMDHB has to help create them. Increasing integration may be achieved in a physical sense by service delivery at the same site or in a virtual sense through established organisational links and information flows. Another essential element is also developing some form of facilitation and coordination service for enrolling and accessing oral health services.

The involvement of primary care in oral health may take many forms. The options include providing a facilitation (and coordination) role, offering services alongside oral health services or for PHOs to fund some oral health services for their enrolled population. The aim has been to identify as many opportunities as possible to incorporate oral health and the awareness of oral health services into the activities of primary care (or secondary care) services already in existence, particularly those that are already attempting to access hard to reach or high need populations.

Currently, some potential options exist for certain oral health services to be delivered together from fixed sites in the community. In particular, there are opportunities to align with ARDS and the ADHB Regional Oral Health Service in the development of ARDS' proposed community bases.

The notion of the development of some community clinics is an attempt to address local access and visibility issues by offering a combination of services at one site and a stable and reliable presence. These clinics would be strategically placed in an attempt to optimise a number of factors such as visibility, transportation options, areas of high congregation, access for population groups of high need, expected population growth, and specifically, proximity to other primary care services.

There are several proposed advantages to community clinics. Fixed sites in the community support mobile services by offering a base for the referral of patients for procedures that cannot be performed in a mobile caravan and for the rotation of staff. Stable and visible sites provide a focal point of contact for both the public and primary care, particularly in emergency situations. If clinics were reliably open for longer hours then this would improve emergency and after hours access. Dental equipment is expensive and this concept provides the option of sharing resources and

capital expenditure among providers. Knowledge and expertise can also be shared. Finally, community clinics could also be the hub around which the rest of a local oral health service network is arrayed.

There are, however, concerns with community clinics. They are by definition situated away from schools and therefore may cause transport issues. However, transport issues currently exist for pre-schoolers and will continue to exist for some school children anyway. There is no guarantee that community clinics will be any more acceptable to high needs populations than are the currently available services. There is also concern that extensive development of numerous community clinics carries with it potentially high financial costs. Finally, the commencement of new services might be perceived as competition by local dentists.

Complementary to fixed community clinics and joint service delivery, there are also opportunities to increase integration in a more virtual sense. This could be accomplished through improved information links, both between oral health providers and between oral health providers and primary care, and through the involvement of primary care in oral health. This is consistent with another overall aim of integrating oral health and oral health services into primary care.

Finding a balance between fixed sites in the community and mobile services or services based at schools is important, as is a balance between integration via physical locality or integration via information flows and links. It is envisaged that the overall configuration of the fixed sites and local 'service network' will differ from community to community. Ideally the balance would be determined by the needs and desires of the surrounding community and the services already available, and developed in partnership with the communities concerned. The potential for partnerships with various different stakeholders exists including Maori, Pacific, and Primary Health Organisations that may be interested in funding some oral health services or engaging in joint service delivery.

Depending on the configuration of stakeholders and partners, different ways of offering services could be piloted e.g. kaupapa Maori services or drop-in clinics. Other linkages that could be developed include with oral health promotion providers,

WINZ, and ACC. Additional services could easily be incorporated at a later date, e.g. a dental educator or PHO funded services.

The possibility of providing some sort of oral health services that deals with the whole family has been raised. This would require the collaboration of several oral health service providers or establishment of an entirely new service model. It is partially hindered by the lack of funding for adults for comprehensive basic dental care, or even for relief of pain. These services could be offered at a community clinic or from a mobile caravan, or may simply consist of a comprehensive facilitation service, with possible assessment and examination followed by referral.

A final avenue of collaboration is with the Auckland University of Technology (AUT) and other educational institutions to provide training options to dentists and dental therapists and share resources with these institutions. Such training might also include some community dentists receiving training to work with children, to encourage and support them in providing Special Dental Benefit services. The new scope of practice for dental therapists and the proposed integrated dental therapy and dental hygiene course at AUT raises the possibility of offering some form of adult services at a reduced rate, with trainees needing experience with adult patients.

3 The role of primary care and Primary Health Organisations

Primary care and PHOs are an important component in the overall vision for oral health and oral health services. Historically, oral health and oral health services have been isolated from primary care. However, with the establishment and development of PHOs and other changes to primary care, opportunities now exist for increasing the contribution of primary care to oral health. In addition, currently oral health is a PHO health promotion priority.

Recommendations:

- **Involve primary care and PHOs in oral health service developments**
- **Explore the possibility of PHOs funding some oral health services**
- **Primary care to facilitate the enrolment and utilisation of oral health services for all age groups**
- **Increase primary care involvement in oral health promotion and education**
- **Incorporate oral health into primary care information systems**
- **Incorporate oral health into daily clinical practice**

Primary care can enhance oral health service provision and integration in several ways. Firstly, PHOs and associated services are an important stakeholder in the development of any community clinics or local service networks. Secondly, PHOs have the option of funding some oral health services, especially to adults. Thirdly, oral health services can be delivered jointly with primary care services, particularly those for children. Finally, primary care has a role to play in facilitating access to services.

As other parts of primary care are likely to encounter children and adolescents more frequently than oral health services, they are a valuable means of assistance in enrolling and encouraging the utilisation of free dental services. This might also include utilising the systems and networks already in place for chasing up patients e.g. community health workers. For this to take place, an increased awareness and understanding of the oral health services available is needed amongst primary care

workers and accurate and easily obtainable information needs to be provided to primary care on how to access oral health services.

Oral health messages can be delivered by all parts of primary care. In order to achieve primary care involvement in oral health promotion and prevention alongside the incorporation of oral health considerations into daily clinical practice, continuing medical education and awareness-raising about oral health issues is required. This has already been commenced by CMCOHG on child oral health issues and should continue. Continuing medical education needs to be extended to cover oral health issues for chronic care patients such as diabetic and rheumatic heart disease patients, and the elderly on multiple medications for whom oral health is important.

