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Te Toka Tumai

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15 February 2021

[redacted]

Re: Official Information Act request – Oral Health Reports

I refer to your Official Information Act request dated 25 January 2021 requesting the following information:

1. **A copy of an information paper describing the status of oral health in the Auckland Region that was presented to Auckland DHB's Community and Public Health Advisory Committee**
2. **A copy of any report or any document that resulted from an urgent review into oral health end-to-end service improvement from 0 to 18 years in the Auckland region, and a copy of any document outlining the scope and reason for the review.**

1. **A copy of an information paper describing the status of oral health in the Auckland Region that was presented to Auckland DHB's Community and Public Health Advisory Committee.**

Auckland DHB's Board meeting agendas and minutes are available to the public. The information paper describing the status of oral health in the Auckland region that was presented to the Community and Public Health Advisory Committee in November 2020 is available at the following link:

https://www.adhb.health.nz/assets/Documents/About-Us/Board-agendas-and-minutes/2020/CPHAC-Meeting-Pack-18-Nov-2020.pdf

2. **A copy of any report or any document that resulted from an urgent review into oral health end-to-end service improvement from 0 to 18 years in the Auckland region, and a copy of any document outlining the scope and reason for the review.**

The Community and Public Health Advisory Committee paper highlights the need for the review. Attached is the proposal made by the Northern Region Alliance on behalf of four Northern DHBs; Northland DHB, Waitematā DHB, Auckland DHB and Counties Manukau DHB, to the Ministry of

Health, for a review. Please note that the contact details of staff have been redacted under section 9(2)(a) of the Official Information Act to protect their privacy.

The process is in its initial stages, so as yet no reports or documentation has been produced from the proposed review.

I trust this information meets your requirements. You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602. Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

Ailsa Claire, OBE
Chief Executive of Te Toka Tumai (Auckland District Health Board)

DHB Led System Improvement Sustainability Initiative:

Northern Region Oral Health End to End Service Improvement Initiative

Submitted by: Northern Region Alliance on behalf of the 4 Northern DHBs: Northland DHB (NDHB), Waitematā DHB (WDHB), Auckland DHB (ADHB) and Counties Manukau DHB (CMDHB)

Project Name	Northern Region Oral Health End to End Service Improvement Initiative
Executive Leads and sponsors	Co led with a Regional Executive Lead and a Regional Equity Lead from across the Northern Region.
Project Manager	Regional Project Manager: Jennifer Kane/NRA, Project Management support
Service / Area	Oral Health for 0-18 year olds across the end to end continuum of care from public health prevention to specialist hospital services
Contact	Kim Arcus (Portfolio Manager, NRA) [redacted] Phone/mobile: [redacted]
Alternate Contact	Jennifer Kane (Project Manager, NRA) [redacted] Phone/mobile: [redacted]

Background	**Background** Across our Northern Region, we are struggling to achieve the level of oral health we would like for our tamariki, particularly our Māori and Pacifica children. Dental disease is a leading cause of potentially preventable admissions to hospital for young children, as well as a significant source of inequity for Māori and Pacific, compared to other, populations. Oral diseases disproportionately affect poorer groups and are closely linked to socioeconomic status and the broader determinants of health. Māori and Pacific children experience much higher rates of dental decay and tooth extractions, and there is no evidence that these inequities have narrowed over the last two decades. These children experience high rates of dental caries but also face a number of barriers to accessing care with high wait times and delays in care. For example, in Metro Auckland alone we currently have 1,700 tamariki awaiting oral surgery to extract teeth. That's a classroom of children (~33), aged mainly 3-6 years old, needing a surgical extraction under anaesthetic, every week for a year. To make things worse, this has been exacerbated during the recent COVID lockdowns where routine oral health services were unable to operate, making these waits and delays worse. Public health prevention and health promotion efforts to stop caries developing in the first place are variable across the region. For example, there are high fluoridation rates in Auckland but not in Northland with different approaches to fluoride applications. There is potential to be more comprehensive and coordinated across the region. When tamariki experience poor oral health it affects multiple aspects of their lives. From nutrition and sleep to support their physical and mental development through to education and being able to concentrate at school as well as their overall wellbeing and wairua, to name but a few. Dental disease is largely preventable through the early establishment of good oral hygiene practices, reduced sugar consumption, effective oral health promotion and good access to primary dental care.

