TARANAKI COMMUNITY ORAL HEALTH SERVICES

CONSULTATION REPORT

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Contents

Executive Summary

This Consultation Report outlines the outcomes of the consultation process undertaken by Taranaki District Health Board on proposed changes to the delivery of the Community Oral Health Service.

The key purpose of the consultation was to engage and obtain the views of family/whanau, young people, oral health professionals and community groups on the proposed changes to the School Dental Service to assist in the development of future models of service delivery. This new Community Oral Health Service model seeks to address the current oral health inequalities that are present in Taranaki while meeting the requirements that are specified in the Ministry of Health's oral health strategic vision document: *Good Oral Health for All, for Life (2006).*

Consultation involved a broad range of groups including oral health professionals; parents; young people; primary and secondary health care professionals; Māori Health Care Providers; and the early, primary and secondary education sector. A mixed methodology of stakeholder interviews, focus groups, questionnaires, on-line surveys and a formal submission process were used to encourage and enable broad participation from all stakeholders. A Māori Health Care Providers working group was also set up to develop a whanau ora model of service delivery that would respond to and address the oral health inequalities faced by Māori.

Over 600 people participated in the consultation, the majority of whom were parents and young people, and a mixture of responses were generated. The responses from parents/caregivers, young people, oral health professionals and Māori Health Care Providers are summarised as follows:

Parents/Caregivers/Families/Whanau:

The most commonly raised concerns related to reduced access to services as a result of moving clinics off school sites. Particular concerns were expressed about the impacts of the changes on lower socio-economic groups. There was a concern that some families/whanau would be less likely to use the service as a result. Many parents in particular expressed disappointment that the service was going to change, highlighting that on-site clinics met their needs very well and that access to the service was easy.

On a more positive note, many parents were pleased to see the service updating and felt that as long as access was improved in other ways (e.g. extending opening hours) then the change was to be welcomed.

When asked what would make oral health care a better experience for parents, caregivers, families/whanau, parents most commonly expressed the following:

- Seeing the same therapist at each visit
- Better communication between schools, dental service and families
- Provision of more oral health education and health promotion

When asked what would make access to the oral health service easier, the following suggestions were most often expressed:

- Flexible appointment times
- Open during school holidays
- Extended opening hours

Young People:

Some of the issues raised by young people were quite different from those raised by parents in that they focused on the clinic environment and clinic staff, as well as access to the service. The most commonly suggested means of making oral health services more attractive to adolescents were as follows:

- Providing oral health services within high schools
- Friendly staff on the dental team
- More colourful clinics
- Sending email/text appointment reminders
- Providing an annual mobile dental service (bus) visit to high schools

Analysis of the comments provided by young people highlighted the importance of providing a service and environment that is young people friendly – friendly staff, comfortable clinics with music and magazines and being able to bring friends for support being some of the examples given. The importance of advertising the service (including the fact that it is free) through modern media (internet as well as radio and newspapers) and using modern communication methods (text, email) was also stressed.

Oral Health Professionals:

As with parents, the key concerns of oral health professionals was the risk that health inequalities could be worsened by moving clinics off site, making access for vulnerable groups more difficult. Despite this, there was a common acceptance that the service needed updating and that the new service would offer opportunities for dental therapists to work together, reducing isolation and promoting professional development. The changes were seen by some as being an opportunity to provide an enhanced service or alternative models of service delivery within more modern and appropriate facilities. However, the move to central clinics also raised concerns about the limitations of the Community Oral Health Service in meeting the new service demands and the risk of exacerbating oral health inequalities, particularly in low decile schools and some rural areas.

In response to these issues, a number of suggestions were made. These included new models of service delivery and service improvements; greater partnership working; more advertising and promotion; and strategies to improve access. The need for ongoing communication and effective change management was identified as a key to the success of the project in future.

Māori Health Care Providers (Focus Group):

Māori Health Care Providers highlighted the importance of ensuring the new service was both accessible and affordable. For those with access difficulties, it was suggested that transport be provided. However, access was not seen purely in terms of location – it was acknowledged that access could also be improved through the provision of a more culturally appropriate service, through the employment of more Māori dental staff and the use of bi-lingual clinic signage. Access could also be

improved by extending opening hours and giving people a choice of which clinic to attend.

Other suggestions included making use of local community knowledge, for example using key contact people, to encourage more Māori to access the service. Using whanau members in the community to deliver oral health education was another idea. The importance of providing a comfortable and user friendly environment to young people was also highlighted.

Māori Health Care Providers (Working Group):

The re-orientated Taranaki Community Oral Health Service must be aligned to He Korowai Oranga, the National Māori Health Strategy and the TDHB Māori Health Plan and Reducing Inequalities Policy Document. The Māori Health Care Providers working group has identified a number of service delivery recommendations to support this aim. These recommendations are included in the key recommendations for consideration by the TDHB Community Oral Health Implementation Steering Group.

The Māori Health Care Providers working group recommended that the Taranaki Community Oral Health Service be re-orientated to reflect a whanau ora model of service delivery. This model has been defined for this project as "Wellness and wellbeing of the whanau as a whole, a holistic approach to health which includes oral health."

The working group believe that a whanau ora model of service delivery can be enhanced by co-locating the Taranaki Community Oral Health Service with the Māori Health Care Providers. It is important that a team culture be developed and nurtured between the Māori Health Care Providers, community oral health educators / promoters and the TDHB oral health clinicians.

The training of current and future oral health team members in tikanga and the application of the principles of the Treaty of Waitangi to their practice is seen as crucial to providing an oral health service that is culturally appropriate, responsive to the needs of Māori and addresses the current oral health disparities.