The incorporation of oral health into primary care information systems could include adding oral health to Kidslink and encouraging the addition of oral health onto practice management systems. This would help support oral health activities in primary care and links to oral health services.

Numerous possibilities exist for PHOs to spend their health promotion funds, including in oral health. To date, health promotion funds have been used to provide continuing medical education sessions to nurses and GPs on oral health and raise awareness of oral health services. Initiatives in primary care have already commenced in offering toothbrushes at immunisation events. The Primary Health Care Strategy (2001) identified water fluoridation advocacy as an example of a potential health promotion activity that PHOs could pursue. As another example, one PHO in the North Island has used health promotion money to facilitate access to adolescent services for their enrolled population.

4 Monitoring and reporting of oral health data

There are a number of information gaps in the area of oral health. Without data about the nature of services and what is being provided, service utilisation, and oral health status outcomes, it is difficult to know which, if any, services are effective (Health Funding Authority 1999, Thomson, Ayers & Broughton 2003), or to monitor oral health inequalities over time. There is very limited information on the oral health status of the Counties Manukau population, as the only routinely collected data is on 5 and 12 year olds.

Improving the information available on oral health is an important tool for achieving many aspects of the Oral Health Plan. It will entail working with the Northern DHB Support Agency (NDSA), ARDS, Healthpac, and other oral health services providers. The commencement of an oral health analyst at the NDSA also offers scope for improved information provision.

Recommendations:

- **Improve the oral health status information available on the population, in particular in adolescents and adults**
- **Increase reporting requirements on oral health services and improve data quality**
- **Use oral health status indicators at age 5 to monitor inequalities in children**
- **Improve information sharing and electronic links between different parts of primary care and oral health services**
- **Incorporate oral health into primary care information systems**

The Public Health Advisory Committee (2004) has emphasised the importance of ethnicity and appropriate socioeconomic status information for the monitoring of inequalities. Oral health indicators at age 5 have been suggested as the best indicator to monitor inequalities in children (Public Health Advisory Committee 2003).

Basic information needs involve some indication of oral health status for each age group or service delivery group, preferably broken down by ethnicity and some measure of socioeconomic status, along with population-based service utilisation data.

In general, oral health services data reporting should be DHB specific, include completion of treatment as well as enrolment, and also be broken down by ethnicity and some measure of socioeconomic status.

ARDS has now commenced the reporting of oral health status for pre-schoolers. The Oral Health Services Agreement for adolescents contains requirements for health status reporting on the DMFT of the patient at the examination just prior to the 16th and 18th birthday. Therefore, adolescent providers need to be encouraged to collect and report this information and Healthpac needs to be in a position to analyse and report on adolescent oral health status. Alternatively, it has been suggested that a school-based survey could be carried out to ascertain the oral health of adolescents in the Auckland region. There is a particular need for information regarding the oral health of adults and any proposals by the MoH for community surveys of the population should be endorsed and encouraged.

Gardner (2002) made a number of recommendations designed to improve oral health data reporting and monitoring, most of which are still relevant. These recommendations consisted of reporting completion data as well as enrolment data, reporting enrolment and utilisation by ethnic group, and reporting data by DHB based on the patient's residence and not by the provider's address. Information on secondary and tertiary referrals, for example SDB referrals for tooth extraction or adolescent extra needs referrals, would complete the picture. Improvements to relief of pain reporting might also include distinguishing the number of individuals from episodes of treatment. Attention also needs to be paid to achieving consistent ethnicity recording and coding across the different oral health services.

ARDS' information technology project is focused on increasing electronic processes and reducing manual processes and in particular, enhancing the ability to share information both internally and externally. It has the potential to allow clinical records to be accessed by any dental therapist regardless of where the child is seen and treated. It has also been suggested that it would be useful for ARDS to have access to Kidslink contact details and vice versa to help maintain up-to-date contact details, particular for pre-schoolers.

5 Increasing oral health promotion and prevention

Treatment alone is not likely to bring about significant changes in oral health status or reduce inequalities (Watt & Sheiham 1999). Interventions that focus on prevention are also necessary. A prevention focus encompasses avoiding the onset of dental disease, identifying and treating problems at an early stage, and acting to prevent a reoccurrence (Scottish Intercollegiate Guidelines Network 2000).

Prevention can involve measures directed at the entire population, such as water fluoridation, measures directed at the group level, and interventions targeted at high risk individuals. Public health approaches continue to be important to encourage and support appropriate oral health behaviour in the whole population. Dental caries, periodontal disease and even dental injury are all highly preventable. At a behavioural level, good nutrition, not smoking, fluorides in one form or another, regular tooth brushing, and regular dental care are the cornerstones of preventing poor oral health.

Recommendations:

- **Encourage all oral health services to have a prevention orientation, incorporating the use of clinical prevention procedures as appropriate**
- **Provide consistent oral health promotion messages from a variety of sources**
- **Existing oral health promotion services to continue to provide oral health promotion at the group level, particularly in Maori and Pacific communities**
- **Incorporate oral health promotion into general health promotion and link with other health promotion interventions that influence oral health e.g. nutrition, tobacco control, breastfeeding**
- **Counties Manukau DHB to adopt a positive water fluoridation policy**

There are several potential benefits from regular visits to a dental health professional. Firstly, they provide an opportunity for prevention activities as well as treatment (Public Health Advisory Committee 2003). For example, the effective removal of plaque through cleaning and scaling can be performed and the application of fluoride or fissure sealants as protective measures can be undertaken. Oral health education regarding appropriate nutrition and tooth brushing can also be given. Secondly,

regular visits allow for the early detection of disease, including the oral manifestations of more systemic disease. As a result, restorative options can be given rather than extraction and disease progression halted or reversed. Thus, oral health services can all be orientated towards prevention.