	As a Northern Region, we want to do better for our tamariki. We have some operational improvements planned or underway already. A hospital surgical oral health service initiative at ADHB (as the lead specialist dental provider for Metro-Auckland) supported by the MoH's Planned Care Fund Initiative. There is also a Community Oral Health improvement initiative within the Auckland Regional Dental Service (ARDS) being proposed as a separate Sustainability Fund proposal to sit alongside this one. However, these two operational service improvement projects are focussed on process improvement and efficiency, and on their own will not be sufficient to achieve the level of oral health desired in the Northern Region. A significantly redesigned equity focused end to end model of care across the oral health continuum is needed. Therefore, in addition to these two operational improvement initiatives, it is proposed an overarching regional initiative is established with a particular focus on equity and the end to end model of care, integration, service design and commissioning/ financial incentives to achieve our desired goals. The two operational projects will be closely tied in and will evolve as the model of care evolves by reporting to and being overseen by this project as outlined in Appendix 1.
Aim & Objectives	**Aim:** With a focus on equity, to improve the oral health of our tamariki in the Northern Region through an improved model of care across the continuum resulting in improved prevention, improved oral health outcomes, reduced dental caries and improved access to services. **Objectives:** With a focus on equity, to redesign an end to end model of care for oral health with improved service access, integration and commissioning/funding arrangements for children (birth to 12 years) and adolescents (13 to 18 years) across the Northern Region. The objectives include: • Collating and assimilating the various national, regional and local reports, evaluations and initiatives done in the past into a combined regional needs analysis and literature review. • Gain a better understanding of current patient flows, experience and barriers faced by whanau currently, with a particular focus on Māori and Pacific • Co-designing and modelling different future end to end options to understand the configuration and scale of services and potential impact on oral health outcomes and inequities. • Confirming the appropriate scale of services and measures required for maximising individual and population based disease prevention, prioritising populations and geographies with the greatest need. • Identifying areas for service improvement, integration and optimisation including areas to maximise early engagement, prevention, and intervention. • Ensuring that there is a sufficiently skilled and culturally competent workforce to deliver the proposed model of care • Further enhancing collaboration and integration of resources between service providers (e.g. between kaupapa Māori, community, hospital and public health and oral health providers) • The development of an implementation and monitoring plan including on-going regional governance (leveraging and evolving existing work), workforce, IT, facilities (including mobile facilities), asset ownership, funding and reporting.
Actions to Address Equity	The project will be focused on short, medium and long term plans that improve oral health outcomes and reduce inequities. Patient and whānau needs will be a central focus for all project work.

	Māori and Pacific clinicians, patients/whānau, and communities will be directly involved in the co-design of the service. Future Model of Care arrangements and service design will take into consideration the four articles of the Treaty of Waitangi and the WAI2575 Treaty Findings and principles. Recommendations will be reviewed by Te Kaahui Arataki (the Regional Māori Clinical Governance Group) and Pacific Clinical Technical Advisory Group for feedback. The community co-design process will include a focus on: • Ensuring the opportunity for patients and whaanau to self-determine their own oral health outcomes • Ways to improve care outcomes, access & patient experience, including increasing communication collaboration and co-ordination of care to work across boundaries. • Population health interventions to address risk factors, focusing on shifting from reactive to proactive care, prevention and early intervention.
Funding	Funding Element: This project falls under all 3 funding themes of this Fund: • Development of DHB cost savings and financial sustainability where is the ability with the right configuration to be more efficient and sustainable • Improving equity with an over focus on Māori and Pacific as well as an element of regional equity of access across the four DHBs • Service improvement aligned to the Ministry of Health measures including the range of Oral Health KPIs and ESPI targets reported to the MoH
Scope / Deliverables	**In Scope** • End-to-end child (birth to 12 years) and adolescent (13 to 18 years) publically funded oral health services in the Northern Region (including NDHB, WDHB, ADHB and CMDHB) • Model of Care Improvements in publically funded community and hospital oral health, focusing on optimal care and service delivery • Oral health promotion and public health strategies • Oral health KPI measurements with a focus on localities **Out of Scope** • Oral Health for adult and older persons (which in general is not publicly funded) • Operational management and delivery of activity at the service location level • Operational activity relating to other work streams • Implementation of recommendations **Deliverables** The main deliverables of this project will be: • A regional oral health needs analysis and summary of national and international work and findings to date • A patient pathway and experience map with a focus on Māori and Pacific • Agreed models of care and service standards for community and hospital child and adolescent oral health that is aligned to population need and demand. • Regionally agreed oral health prevention strategies with a focus on Māori, Pacific and high needs and vulnerable population groups. • Regionally agreed oral health outcomes and measurements with a focus on Māori, Pacific and high needs and vulnerable population groups. • Regionally agreed multi-year implementation and funding and asset proposal to improve equity of access and overall oral health status. Success Factors include obtaining regional agreement on all key deliverables, with a clear implementation plan at the end of the project. Having Māori and Pacific clinical and