1.0 Background

Good oral health is integral to general health and wellbeing. Improving the oral health of the Taranaki community is an identified priority in the strategic direction of the Taranaki District Health Board (TDHB) and is consistent with the TDHB District Strategic Plan 2005 – 2015 and the District Annual Plan 2006 – 2007.

In August 2006 the Ministry of Health released *"Good Oral Health for All, for Life – The Strategic Vision for Oral Health in New Zealand"*. In this document the Minister of Health confirms the Governments intent to invest in community based oral health services making them a visible and integrated part of primary health care. The first Action Area identified by the Ministry of Health is the re-orientation of Child and Adolescent Oral Health Services.

Taranaki DHB has developed a Business Case based on Ministry of Health guidance within "*Business Case Guidelines for Investment in Oral Health Services"* and *"Community Oral Health Service Facility Design Guidelines" (August 2006).* The service configuration proposed is designed to evolve into a Whanau Ora / Family Oral Health Service in future that can treat low income adults in a community based setting.

The direction for the Business Case has been set by the Taranaki District Health Board's "*(Taranaki) Child and Adolescent Oral Health Plan",* approved on 9 June 2005. Board level support was confirmed when the Taranaki DHB Community and Public Health Advisory Committee (CPHAC) moved on 24 October 2006 "*That the Community and Public Health Advisory Committee recommend to the Taranaki District Health Board the endorsement of the Taranaki Child and Adolescent Oral Health Plan."*

To support this direction, Taranaki DHB has developed a strategic vision that has the potential to improve oral health outcomes for its children and adolescents (aged 0–18 years). The strategic vision incorporates services across the continuum of care. Health promotion, preventive and educative strategies targeting individuals and populations, and can influence behavioural changes to mediate some, but not all, of the association between socio–economic determinants and oral health outcomes.

The caries rate and uptake of current services to early pre-school children and adolescents in Taranaki is of concern, particularly in the Māori and Pacific populations. It is expected that promotion and social acceptance of good oral health habits from an early age, reinforced during adolescence, will help mitigate caries development. Oral health activities must also be linked to other major health directions to improve health and wellbeing such as obesity, nutrition, diabetes and physical wellbeing, smokefree and smoking cessation.

The current Taranaki School Dental Service which successfully treats 99 percent of children from Year 1 to Year 8 is proposed to evolve into a Community Oral Health Service treating children and adolescents 0–18 years in line with the Ministry of Health's direction. The Clinics will be sited in communities with high identified oral health needs, either on DHB owned land, Iwi land, school sites or aligned to current primary care services. To maximise service coverage and where a fixed site is not appropriate mobile service delivery is incorporated into the service model.

Adolescents will be targeted to improve the current estimated 54 percent treatment rate, with adolescents able to receive service from public or private providers supported by the existing adolescent dental co–ordination service. For maximum effectiveness, initiatives need to be delivered in ways appropriate to the priority groups of Māori, Pacific peoples and families with low socio-economic status.

The analysis that has been undertaken as part of the development of the Taranaki DHB Business Case indicates a number of key inequalities and determinants of health:

- Early pre–school enrolment levels are low and disproportionately lower for Pacific and Māori children
- All ethnic groups have an increasing number of decayed, missing, and filled primary teeth (dmf) at age five, but the dmf is worse for Māori and Pacific children compared with other children

- Māori and Pacific five–year–olds have a significantly higher dmf and a smaller proportion is caries free than other five–year olds
- Access to dental services appears to influence the inequality trends
- Oral health status improves for all ethnic groups at age 12, in contrast to status at age five
- Inequalities in oral health status at age 12 are widening between the lowest socio-economic group children and other children
- Access to Fluoridated water has a direct and measurable impact on oral health outcomes

Acknowledging these issues and noting the Ministry of Health's commitment to improving oral health outcomes through the re-orientation of child and adolescent oral health services, Taranaki District Health Board has developed a model of **Community Oral Health Service Clinics and Outreach Services.** This is a 'hub and spoke model' comprising of community fixed–site clinics with mobile treatment outreach services and health promotion services.

The key features of the option below may change depending on the decisions made after analysis of the stakeholder consultation and it is also dependent on the actual funding received from the Ministry of Health.

- The closure of the 30 existing Taranaki School Dental Service Clinics
- The proposed establishment of seven new Community Oral Health Service Clinics
- The construction and deployment of two motorised Community Oral Health Service mobile dental units
- The deployment of a Community Oral Health Service Dental Caravan for examinations and treatment

The establishment of this service was proposed to be over 36 months from the time the funding for Phase One was approved by the Ministry of Health in March 2007.

Funding is essential to realise this vision which will involve considerable capital investment and ongoing additional operational investment. In total, Taranaki DHB is seeking capital funding of $3.68 million from the Ministry of Health, additionally $902,539.00 of new annual operational funding will be required. Capital funding requirements over the three establishment phases are, Phase One: $1.63 million, Phase Two: $1.64 million, Phase Three: $0.58 million. The full impact of the Operational Funding increase would be in Phase Three.

While Taranaki DHB supports the model and vision presented in the Business Case, if all of the new funding is not available in line with the indicated cost estimates, Taranaki DHB will not be able to establish the Taranaki Community Oral Health Service to the extent or within the time frames indicated. Taranaki DHB would consider some reprioritisation of existing funding to support this service model however, this would have implications for overall DHB funding prioritisation and would have to be balanced against other health needs.

A detailed consultation on facility siting, service initiatives and model of service delivery was initiated in October 2007 and has now been completed. Meaningful consultation and public discussion is fundamental to support the roll out of any funding allocated to this vision of Community Oral Health Service in Taranaki. The implementation of this service will require ongoing change management facilitation and the support from both the Taranaki DHB and the Ministry of Health.