The ARDS individualised dental care project is designed to tailor the care provided by the school dental service to each child's need. It involves the development of a risk assessment tool to inform decision making. Among other things, this will enable the appropriate targeting of clinical prevention measures in children. Furthermore, there is strong evidence to recommend the use of fissure sealants in a targeted fashion to reduce the occurrence of dental caries. To this end, as part of the aforementioned project, ARDS plans to increase the use of fissure sealants in high needs children or selected geographic areas.

As previously highlighted, all workers in primary care are in a position to deliver oral health education and prevention messages, as are all oral health services and secondary and tertiary health services. It is important that these messages are consistent and are delivered through a variety of media. In addition, the Body Odyssey exhibition and health festival planned for 2005 presents an opportunity for large scale oral health education and oral health promotion activities.

The WHO (2003) espouses integrating oral health promotion with general health promotion, and adopting a common risk factor approach to chronic disease prevention. Good nutrition is of major importance for a number of chronic diseases, including oral health. Therefore diet issues related to oral health can be tackled in conjunction with the implementation of the Ministry of Health's (2004) ***Healthy Eating Healthy Action*** strategy and in particular for CMDHB, the implementation of the Integrated Diabetes Strategy. Similar arguments apply to smoking cessation and prevention, injury prevention, and breastfeeding promotion.

Water fluoridation acts at a population level to help prevent dental caries over the lifetime and to reduce oral health inequalities. At present, the MoH will provide significant subsidies to local authorities to establish water fluoridation. The water fluoridation advocacy role at the Auckland Regional Public Health Service (ARPHS) continues to be unfilled and the MoH (who funds this service) and ARPHS should be

encouraged to continue the service. Through its relationship with local authorities, the CMDHB can advocate for the maintenance and initiation of fluoridated water supplies. PHO health promotion activities can also adopt a similar advocacy role.

6 Pre – schoolers

Only about a third of the pre-school population in Counties Manukau are enrolled with ARDS and although this is improving, there is also difficulty in achieving attendance following enrolment. Pre-schoolers have greater levels of decayed teeth than filled i.e. treated teeth and there has been considerable concern expressed at the number of pre-schoolers being referred for extensive dental treatment, particularly for tooth extractions under general anaesthetic.

Furthermore, maternal oral health is closely linked to the oral health of pre-schoolers. Breastfeeding is also beneficial in the prevention of dental caries in children. Additionally, the pre-school time is a critical period for the development of oral hygiene practices and appropriate nutrition. Caregiver and family attitudes and behaviour contribute to the development of appropriate oral health behaviour in children (Thomson, Ayers, & Broughton 2003). Parents and caregivers are responsible for the nutrition children receive, in helping children to clean their teeth until their manual dexterity improves, in taking the children to dental services, and in teaching them about oral health. To this end, improvements in the oral health of pre-schoolers especially, cannot be achieved without considering the entire family.

Recommendations

- **Target the early and increased pre-school enrolment and utilisation of oral health services in children from high deprivation areas, Maori, and Pacific children**
- **Improve the oral health of mothers (see section 7) and endorse breastfeeding initiatives**
- **Increase the involvement of primary care, particularly Wellchild services, in pre-schooler oral health**
- **Support CMCOHG and ARDS in developing strategies for hard to reach children**
- **Collaborate with ARDS on the pre-school project**
- **Increase information sharing between providers of pre-school services**
- **Improve access to SDB services (see section 13)**

There are many different health services available to pre-school children and therefore it is important that there is some coordination and integration of these services. This is to prevent multiple visits being required of families and receiving the attention of large numbers of health care professionals. Information sharing and collaboration between ARDS, Wellchild, KidzFirst, and other parts of primary care is important.

Primary care and Wellchild providers are in a good position to help with the enrolment of pre-school children with ARDS. It is intended to try and link pre-school enrolment follow-up with already existing primary care outreach services that deal with immunisation, rather than duplicate this approach for oral health. Wellchild providers also have an important role to play in promoting the school dental service and encouraging oral hygiene, breastfeeding, appropriate nutrition, appropriate bottle feeding, and injury prevention.

The Counties Manukau Child Oral Health Group has been focused on pre-schoolers during the last year and has been involved in a number of activities. They successfully secured sponsorship from Skycity for an oral health promotion campaign directed at young children and the purchase of a mobile dental caravan.

The intention is for CMCOHG and ARDS to develop strategies to access hard to reach pre-schoolers. This might involve a range of pre-school services being offered in the community, in selected geographical areas, on a drop in basis for a short period of time. As well as ARDS, the services might include immunisation, Plunket, and ear and vision testing. The joint delivery of mobile services by Plunket and ARDS on a drop-in basis out in the community has already been successfully trialled. Some improvements to the ARDS enrolment form have been suggested, such as the addition of a clear postal address to send the enrolment form to or the use of free stamped envelopes.

ARDS is also currently conducting a feasibility study into the resources required to deliver a child's first dental examination by one year, as per recommended best practice, and providing continuing care in line with recommended best practice. This is based on strong evidence in support of engaging early with children and families to improve oral health and the project also acknowledges the pivotal role of the mother in the dental caries process.

7 Maternal oral health

Focusing on maternal oral health is an opportunity to improve adolescent and adult oral health as well as oral health in children. Mothers have several influences on the oral health of their children. Maternal oral health plays an important biological role in the commencement of the caries process in pre-school children (Mueller 2003, Thomson, Ayers & Broughton 2003). Prevention aimed at pregnant mothers and mothers of pre-schoolers in the form of dental treatment, including topical antibacterial agents and education, has shown a 30 -50 % reduction in the amount of caries in children (Gardner 2002b). There is also good evidence to suggest that improved maternal oral health has flow on effects for the rest of the family.