	community engagement will be critical to project success.
Timescale & Milestones	

Milestones & Tasks	Date
Recruit Clinical Lead and Data Analyst	Nov 2020
Formation of Project Team and Governance including the operational service improvement sub-projects	Nov 2020
End-to-end pathway: Patient Journey Mapping	Dec 2020
Collect Service Delivery Data	Dec 2020
Complete initial regional and localities analysis	Jan 2021
Co-design Workshop: Patient stories and experience	Feb 2021
Identify Service Touch Points and Hot Spots	Feb 2021
Co-design Workshop: Near to Long Term Vision	March 2021
Complete stakeholder needs analysis (based on workshop findings)	April 2021
Collate stakeholder feedback on identified options	April 2021
Improvement analysis: SWIFT (Strengths, Weaknesses, Individuality, Fixes and Transformation)	April 2021
Improvement analysis: data modelling and localities analysis	April 2021
Service blueprint: model of care improvements	June 2021
Identified prevention strategies	June 2021
Multi-year implementation plan and funding plan including regionally agreed oral health outcomes and measurements, oversight and governance	June 2021

Project Structure & Resources

Project Structure and Governance:

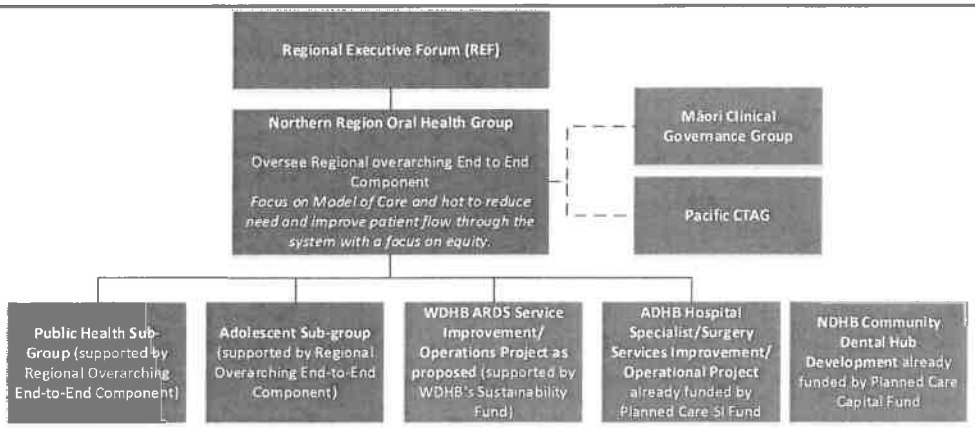
Governance:

An overarching Northern Region Oral Health Strategy Group will be established with an equity focused membership to oversee both this project and other strategic oral health issues in the Northern Region. The group will be a variant of one previously proposed by the Regional Oral Health Group but with stronger executive leadership, equity and links to the operational improvement initiatives via input from the chairs of each of those project groups as well as input from Northland.

The group will regularly seek input and advice from the Regional Māori Clinical Goverannce Roopu and Pacific Clinical Technical Advisory Group and be co-lead by a nominated lead from one of those groups.

Analysis, deliberations and recommendations will be done with an equity lens first and whole of population lens second to reinforce the equity focus of this activity.

This governance group will report to, and ultimately make final recommendations to, the Regional Executive Forum which is made up of the four DHB CEOs and four CMOs across the Northern Region.



Operational sub-groups will or have already been established for the ARDS and ARHSD service improvement projects. The chair of these project groups will be a member of this overarching strategic group. Given those two initiatives are Auckland centric, provision would also be made for operational input from Northland.

Two smaller new sub-groups will be established. One for oral health promotion/public health prevention and one for adolescent oral health. Similarly, the chairs of those groups will sit on the overarching strategic group.