1.1 Objectives of Consultation

The consultation sought to engage affected families/whanau and individuals as well as professional and community groups to ensure quality decision making relating to the future design and implementation of the re-orientated publicly funded oral health service for 0-18 year olds in Taranaki.

The identified objectives of the consultation were as follows:

- Build positive relationships with stakeholders including consumers, TDHB oral health staff, private practice dentists, providers and the wider community
- Enhance decision making by receiving information, opinions, ideas and feedback from communities about their different needs and priorities, all of which helps to identify and avoid pitfalls in the service re-design process
- Maintain, and build upon, existing good relations with local Māori Health Care Providers and Iwi representatives to identify and address the factors that contribute to health inequalities between Māori and non-Māori
- Identify access barriers and service gaps in the Taranaki publicly funded oral health service for 0-18 year olds
- Ensure any changes to models of service delivery have broad political, professional and public support by encouraging community and sector ownership and support of decisions made
- Identify consumer perceptions and practices relating to oral health care that could be used to develop programmes aimed at promoting oral health
- Ensure that any future service re-design is driven by the needs of consumers, particularly those facing greatest inequality
- Maintain and build upon existing good relationships with the whole oral health sector to ensure that any re-design of service delivery reflects their ideas, concerns and priorities
- Inform future workforce development, both within and beyond the oral health sector
- Inform all affected stakeholders and community groups of any proposed service changes, allowing affected and interested groups the opportunity to have meaningful input into key decision-making and service re-design

2.0 Overview of Consultation Process

2.1 Purpose of Consultation

The purpose of this consultation was to provide the Community Oral Health Steering Group with the information needed to develop recommendations on the future model of service delivery for the Taranaki Community Oral Health Service and the locations of the New Plymouth fixed facility oral health clinics. In particular, the information will be used to develop a recommended model of service delivery that addresses the current oral health inequalities that are present in Taranaki while meeting the other requirements as specified in the Ministry of Health's oral health strategic vision document *Good Oral Health for All, for Life.*

2.2 Target Audiences and Communication Strategies

Given the extent of health professionals that are involved with the client group of 0 - 18 year olds and also the extent of the community who receive publicly funded oral health care in Taranaki, the consultation needed to be as broad as possible in canvassing the views of Taranaki health professionals and the community as a whole.

The target audience is listed as follows:

- Youth 12-18
- Parents / Caregivers
- Early Childhood Education Centres / Kohanga Reo
- Schools & Boards of Trustees
- Ministry of Education
- Dentists - NZDA
- TDHB Dental Therapists - NZDTA
- TDHB Dental Assistants
- TDHB Paediatricians Team
- TDHB Maternity Team
- TDHB Public Health Nurses
- Well Child Providers
- PHO's
- General Practitioners
- Māori Health Care Providers
- Iwi Health Representatives
- Local MP – H. Duynhoven
- New Plymouth District Council
- Taranaki Regional Council
- South Taranaki District Council

2.3 Responsiveness to Māori

Māori Health Care Providers and members of the TDHB Māori Health team were involved in developing a proposal for the future model of service delivery for the Taranaki Community Oral Health Service. The Māori Health Care Providers who took part in this working group were from the following organisations:

- Piki Te Ora Nursing Services
- Toi Ora Healthy Lifestyles Ltd
- TDHB Māori Health Team
- TDHB Kaumatua
- Manager Te Tihi Hauora O Taranaki PHO
- Te Atiawa Medical & Dental Service
- Manaaki Oranga

The group met three times between November 2007 and February 2008. The main focus of the group was to look at how the proposed new oral health service could be delivered to address the current oral health disparities that exist between Māori and other ethnicities. The recommendations from this group on the future model of service delivery are included in the key recommendations to be considered by the TDHB Community Oral Health Steering Group.

2.4 Consultation Methodology

A mixed methodology was used for the consultation, including the use of stakeholder interviews, focus groups, questionnaires, on-line surveys and a formal submission process. The use of several different methods was selected to improve the rigour of the data as the weaknesses inherent within one method may be compensated by the strength of another. Using different methods can also allow for the triangulation of data. This means that where the same findings are being reported from three different sources, or via three different methods, we can assume them to have a high level of validity. The use of a mixed methodology, including more participatory methods such as focus groups, was also chosen to ensure the consultation was accessible to a wide range of community groups. For example, focus groups can include those with lower literacy levels for whom questionnaires are not appropriate.

Stakeholder Interviews:

Stakeholder interviews are well suited for the collection of data from people with key information. Although time consuming, they have the benefit of allowing time for in-depth discussion and reflection.

Stakeholder interviews were held and the key themes that were identified were used to inform both the overall consultation and the development of the questionnaires and surveys used in the consultation.

Stakeholder interviews were held with:

- Highlands Intermediate Principal
- Devon Intermediate Principal
- Eltham Primary School Principal

- Waverley Primary School Principal
- Manaia Primary School Principal
- Normanby Primary School Principal
- Kaponga Primary School Principal

Stakeholder meetings were held with:

- NZDTA – New Plymouth Branch
- TDHB Dental Therapists
- TDHB Dental Assistants
- Māori Health Care Providers
- Te Kotahitanga Health Care Providers
- Hauora Taranaki PHO clinical staff
- Coastal Taranaki Friends of the School
- Taranaki ki te Tonga, Ngati Ruanui Health Care
- Te Atiawa Medical & Dental Services
- Te Tihi Hauora O Taranaki PHO
- PHO Forum

Focus Groups:

Focus groups can generate valuable and detailed information that can highlight common themes and issues relating to a particular subject. They are particularly useful for small homogenous groups of people that you wish to interview together, and can be a quick and reliable way to identify common issues and themes.

A number of focus groups were held during August and September with different groups of stakeholders. The key themes identified within the focus groups were used to inform the development of the questionnaires and surveys used in the consultation.