Recommendations:

- **Consider funding some form of general dental care to pregnant and new mothers mothers, targeted at low income, Maori, and Pacific mothers**
- **Ensure pregnant adolescents access the free adolescent oral health services**
- **Utilise primary care services that have contact with mothers, particularly of high needs children, for the promotion of oral health issues**
- **Encourage the inclusion of oral health education in antenatal classes**

A possible service to improve the oral health of pregnant mothers is envisaged as consisting of an examination and treatment as necessary during pregnancy followed by an appointment approximately a year later. This service could also be linked to the enrolment or first visit of the pre-schooler, particularly if offered at the same site and even at the same time. It could also include dental education information including preventive advice for the mother and baby on nutrition and care of the teeth and be targeted at low income, Maori, and Pacific mothers.

In the case of teenage mothers, free services are already available through the adolescent service. They should be a high priority group to ensure access to this service. The proposal for two school teenage pregnancy units in Counties Manukau offers a way to assist in linking the mothers to adolescent services, potentially through mobile providers to the school.

Similarly, there are a number of services that have contact with young mothers, including general services such as lead maternity carers and Wellchild and more targeted services such as Mother and Pepe. Work with the providers of these services could be done to raise awareness of oral health services and oral health issues for mother and child, so that oral health can become part of the service they provide.

Information that could be delivered through an antenatal care setting to mothers might consist of the importance of maternal oral health, how to look after their children's teeth, the impact of fruit juice and inappropriate bottle feeding on children's teeth, and the services provided by the school dental service. ARDS has also expressed an interest in working through antenatal classes.

8 Adult dental care for low income adults

There are few publicly funded dental services available for adults and what is available tends to be only for emergency treatment. As seen in the last New Zealand Health Survey (Ministry of Health 1999), general dental care is not utilised by most adults. Low-income adults in particular do not access general dental care, and are more likely to have teeth extracted than restored. The biggest proportion of adults requiring hospitalisation is those from very deprived areas. The main barrier to the use of regular dental care for adults has been identified as cost, although fear and lack of knowledge about oral health may also play a role, as well as attitudes to oral health. Engaging adults in positive experiences of oral health is also an important part of improving child oral health, as caregiver attitudes and experiences impact on children.

Low-income adults have a need for accessible general dental care. This group is likely to have the worst oral health among adults, and currently demand for relief of pain services exceeds supply. Adults with poor oral health status or with dentures in poor condition may receive less ACC cover for dental injuries. Yet, those with poor oral health status are usually those least able to afford the extra ACC fees.

Recommendations:

- **Low income adults to be a priority group for the provision of more general dental care with any new funding opportunities**
- **Investigate the possibility of piloting some form of outreach service for low income adults**
- **Establish links with educational institutions giving training in adult dental care and explore the possibility of offering services by trainees at reduced rate to adults**
- **Increase relief of pain volumes and coverage**
- **Endorse regional and national discussion concerning WINZ and ACC funding for dental care**

With limited funding, improving adult oral health services is challenging. Public health and population health activities are particularly important for adult oral health given the limited funding available for adult oral health services. Fortunately, there

has been a recent increase in funding by ACC to dentists, which should mean the patient has to pay less than previously in the case of dental injury.

Low-income adults should be a priority group for the provision of more general dental care should any new funding become available. In the interim, relief of pain services and coverage need to be increased. There is the potential for PHOs to fund some services to adults, possibly using SIA funding or Care Plus funding. Such services might be offered through a community dental clinic, from a mobile caravan, or at other primary care sites and targeted at adults groups such as diabetics or mothers-to-be.

The newly acquired CMDHB mobile dental caravan, although predominantly to be used by ARDS, could potentially be used to develop an outreach service of some description. It might offer oral health services for which there is currently funding, such as ACC, relief of pain, or even WINZ but it could also include oral health education, a facilitation service or any other new service that is developed.

The recently increased scope of practice for dental therapists extends the services they will be able to provide to include adult patients, following an approved course of study. This has a number of implications. Firstly, there will be a need for adult patients for training purposes. Therefore there is an opportunity, possibly through the community clinic concept, to work in conjunction with AUT and offer dental therapists training options i.e. adult patients. This raises the possibility of providing some general dental care at a reduced rate to the local adult population.

Secondly, dental therapists will be able to work outside the school dental service and can be utilised for all patient groups, although they will need to work in conjunction with dentists. This makes the possibility of whole family models of care more feasible. They could also be employed out in the community including by primary care providers, particularly by Maori for Maori and by Pacific for Pacific providers.

9 Maori

There are three reasons for discussing oral health specifically with respect to Maori. Firstly, oral health is a priority that has been identified by Maori, most recently in *He Korowai Oranga* (2002). Maori children appear to have poor oral health and historical and anecdotal evidence suggests that adult Maori also have poor oral health. Maori are also more likely to under utilise oral health services. Currently in Counties Manukau there is one Maori regional provider of oral health promotion and no 'by Maori for Maori' providers of dental care services.

Within an oral health framework, the need for more appropriate oral health education resources for Maori has been highlighted as well as the need for better knowledge regarding service availability and eligibility. The importance of nutrition issues for Maori has also been emphasised.

Secondly, the DHB's commitment to the Treaty of Waitangi entails working to reduce inequalities between Maori and non-Maori, including the oral health inequalities that currently exist. Finally, over and above this, the Treaty and its principles encompass consultation, participation, and partnership with Maori and the allowance of self – determination by Maori, regardless of the existence or direction of oral health inequalities. Thus, Maori are an important part of the design and implementation of the Oral Health Plan.

Obviously, many of the recommendations discussed in other sections are relevant and have implications for Maori, particularly as the child and adolescent population in Counties Manukau will increasingly be comprised of Maori.

Recommendations:

- **Implementation of the Oral Health Plan in conjunction with Maori**
- **Increase the utilisation of all oral health services by Maori in particular pre-schoolers and adolescents**
- **Encourage and support Maori service development in the area of oral health**
- **Ensure that information regarding oral health services and oral health promotion messages are appropriate for Maori**

♦ Encourage Maori into the dental workforce

In order for Maori to be involved in the implementation of the Oral Health Plan, there is a need to identify appropriate groups and processes to allow participation and partnership with Maori. This is particularly relevant for decisions regarding the development of community clinics and local service networks as well as new oral health service developments. In addition, there are several possible links of the Oral Health Plan to the Maori Health Plan; such as increasing Well Child checks for Maori, increasing access to health services especially primary care services for Maori, and decreasing smoking rates for Maori.