Project Team:
To progress and support the work the Northern Region Alliance (NRA) acting on behalf of the region will employ a Project Manager, an Independent Clinical Lead (potentially out of region), a Data Analyst (with a particular focus on equity), and contract in additional expertise as needed. The project will consist of the main project work focusing on the model of care initiative as well as public health prevention measures and improvements to adolescent service delivery. Members of the project team will include and co-opt oral health clinical and service delivery roles at one of the four northern DHBs. Members will be nominated by their respective DHBs.

Required resources:

- Project Manager (1.0 FTE)
- Clinical lead(s) (0.2 FTE), independent of the northern region.
- Data Analyst (0.2 FTE) required for localities analysis and modelling
- Co-design workshops and consumer feedback sessions with at least one with Māori and one with Pacific

Dependencies and risk

Key Risks to the project progressing as planned:

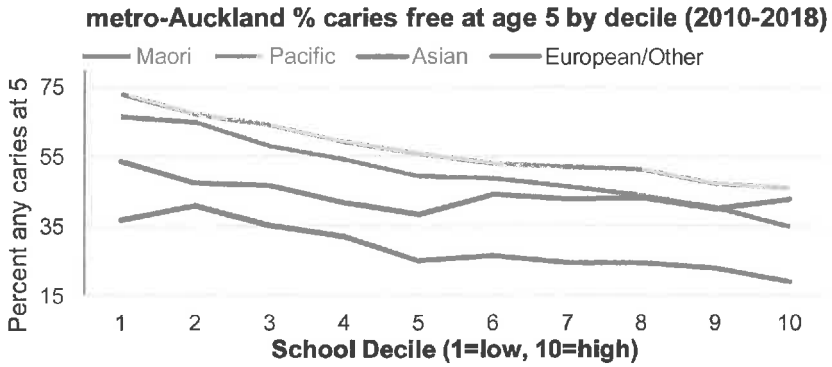
Identified Risk	Mitigation Strategy
Force majeure (e.g. COVID-19 emergence, natural disaster/emergency)	• Establish regional ways of working within the project group • Develop contingency plan for running co-design workshops • Identify which work can continue during Level 4 and Level 3 lock down

	Scope is ill defined and project team misunderstands requirements	• During project initiation, project scope workshopped with project group • All team members agree and sign off on the project scope and deliverables
	Unable to come to an agreement: stakeholder differences over proposed changes	• Obtain upfront agreement with project group on methods for addressing differences in opinion
	Project deliverable is not sustainable and is not adopted within the service	• Service managers and clinicians involved in design process, ensuring that deliverables are practical within service
	Delays to stakeholder approvals impact the project	• Have clear timelines with due dates • Options are provided to stakeholders for decision making
	Constraints • While the clinical lead and project manager will be dedicated to this project a broader project team will consist of other DHB representatives, clinicians and staff. Their ability to participate in project activities will need to be balanced by their day-to-day 'business as usual' activities. • Data may have inaccuracies that will be hard to mitigate and there is minimal to no data on oral disease prevalence for adolescents. **Dependencies**: • This project relates to other initiatives being run and/or proposed in the Northern Region. This includes the approved Planned Care Improvement Initiative for Oral Health at ADHB, Planned Care Capital Fund Community Dental Hub Development at NDHB and the proposed Sustainability Funding Proposal for ARDS led by WDHB. • Additionally work being done nationally and locally may impact the project outputs. This includes work previously done within the Northern Region Oral Health Group and the National Oral Health Group: CDA Review, and the National Oral Health Promotion Strategy.	
Budget	Expected total cost based on resources listed below: **$170,000** • Project Manager (1.0 FTE) • Clinical lead (0.2 FTE) • Data Analyst (0.2 FTE) • Co-design (consumers, venue, catering, etc.)	
Data & Measures	Substantial oral health inequities exist, with Māori and Pacific children and adolescents and those from lower socio-economic areas having a higher number of tooth extractions due to decay, infection or disease. Oral Health is an area facing sustainability pressures and long waits for children and adolescents both in community and hospital setting. Auckland Regional Dental Service (ARDS) and Northland DHB have established oral health service reporting to HAC/CPHAC and MoH. This includes the following: • Pre-school (0-4) o Percentage of infants enrolled at 2 years (CPHAC) and 0-4 years (MoH) by ethnicity o Percentage of enrolled utilisation at 2 years (CPHAC) and 0-4 years	