The following focus groups were held:

- Parents from Highlands Intermediate School
- Parents from the Waitara community
- Parents from Francis Douglas Memorial College
- Young people (13-18 years) from New Plymouth Swimming Club
- Young people (13-18 years) from Coastal Taranaki Area School
- Māori Health Care Providers
- TDHB Māori Health Team members

Questionnaires & On-Line Surveys:

Questionnaires and surveys are generally a cost-effective method of obtaining views from a large population. They allow for the collection of standardised responses from a large number of people and can give an indication of the strength of feeling of a particular topic, although there is much potential for results to be biased (e.g. through misinterpretation of questions). Questionnaires also tend to exclude the views of those with lower literacy levels.

Three questionnaires were developed from the information gained through the earlier stakeholder interviews and focus groups:

- A short questionnaire attached to a small information leaflet outlining the proposed changes to the oral health service (aimed at parents/caregivers).
- A short on-line youth survey, accessed via the DHB website, advertised on a postcard. Completion of the survey enabled entry to a prize draw for one of ten ipod shuffles (aimed at young people).
- A general on-line survey, accessed via the DHB website. The availability of this more detailed survey was advertised on the small information leaflet and the regular oral health project newsletters sent to schools, clinics etc.

In October 2007, 20,000 consultation questionnaires, postcards and newsletters were delivered to Taranaki Secondary Schools, Primary Schools, Kura Kaupapa Māori, Whare Kura, Te Kohanga Reo, Early Childhood Centres and Youth Centres. The consultation questionnaires were to be distributed by the schools and early childhood centres to all families/whanau. Instructions, a collection envelope and stamped reply paid envelopes were included with all consultations documents so that the organisations and schools could send the replies back to the DHB after the requested two week period.

The postcards were to be distributed to young people inviting them to register their views via the on-line survey on the TDHB website and take part in the prize draw. The prize draw was completed at the end of the consultation process in December 2007.

Formal Submission Process:

A full project consultation document and submission response form was placed on the Taranaki DHB website on 30 October 2007. The consultation document and submission template were also distributed in hard copy to Taranaki DHB Dental Therapists, Dental Assistants and Dentists. Newsletters advertising the availability of the consultation document and submission template were sent out electronically to all identified stakeholders, including Primary and Secondary Schools families/whanau, Health Care Providers, Primary Health Organisations, GPs, Māori Health Care Providers, Iwi representatives and District/Regional councils.

Press releases and paid newspaper advertisements were also used to encourage the community to access the consultation documents and participate in the consultation process.

Those wishing to make a formal submission could do so in the following ways:

- Complete a paper copy of the submission response template and return it to the Oral Health Project Manager
- Complete an electronic submission response form and email it to the Oral Health Project Manager
- Write/email their own submission response and send it to the Oral Health Project Manager

A letter was also sent out to all New Plymouth School Principals, Boards of Trustees and Te Atiawa Iwi Authority requesting any expressions of interest in providing the land for the New Plymouth Central fixed facility oral health clinic to the Project Manager by 29 November 2007.

2.5 Consultation Timeline

The consultation process started in August 2007 with the development of the Consultation Plan. The formal consultation process was open from 15 October 2007 to 30 November, although any late feedback received up to 24 December 2007 was also included in the analysis.

Date	Actions
August 2007	• Consultation Plan developed and approved
September 2007	• Information meetings held with all TDHB Dental Therapy and Dental Assistant staff, Clinical and Ambulatory Manager, TDHB Employee Relations Manager, PSA representative, TDHB Service Planner, DHB Dental Management and Public Health Dentist
October 2007	• Questionnaires and postcards sent to all Schools, Kura Kaupapa Māori, Whare Kura, Te Kohanga Reo, Early Childhood Centres, Youth Centres and School Dental Clinics in Taranaki • On-line surveys go live on TDHB website • Newsletters advertising consultation process sent to all key stakeholders • Letter sent to all New Plymouth School Principals, Boards of Trustees and Te Atiawa Iwi Authority requesting expressions of interest in providing land for the New Plymouth Central fixed facility Oral Health Clinic
November 2007	• Hardcopy of full consultation document and submission template posted to all TDHB Dental Therapists, Dental Assistants and Dentists • Advertisements placed in local newspapers advertising consultation process • Māori Health Care Providers working group established to develop recommendations for new model of service delivery • Project update meeting with all TDHB Community Oral Health staff
December 2007	• Consultation period ended and data forwarded for analysis
January 2008	• Consultation analysis completed and key recommendations identified • Consultation letters sent to Te Atiawa Iwi Health Board, Te Atiawa Iwi Authority, Te Tihi Hauora O Taranaki PHO, Hauora Taranaki PHO, Pinnacle Taranaki PHO and Ngati Te Whiti Hapu requesting suggestions for location of the New Plymouth Community Oral Health Clinic
February 2008	• Māori Health Care Providers working group submit proposed model of service delivery and key recommendations for inclusion in consultation report • Consultation report circulated to Community Oral Health Project steering group
March 2008	• Consultation report approved and widely circulated to key

	stakeholders and submitters

3.0 Analysis of Feedback

3.1 Quantitative Analysis

The quantitative analysis of questionnaire and survey feedback was carried out using SPSS (Statistical Package for the Social Sciences). Data was mainly analysed by total population, although the design of some questions allowed the analysis of data by ethnic group, location of respondents etc. In some cases it was necessary to analyse data by total population where identified sub-populations (e.g. certain ethnic groups) were so small that the validity of the data would be unreliable.

3.2 Qualitative Analysis

A range of qualitative data was generated through the consultation, including interview and focus group notes, comments included on questionnaires and surveys, and feedback on formal submission forms, letters and emails.