He Korowai Oranga emphasises whanau ora or the wellbeing of the family. In relation to oral health, efforts to improve oral health cannot be solely focused on children alone. Furthermore, as previously mentioned, the oral health of the family and the involvement of the family are vital to the oral health of children. There are difficulties in attempting to fit a narrow focus on oral health and dental disease into a more holistic and family-centred approach that might be preferred by Maori. This latter approach does not fit easily into existing funding and contractual structures, which tend to be directed at specific age groups, nor with the separation of oral health services from other primary care services. There are particular difficulties in being able to offer comprehensive services to all age groups or the whole family, given the lack of funding for general adult dental care.

However, it is hoped that opportunities for Maori to develop and implement by Maori for Maori oral health programmes and services can be created or that oral health can be incorporated into already existing services and interventions. There may also be opportunities for joint service delivery with oral health services. Broughton (2000, 2001) describes some of the 'oranga niho' services that have been developed around the country. These include a whanau dental clinic concept, a mobile caravan operation, partnerships with mainstream services, and iwi based initiatives. Many of these services only operate for a short period of time but are reported as being well utilised and accepted. Another pilot project Broughton (2000, 2001) described encompassed a team of dentist and dental therapist working within an existing Maori health provider, supported by a community health worker and offering services to all age groups. In addition, the results of the review and evaluation by the MoH of

existing Maori child oral health services might also provide other potential service model options. The new ability of dental therapists to work outside the school dental service and with all age groups offers opportunities for different models to be tried. It has also been suggested that Maori health initiative funding might be a source of funds with which to set up an initiative aimed at improving oral health in Maori.

Oral health workforce development activities should be linked to the wider issue of Maori workforce development and recruitment in the health sector. The advent of training for dental therapist at AUT in Auckland makes access easier for Maori students in Auckland. Previously students had to train at Otago University in Dunedin. The South Auckland Health Foundation now has an annual scholarship available for a Maori student to train in dental therapy at AUT in Auckland, thanks to the efforts of CMCOHG.

10 Pacific

Pacific children appear to have very poor oral health. Among Pacific adults oral health status is likely to be more varied. Those born and raised in the Pacific Islands are reported to have very good oral health, while those adults born and raised in New Zealand are more likely to have very poor oral health. One of the impacts of immigration on Pacific families has been a change in diet detrimental to oral health.

It has also been pointed out that there are a number of cultural reasons why oral health becomes a secondary priority for Pacific, both in terms of undertaking preventive oral hygiene behaviours and attendance for regular dental care. Consideration of the whole family dynamic and Pacific way of life is considered essential to designing services that will be utilised. In addition, the need for better knowledge about service availability and eligibility, as well as appropriate educational and promotional resources, has been highlighted.

Socioeconomic factors also have a large role to play in influencing oral health for Pacific families. In particular, cost is a major barrier to dental care for adults. Many Pacific adults do not have Community Services Cards despite being eligible (Health Funding Authority 1999), and therefore cannot even access relief of pain services. Therefore the development of any low cost adult services would also benefit Pacific adults.

Obviously, many of the recommendations discussed in other sections are relevant and have implications for Pacific, particularly as the child and adolescent population in Counties Manukau will increasingly be comprised of Pacific.

Recommendations:

- **Implementation of the Oral Health Plan in conjunction with Pacific**
- **Encourage and support Pacific service development in the area of oral health**
- **Increase the utilisation of all oral health services by Pacific, particularly in pre-schoolers and adolescents**
- **Ensure that information regarding oral health services and oral health messages are appropriate for Pacific**

- **Encourage Pacific into the dental workforce**

In order for Pacific to be involved in the implementation of the Oral Health Plan, there is a need to identify appropriate groups and processes to allow participation by Pacific. This is particularly relevant for decisions regarding the development of community clinics and local service networks as well as new oral health service developments. In addition, there may be links to the CMDHB Pacific Health Plan that is currently under review.

There are difficulties in attempting to fit a narrow focus on oral health and dental disease into a more holistic and family-centred approach that might be preferred by Pacific. This approach does not fit easily into existing funding and contractual structures, which tend to be directed at specific age groups, nor with the separation of oral health services from other primary care services.

A facilitation service currently exists for Pacific pre-schoolers. However, it is hoped that opportunities for Pacific to develop and implement by Pacific for Pacific oral health programmes and services can be created or that oral health can be incorporated into already existing services and interventions. There may also be opportunities for joint service delivery with oral health services.

The advent of training for dental therapist at AUT in Auckland makes access easier for Pacific students in Auckland. Previously students had to train at Otago University in Dunedin. The South Auckland Health Foundation now has an annual scholarship available for a Pacific student to train in Auckland at AUT. This is part of the wider issue of Pacific workforce development and recruitment in the health sector and oral health should be linked to activities in this area.

11 Rural areas and areas without fluoridated water

Oral health status in those who reside in areas without fluoridated water is consistently poorer than those who have access to fluoridated water. In Counties Manukau, it is expected that the remaining unfluoridated area in the Papakura district will be fluoridated from next year, completing coverage of most urban areas. The remaining unfluoridated areas will then be in the more rural local authority district of Franklin. This district also happens to be where many schools lack dental clinics.

In many rural areas, water fluoridation is not a feasible option. In order to mitigate the effects of this, access to dental services and prevention at all levels through other means becomes even more important.