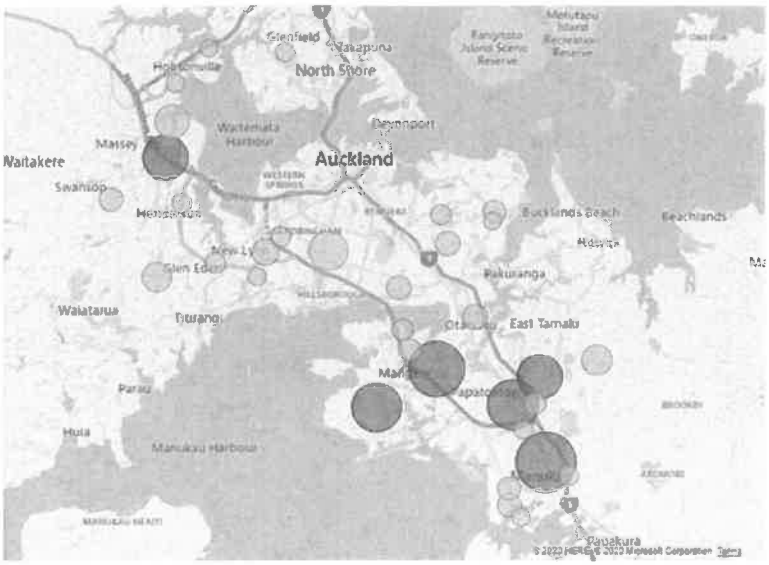
(MoH) by ethnicity
    - Percentage of exam arrears and/or when children were last seen for 0-4 years by ethnicity (HAC and MoH)
    - Number/percentage of children caries free at age 5 (annual)
    - Mean decayed, missing or filled teeth (DMFT) at age 5 (annual)
- Childhood (5 – age 12 or school year 8)
    - Percentage of exam arrears for children aged 5 – Year 8 by ethnicity (HAC and MoH)
    - Ratio of DMFT at year 8

Adolescents (school year 9 or age 13 to age 17) data for both metro Auckland and Northland DHB is reported by utilisation percentage (annually when available) by ethnicity (MoH)

The data shows that Māori and Pacific children have poor oral health across all school/education deciles.



In metro-Auckland, 48% of secondary services referrals come from Māori and Pacific children primarily residing in South and West Auckland.



This project will aim to expand on the existing data reported, to provide localities based

	view to aid in Model of Care improvements.
Sustainability & Spread	From the outset this initiative is being designed as a regional project with the explicit intent it is implemented across the region as a whole. Many services are already delivered on a metro-Auckland basis so any change to those services will have an impact across at least three DHBs. This may include the development of locality specific solutions to population needs in order to improve oral health outcomes and equity. To assist with the roll out process, Service Managers and Clinicians views will be sought as inputs to the regional design process. Their input will help ensure the key Model of Care implementation components have been considered. An implementation plan associated with the final recommendations will be included to ensure roll out across the region is implementable within the resources available.
Authorisation	This is an initiative has the support of the Regional Executive Forum which is made up of all four DHB Chief Executives and CMOs in the Northern Region. Similarly, the four Regional Chief Executives have agreed to put this bid forward through funding pooled regionally from the individual DHB allocations as part of the overall Regional response to the Ministry's Sustainability Funding initiative. This individual bid has been reviewed and supported by Oral Health planning and funding leads across the region.

Northern Regional Alliance
He Hononga o te Raki

Appendix 1 – Regional Oral Health Project overview and reporting structures

Regional Overarching End to End Oral Health Improvement Initiative (this proposal)
A focus on equity, and with that, the best model of care across the continuum, reduced barriers to access, improved integration between services, commissioning and improved performance.

Public Health/ Prevention sub group (supported through this proposal)

Adolescent sub group (supported through this proposal)

ARDS (WDHB) Service Improvement/ Operational Project with focus on service redesign, workforce and mobile clinic design (see separate Sustainability Fund proposal as a partner to this proposal ~$195k)

ARHSD (ADHB) Hospital Specialist Dentistry Service Improvement/ Operational Project as already funded by Planned Care Initiative Service Improvement Fund. Focus on equity, pathways, efficiency, and surgical capacity in the community $195k

NDHB Community Dental Hub Development as already funded by Planned Care Capital Fund $4.2m