An analysis was carried out to recognise key themes identified by respondents to the consultation questions. Key themes within the data were identified by analysing whether:

- The issue or comment was mentioned frequently
- The comment was opposed to the proposed service changes
- The comment highlighted an aspect of the current service that worked well
- The comment highlighted a gap within existing or future oral health service provision
- The comment highlighted an area of oral health inequality

4.0 Consultation Findings

4.1 Stakeholder Interviews & Focus Groups

A number of key themes emerged throughout the stakeholder interviews and focus groups, reflecting the concerns of parents/carers, young people and Māori Health Care Providers:

Parents/Carers:

Benefits of proposed service changes:

- More privacy
- Improved service, particularly x-ray processing on-site, and better access to specialist care
- Updated equipment and facilities
- Targeting the service to lower socio-economic groups and non-attenders
- Treating children in families together
- Not always having to take children out of school for appointments
- Greater access and convenience of mobile service

Disadvantages of proposed service changes:

- Reduced access for working families and those without transport
- High costs of fuel for travel
- No direct access for children – need adult to take them to clinic
- Some families are less likely to attend
- Restricted opening hours of clinics
- Disruption to schools
- Limitations of mobile service – once or twice a year visit is not enough

Other comments:

- Need longer opening hours/open during school holidays to meet needs of working parents
- Need help with travel for those families who do not have transport, e.g. bus
- Mobile dental service in High Schools would work well
- Mobile “back up” for schools with poor attendance at fixed clinics
- Good communication between mobiles and fixed clinic, as well as with school
- Parents need to be told they have a choice
- Maintain personal relationships with therapist and be able to see same therapist
- Better advertising and promotion of service – need to advertise that it is free
- More proactive enrolments
- More oral health education, of both children and parents
- Need for social marketing with teenagers – e.g. promoting what teenagers get out of the service, focus on image, etc.

***Young People*:**

Reasons that young people do not like and/or do not access oral health services:

- Do not need to go (i.e. only attend when experiencing a dental problem)
- Scary, fear of pain (service is nicknamed the “murder house”)
- Previous bad experience
- Cost / do not know it is free
- Cannot get to the dentist
- Don’t care about oral health - see it as a waste of time
- Lack of time and availability to attend clinic
- Pain and grinding (drilling) of teeth
- Bright lights shining in face
- Strangers looking in your mouth
- Do not like dentists with big hands
- Dentists do not talk to young people

Reasons that young people do like and/or do access oral health services:

- Toothache
- Preventative care – want to keep teeth healthy
- Routine check ups
- It is easy to get to
- Free service
- Given freebies (e.g. lollipop) at visit

Suggestions for service improvements to attract more adolescents:

- Use of text messaging to book appointments/send reminders
- More advertising about service and costs
- Friendly and approachable staff - dentists should talk to, not over, young people
- More privacy
- Music, magazines, colourful clinics and less bright lights
- Mobile service at school so do not have to take too much time out of lessons
- Extend opening hours but Saturday attendance will depend on sports season
- Phone calls to parents to book/remind about appointments
- Dentist should wear masks
- Freebies (e.g. free samples, lollipops)
- Have the choice of bringing support people

Māori Health Care Providers:

Suggestions for service improvements:

- More Māori dental staff
- Culturally appropriate service
- Bi-lingual clinic signage – English and Te Reo Māori
- New service needs to be accessible and affordable
- Provide more visible information about service
- Providing transport if clinic off site
- Extend opening hours to include evenings, weekends and school holidays
- Use local knowledge of community – use key contact people
- Give choice over which dental clinic to attend
- Involve adolescents in planning of new service

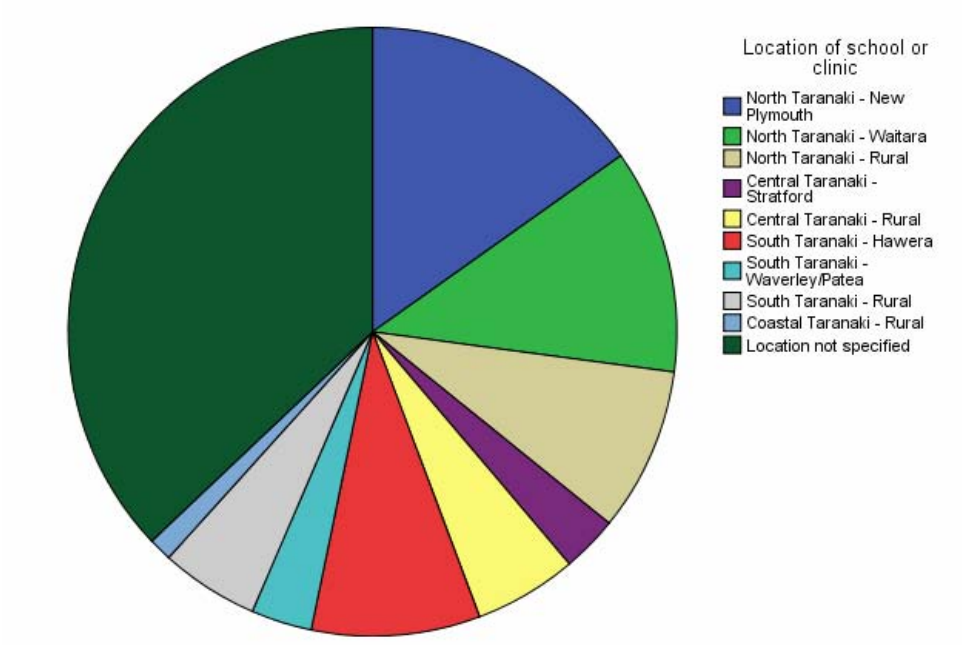
- Need comfortable and user friendly environment
- Provide mobile dental service at Boarding Schools
- Oral health education by whanau members in community
- Need good change management – keep stakeholders informed