Recommendations:

- **Continue the use of mobile services in rural areas by ARDS and adolescent providers**
- **Explore the possibility of providing an outreach service for adults in rural areas (see section 8)**
- **High risk children and adolescents living in unfluoridated areas to have appropriate clinical interventions to assist in prevention e.g. fissure sealants or fluoride tablets**
- **Target oral health promotion and education to areas without water fluoridation**
- **CMDHB to encourage local authorities to fluoridate the water where feasible**

Some scope remains for water fluoridation in the Franklin area and the cost of this can be assisted through the use of the available government subsidy for initial set up costs. In the absence of water fluoridation, the protective benefits of fluoride must be obtained through tooth brushing with fluoride toothpaste and other avenues such as fluoride rinses, tablets, and topical applications by dentists where appropriate. Furthermore, fissure sealants have an important role to play in children.

The risk assessment tool being developed by ARDS is likely to take into consideration access to fluoridated water and therefore lead to increased oral health education and clinical prevention procedures for children from unfluoridated areas.

The provision of oral health services to rural areas is also related to more general issues of providing services to rural areas and the challenges of transport, small numbers of people spread over a large geographical area, and workforce retention. Mobile or outreach services in conjunction with a stable community base offer a potential solution. A stable community presence is particularly important in urgent and emergency situations.

12 School dental service and provision of Special Dental Benefits

In 2003, the MoH and the School Dental Technical Advisory Group (2003b) released the School Dental Service Facilities Discussion document. Several problems with the current state of the school dental service were highlighted. This has been followed by a nation wide review of the school dental service. Many of the difficulties for the school dental service have been confirmed by ARDS as existing in the Counties Manukau region.

Most importantly, there are a declining number of schools with fixed clinics on site from which to provide services and new schools are now being built without clinics. Due to changing disease patterns and workforce decline, the school dental service now spends only a few weeks at each school during the year. This increases the chances of missing children, especially mobile children. The lack of fixed clinics has decreased access and created transport issues for children as a result of having to go to another site to see the dental therapist. These problems are exacerbated in rural areas. Finally, the lack of a constant and stable presence of a dental therapist makes emergency access during the day more difficult for parents, particularly as SDB dentists can only be accessed after-hours for emergencies.

Furthermore, there are several concerns regarding the provision of SDB services. Work under the SDB is not attractive to dentists as it is generally time-consuming and difficult, involves dealing with children which dentists may not be used to treating, and the remuneration is considered to be inadequate. A lack of provision in the community increases the workload of the hospital, which is already performing SDB work that could potentially be performed by a community dentist. According to ARDS, Counties Manukau is reasonably well served by some dedicated dentists who are prepared to do SDB work but this is a fragile situation that could change.

Recommendations:

- **Align with and endorse ARDS's proposed new vision and service development projects**
- **Encourage stronger links between ARDS and primary care**

- **Finalise the Service Level Agreement between CMDHB and ARDS**
- **Endorse the increased use of fissure sealants and other clinical preventive measures by ARDS**
- **Explore alternative models of care for SDB provision while continuing to support the current arrangements for SDB provision**
- **CMDHB to assist with dental workforce development**

The future direction that ARDS is contemplating for their school dental service contains many elements that are in alignment with the Counties Manukau Oral Health Plan. It includes:

- Moving to more individualised dental care and risk assessment
- Targeting pre-schoolers and high needs children
- A mixture of school based clinics and mobile clinics
- The development of some community based clinics
- Increasing links with other primary care services
- Extended and more flexible opening hours particularly at the fixed community clinics
- Developing more effective information technology
- Increasing the use of fissure sealants
- Employing dental educators
- Exploring the possibility of ways to work with whole families in the future

In conjunction with the above strategic direction, four major specific projects are also under development by ARDS. The individualised dental care project aims to offer the appropriate evidence-based care to each child and involves the development of a risk assessment tool to help determine appropriate care, including clinical prevention procedures. The accommodation and facilities project has strong links to the school dental service review and includes determining the mix of facilities that will be needed to support the service in its desired direction, especially integrating with primary care. The information and communication technology project will seek to enhance ARDS information systems so there is easily transferable and shareable information with primary care and other services, access to dental records from any site, and less time needed by dental therapists on data input. The pre-school project

aims to determine the resources necessary to deliver pre-school services that fulfil international best practice.

ARDS has also been exploring the option of employing some salaried dentists to provide SDB services and this work should encouraged by CMDHB. It will be necessary to continue to actively recruit dentists onto SDB and support those dentists currently providing SDB services. One way of supporting and encouraging dentists to continue with SDB work may be to provide some training for working with children. Other suggestions have been for the CMDHB to top up the funding or to allow dentists to see emergency cases during the day if a dental therapist is not easily reached.

The conscious oral sedation pilot has been developed in conjunction with the hospital service and local SDB providers and is designed to deliver treatments to children, many of whom are pre-schoolers, by conscious oral and inhalational sedation rather than by general anaesthetic and at sites within Counties Manukau rather than at Greenlane Hospital. It is attempting to improve access for these children, to reduce the need to use a general anaesthetic, and to decrease the waiting times at Greenlane Hospital for those children who need to be seen at Greenlane.

The Body Odyssey exhibition and health festival also offers a recruitment opportunity for the dental workforce. Interest has also been expressed in using the CMDHB mobile caravan to help promote dental workforce options.

13 Adolescent coverage and utilisation

Little is known about the oral health status of adolescents in Counties Manukau. Adolescent enrolment has been increasing and for those adolescents that enrol there are high rates of completion of the course of treatment. Nonetheless, the overall utilisation of this free service remains well below the MoH target of 85% utilisation. There is a general lack of awareness and easily accessible information regarding adolescent dental services, both in the community and amongst primary care workers and providers. Concerns over the transition of children from ARDS to adolescent providers have also been raised.