4.2 Questionnaires

Locations of Schools/Dental Clinics Who Returned Questionnaires:

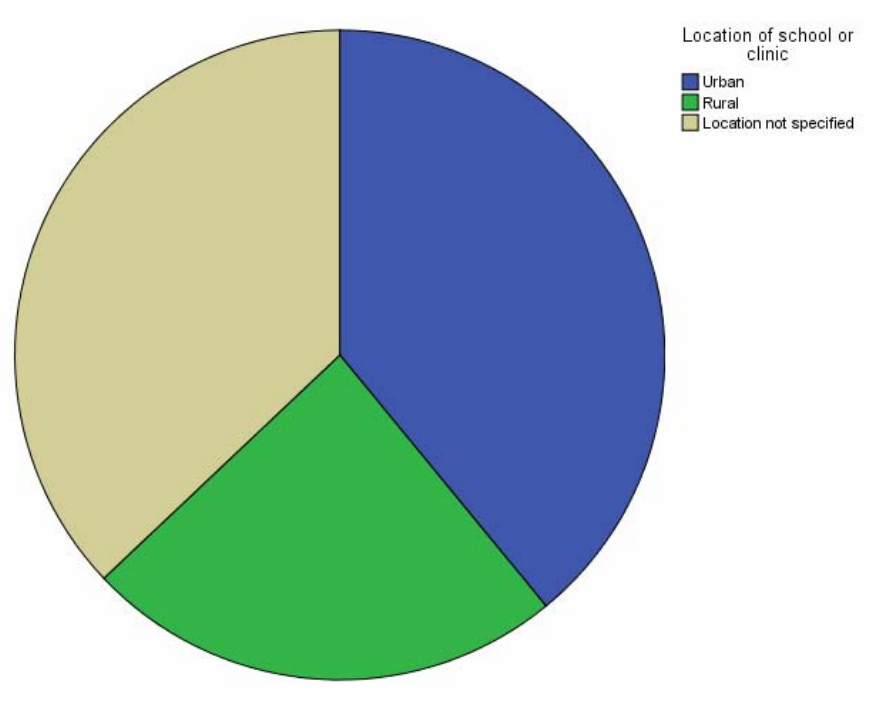
A total of 402 questionnaires were returned. Approximately a third (37.1%) of the questionnaires were returned in envelopes that had not been stamped with a school/clinic address. The remaining questionnaires were coded as '*urban*' or '*rural*', depending on the stated address of the school or clinic. This allowed the data to be analysed in greater detail, comparing **urban** and **rural** responses. However, the **total** sample was also analysed to ensure that the responses of those in unspecified locations were included in the overall analysis.

Figure 1: Pie Chart of Locations (Total Sample)



Breakdown of responses from Rural and Urban Schools/Dental Clinics within total sample

Figure 2: Pie Chart showing percentage of responses from Rural & Urban areas



Analysis of Questionnaire Responses:

Respondents were asked the following three questions:

1. How can we make oral health care a BETTER experience for you and your family?
2. How can we make it easier for you and your family to access the new oral health service?
3. Do you have any comments on the new service?

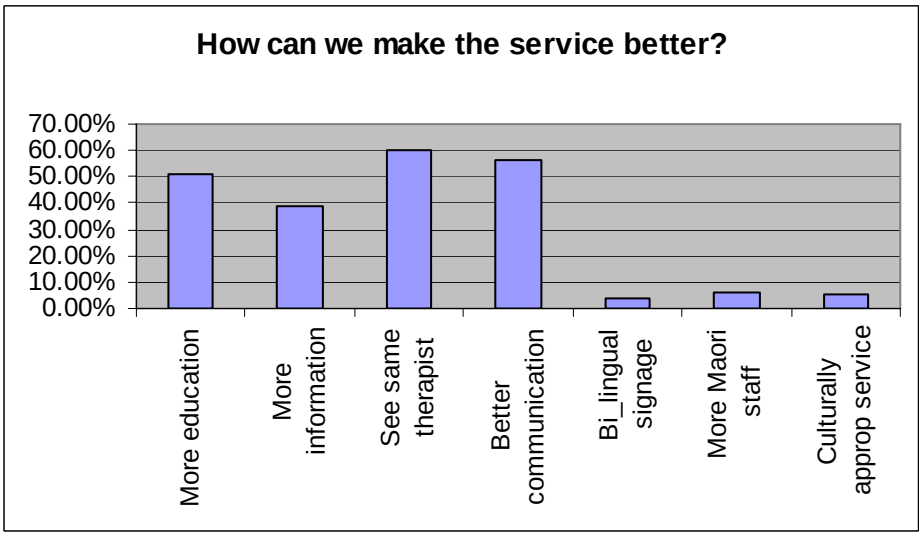
For each question the results are reported by TOTAL population, and then compared for RURAL and URBAN population groups.

QUESTION 1
How can we make oral health care a BETTER experience for you and your family?

Results for TOTAL sample:

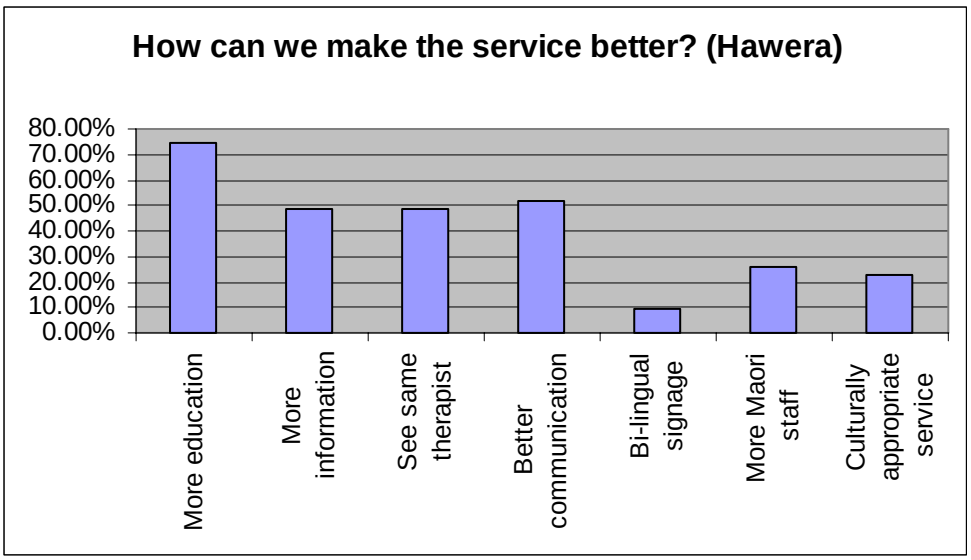
For the total sample, being able to see the same therapist at each visit was selected by over half of the respondents as a way of making the service better (60%), followed by good communication between the school and dental service (56%) and provision of more oral health education and health promotion (51%).

Figure 3: Bar chart of TOTAL responses to Question 1



While the provision of bi-lingual signage, more Māori staff and a culturally appropriate service ranked relatively low (4%, 6% and 5% respectively) for the total sample, there was a noticeable difference in the responses from Hawera (total sample size = 36). For this sample, having more Māori staff in the dental team was selected by 25% of respondents and providing a culturally appropriate service was selected by 22% (*see Figure 4 below*).

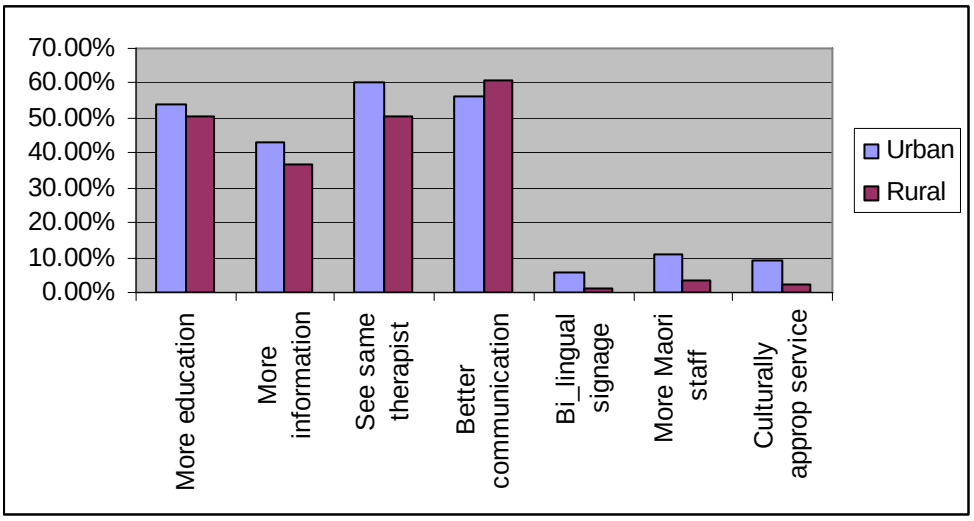
Figure 4: Bar chart of Hawera responses to Question 1



Comparison of results for URBAN and RURAL areas

There were no major differences between the responses from rural areas and those from urban areas. The three areas most likely to be selected by both urban and rural respondents as making the service better were: seeing the same therapist at each visit, better communication (between school and dental service) and the provision of more oral health education.

Figure 5 – Bar chart comparing RURAL and URBAN responses to Question 1

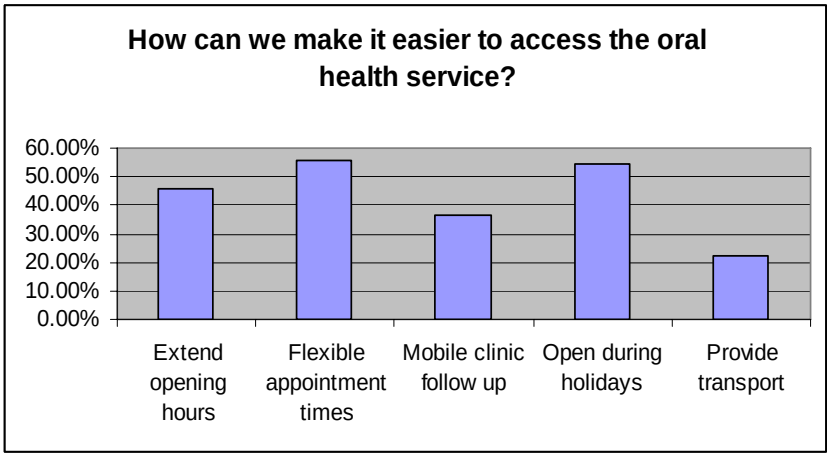


QUESTION 2
How can we make it easier for you and your family to access the new oral health service?

Results for TOTAL sample:

For the total sample, providing flexible appointment times (55% of respondents) and having clinics open during school holidays (54% of respondents) were most commonly identified as a means of making access to the oral health service easier. Almost half of the sample (45%) felt that extending service opening times would also make access easier.