Recommendations:

- **Increase the utilisation of free oral health services, particularly among Maori, Pacific, and adolescents from areas of high deprivation**
- **CMDHB to identify a future funding track for expected increases in adolescent volumes**
- **Endorse the activities of the regional adolescent coordinator in working with schools, PHOs, Maori providers, Pacific providers and others to raise awareness of the service and to facilitate access**
- **Expand mobile adolescent services**
- **Carry out an evaluation of the mobile adolescent services**
- **Complement mobile services with the use of fixed clinics**
- **Encourage OHSA providers to report oral health status information and increase information sharing between ARDS and adolescent providers**
- **Continue to encourage dentists to move from GDB contracts to OHSA contracts**

The role of the regional adolescent coordinator has been expanded from working with schools and providers to establishing relationships across primary care and elsewhere. This provides the opportunity of raising the awareness of adolescent services among primary care, particularly among services that have contact with adolescents likely to be of high need, for example, AIMHI year 9 assessment process and teenage pregnancy units. The adolescent coordinator is also in a position to disseminate up-to-

date information on providers to primary care on a regular basis. There are also plans to re-design the enrolment form and pack to be more appealing to adolescents.

The regional adolescent coordinator can potentially direct energies to those geographical areas of greatest need and lowest enrolment. In order to do so, improved information is required regarding enrolment, accurate ethnicity recording, and most importantly oral health status information. In particular the latter would allow a review of the policy of mobile providers being assigned to low decile schools, to ensure services are being targeted appropriately. This in turn is related to an earlier recommendation of Gardner (2002) of the need to evaluate mobile services. There is good anecdotal evidence to suggest that they are a valuable asset but this requires confirmation.

With ongoing efforts to increase the overall level of utilisation of services by adolescents and a growing adolescent population in Counties Manukau, volumes are set to increase and funding needs to be identified for this accordingly. In order to improve the handover process from ARDS to adolescent providers, it may be necessary to find ways of sharing information between these two different services.

14 Other issues

Currently services to special needs patients are provided both by ARDS and the Auckland regional hospital dental service. There is some uncertainty over the responsibilities for the delivery of dental care to special needs patients, and concern that this group may be missing out as a consequence. The role and coverage of the hospital and school dental service would benefit from clarification. Access to the hospital for many of these patients is difficult and unpleasant and it has been suggested that a community setting is a much more appropriate environment for treatment. As a group these patients are considered by providers to have poor oral health and low service utilisation.

Recommendation:

- **Review oral health services to special needs patients**

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Draft Proposed Action Plan

Enablers	Year 1 (01.01.05 – 31.12.05)	Year 2 – 5
Information systems and management		
• Improved oral health status information	ARDS to report on pre-school oral health status (already commenced) Encourage the MoH to fund community surveys of oral health including in the adult age group Request that providers of adolescent services collect and report the required oral health status information as specified in OHSA	Consider a regional adolescent epidemiological survey through schools
• Improve information sharing and electronic links between primary care and oral health services	Increase information sharing between providers of pre-school services Collaborate with ARDS on their information and communication technology project Improve the information available to primary care about how to access oral health services and update this on a regular basis	Investigate the sharing of information between ARDS and adolescent providers to improve the handover process Encourage the inclusion of oral health on PHO practice management systems Work towards the inclusion of oral health on Kidslink
• Use oral health health status indicators at age 5 to monitor inequalities in children		
• Ensure consistency of ethnicity recording and coding across oral health services		
Funding and contracting		

• Increasing the prevention focus of oral health service contracts	Continue to encourage adolescent providers to move from General Dental Benefit contract to OHSA Finalise the Service Level Agreement between CMDHB and ARDS	
• CMDHB funding	Identify future funding track for expected increase in adolescent volumes Support and fund the work of the CMCOHG	
• Other	Inclusion in contracts with those who provide antenatal care of the requirement to attend health education training sessions Increased reporting requirements in Relief of Pain contracts	
Facilities development		
• Support the development of some strategically placed community clinics	Community clinic pilot site at Buckland Road, Mangere Review DHB facilities policy for rental agreements	Align with ARDS developments and community clinic sites Align with ADHB Regional Oral Health Service regarding community clinics Other potential sites include Manukau Institute of Technology, Manurewa, Papakura
• Continue the use of mobile and school based services		Community clinics to act as a base for mobile and/or outreach services ARDS to upgrade many school clinics
Workforce development		
• Assist with workforce recruitment and	Utilise Body Odyssey Health Festival as a	Link to wider workforce development programmes

involvement of Maori and Pacific in dental workforce	recruitment opportunity Continue with South Auckland Foundation dental therapy scholarships for Maori and Pacific students	
• Continue to actively recruit dentists onto SDB and support those dentists currently providing SDB services		Offer training opportunities to community dentists for working with children
• Collaboration with educational institutions to offer training opportunities, particularly in adult dental care	Continue to pursue links with Auckland University of Technology	
• Carry out awareness raising and education of oral health issues with primary care workers	CMCOHG to carry on with their continuing medical education programme and up-skilling of the primary care workforce in child oral health issues	To extend primary care continuing medical education on oral health issues to cover adults, particularly chronic care patients and the elderly
Collaboration and partnerships		
• Implementation of the Oral Health Plan in conjunction with Maori	Identify appropriate groups and processes to allow participation and partnership with Maori Link the Oral Health Plan with the CMDHB Maori Health Plan	Explore the potential for partnership with Maori in the development of community clinics and service networks
• Implementation of the Oral Health Plan in conjunction with Pacific	Identify appropriate groups and processes for the involvement of Pacific with the ongoing implementation of the Oral Health Plan Link the implementation of the Oral Health Plan with the new CMDHB Pacific Health Plan	Explore the potential for partnership with Pacific in the development of community clinics and service networks
• Identifying as many opportunities as possible	Primary care to facilitate the utilisation of oral	Involve PHOs and primary care in the development

for the increased involvement of primary care	health services in all age groups Encourage joint service delivery projects between primary care and oral health services	of any community clinics and service networks
• Endorse the activities of the regional adolescent coordinator		
• Endorse regional and national discussion concerning WINZ and ACC funding for dental care		

Service Development — Year 1 (01.01.05 – 31.12.05) — Year 2 – 5

Development of new services and models of care		
• Facilitation services	Develop some form of facilitation and coordination service to help people access existing oral health services Utilise existing community health worker networks to facilitate enrolment and attendance at free oral health services Encourage Wellchild providers to facilitate enrolment with ARDS	
• Mothers	Utilise services that have contact with mothers for the promotion of oral health issues Consider funding some form of general dental care to pregnant mothers, targeted at Maori, Pacific, and low income mothers-to-be	Assist PHOs in the development of oral health SIA initiatives

• Low income adults	Explore the possibility of providing a mobile outreach service for adults, particularly in rural areas Explore the involvement and role of ADHB Regional Oral Health Service	Assist PHOs in the development of oral health SIA initiatives Priority group for new funding
• Explore options for offering whole family services		Support and encourage the development of kaupapa Maori oral health services Support and encourage by Pacific for Pacific providers and PHOs in offering oral health services
• Explore alternative models of care for SDB provision	Continue with the development of the pilot using conscious oral and inhalational sedation	
Developments to existing services		
• Auckland Regional Dental Service(ARDS)	Collaborate with ARDS on pre-school project Request a review of the ARDS consent process ARDS and CMCOHG to develop strategies for hard to reach children CMCOHG to work with ARDS on improving the enrolment form	
• Adolescent service	Provide adolescent service information and enrolment packs to AIMHI schools year 9 assessment, teenage pregnancy units, and other appropriate adolescent services Link proposed/planned school teenage pregnancy units with school adolescent mobile providers	Carry out an evaluation of adolescent mobile services

• Other services	Review oral health services for special needs children, adolescents, and adults Increase relief of pain volumes and coverage Continue and expand South Seas facilitation service for pre-schoolers	Work with relevant Maori service providers on how to incorporate oral health into their existing services Work with relevant Pacific service providers on how to incorporate oral health into their existing services Work with ADHB Regional Oral Health Service
Alignment and collaboration with other service developments		
• Align with ARDS projects and initiatives and results of the national school dental review		
• Collaborate with the activities of the adolescent services coordinator	Awareness raising of adolescent services among providers of services to young people, particularly those with contact with high needs adolescents Promote access to care for special needs adolescents Development and distribution of a new enrolment pack Information provision to primary care of providers of adolescent care Primary care facilitation and assistance with enrolment	

Prevention Activities	**Year 1(01.01.05 – 31.12.05)**	**Year 2 - 5**
Oral health promotion and education		
• CMDHB to adopt a positive water	Pursue continuance of water fluoridation	Work with local authorities to increase and maintain

fluoridation policy	advocacy role in Auckland with ARPHS and MoH public health directorate Consider using Northland DHB water fluoridation policy as a model	fluoridated water supplies
• Target oral health promotion and education to areas without water fluoridation	Explore the school brush-in initiative from Northland as an option for rural schools to encourage tooth brushing with fluoride toothpaste	
• Primary care to be part of the delivery of oral health education and promotion	Free toothbrushes at immunisation or other Wellchild events Encourage the inclusion of oral health education in antenatal classes Utilise primary care services that have contact with mothers for oral health promotion	PHO health promotion work to encompass supporting water fluoridation Primary care to emphasise the importance of oral health in certain adult groups; diabetics, rheumatic heart disease patients, elderly on multiple medication
• Other activities	Utilise the Body Odyssey Health Festival as an oral health education and promotion opportunity Oral health promotion services to continue to provide oral health promotion at the group level, particularly to Maori and Pacific communities Link with Housing New Zealand (Clendon renewal project) toothbrush initiative Ensure that information regarding oral health services and oral health messages are appropriate for Maori and a Maori language option	

	Ensure that information regarding oral health services and oral health messages are appropriate for Pacific.
• Incorporate oral health promotion and prevention into other relevant areas of health	Endorse and continue breastfeeding initiatives Identify overlap of oral health nutrition issues with obesity prevention and Diabetes strategy
Oral health services and prevention	
• Endorse and encourage the use of clinical prevention procedures as appropriate e.g. fissure sealant	Support ARDS individualised care project Endorse the increased use of fissure sealants and other clinical preventive measures by ARDS High risk children and adolescents in unfluoridated areas to have appropriate clinical interventions to assist in prevention
• Increasing utilisation of oral health services by priority groups	

Appendix 1 – Oral Health Reference Group

Membership

Kirstin Lindberg, CMDHB

Sue Dashfield, CMDHB

Shirlee Fistonich, Oral Health Manager, NDSA

Dr Alan Simpson, Community Paediatrician at KidzFirst and Representative of Counties Manukau Child Oral Health Group

John Falkiner, Mighty Mouth Dental

Mike Lamont

Binki Tapau and Mavis Roberts, Hapai Te Hauora Tapui

Sena Mikha, People's Centre

Mamere Ah Hing, Work and Income New Zealand

Linda Huron/Doreen Morrison, Auckland Regional Dental Service

Dr Luteru, Pacific dentist

Dr Clive Ross, Clinical Director, Oral Health Regional Service

Meetings

June 17th

August 11th

October 14th

December 8th

Appendix 2 – Stakeholders and linkages

Regional DHB Dental Group

NDSA Oral Health Manager

Counties Manukau Child Oral Health Group

Primary Health Organisations

Auckland Regional Dental Service (School Dental Service)

Oral Health Regional Service (hospital service)

Mighty Mouth Dental

Regional adolescent coordinator

Community dentists

Wellchild providers

Auckland University of Technology

South Seas Healthcare

KidzFirst

Maori

Pacific

Local authorities

Appendix 3 – Counties Manukau Child Oral Health Group Members

Community Paediatrics, KidzFirst

Auckland Regional Dental Service

Total Healthcare Otara PHO

Procare PHO

Hapai Te Hauora Tapui

South Seas Healthcare/Ta Pasefika PHO

Mighty Mouth Dental

Plunket

South Auckland Health Foundation