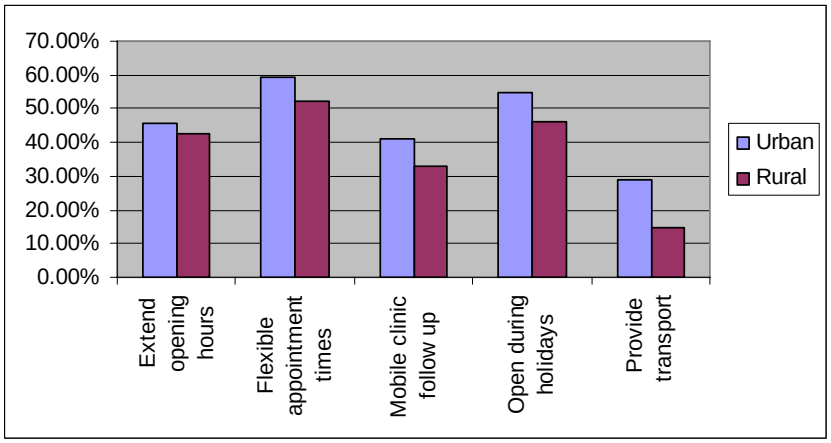
Figure 6: Bar chart of TOTAL responses to Question 2



Comparison of results for RURAL and URBAN areas:

As with Question 1, rural responses were very similar to urban responses with flexible appointment times, clinics being open during school holidays and extended opening hours being most often selected as a way of improving access to the oral health service. It is interesting to note that the percentage of rural respondents who felt access would be improved by providing transport to take children to clinics was half that of the urban sample (14% compared to 28%). This may reflect the fact that many families in rural areas already have to use their own transport to travel to off-site dental clinics so may not see this as a 'need'.

Figure 7 – Bar chart comparing RURAL and URBAN responses to Question 2



QUESTION 3
Do you have any comments on the new service?

175 of the questionnaires included comments that, on the whole, related to both the existing oral health service and the impact of the proposed changes. These comments were analysed and found to reflect a number of key themes:

Access & Inequality issues:

Most commonly raised were comments about access and inequality. Access issues focused around transport, with a common concern being raised about parents being unwilling or unable, to take their children to the new central clinics:

> *"Busy parents will not take children to new service"*

> *"Parents can't afford time off work/travel costs"*

Cost of dental care for adults was also recognised as an access issue by some parents:

> *"Should offer the same service for adults on CSC card"*

The provision of a mobile service was seen as key to addressing both access and inequality issues:

> *"Transport for clinic is a good idea, especially for out of town"*

"A mobile clinic will help rural families"

"Good to have mobile clinic where oral health bad"

In particular, a number of comments highlighted Okato and Auroa School as being in need of a mobile service:

"We were promised a mobile in Okato - the old service was great"

"Mobile should visit Auroa School, the roll is now over 170!"

Service works well and should not change:

Parents stated they were happy with the service; it works well and did not need to be changed. Several suggested the service could not be improved in any way:

"The service is excellent – don't change what isn't broken"

"What is wrong with the service we love?"

"Why change? It is already easy to use. Just do more follow up?"

A number of parents felt the service should not be changed to accommodate those who were not accessing it and that responsibility for access should lie with parents. There were also concerns the new service would be inferior:

"The service already works. Parents should take more responsibility"

"On site ensures teeth checked, new service will not"

"Upgrade clinics. New service will have a negative impact"

Appointment bookings and frequency of dental check ups:

The majority of these parents wanted more dental check ups (six monthly as opposed to annually) and for dental visits to be more regular and consistent. Parents also stated that appointment reminders (including email reminders) would be helpful:

"No more than six months between checks"

"More consistency with visits would be helpful"

"Too short time between getting appointment card and appointment date"

"Send reminders as good for busy parents"

Positive comments about existing School Dental Service:

Those comments praising the school dental service largely focused on the standard of care and professionalism shown by the dental therapists:

"You guys already do a great job!"

"You do a great job. Thank you for caring"

Comments also focused on the flexibility of the service, and the fact that the service was friendly and approachable.

Need for more education and health promotion:

Comments on the importance of education and health promotion highlighted the role of parents and schools, as well as dental therapists, in educating about good oral health from an early age. Early childhood centres were seen as key audiences. Education about the affect of certain foods on teeth, and the impact of oral hygiene on overall health, were identified as key issues:

"Make dental visits informative about prevention"

"Dental therapists visiting childcare centres. Give talks to kindy parents"

"More info that is fun for children to learn"

"Educate parents on importance of oral health and effect of specific foods on teeth"

Suggestions for service improvement::

A number of creative suggestions for service improvement were made, largely focusing on how the service could promote clinic attendance by children and adolescents. Ideas included giving out free toothbrushes, offering home visits, allowing parents to have check ups with their children and providing age appropriate information to teenagers.

Several suggestions highlighted the importance of promoting the service within the community:

"Operate where youth attend e.g. WAVES"

"Use supermarkets/public areas to promote service"

"Use Plunket to set up visits for under 2's"

"Promote through Plunket to ensure enrolment"

Positive comments about the proposed service changes:

These parents were particularly encouraged by the development of a new mobile service to support rural areas. Seeing children together as a family and the modernisation of the service was also supported:

"Great that children will be seen together as a family"

"Good that clinics updating – old ones were scary!"

The importance of relationships with dental therapists and continuity of care:

The importance of continuity of care, and building trusting relationships with the same dental therapist on each visit, is reflected in the questionnaire results (over half of

parents in the sample identified “seeing the same therapist” as a way of making the oral health service a better experience). The comments around continuity of care reflected this:

“Important to see same dental nurse who you trust “

“I hope centralisation doesn’t lose 'personal' service”

Some of the parents also identified having a choice of dental therapist as being important:

“More than one dental therapist to choose from”

General comments:

These comments related to the importance of good communication, a need for more information on specialist and orthodontic care, and previous bad experiences of dental care. Concerns were also expressed at the delay in implementing the new service:

“Waitara has shortage of clinics, why wait till 2009?”

4.3 On-line Youth Survey

Analysis of questionnaire responses:

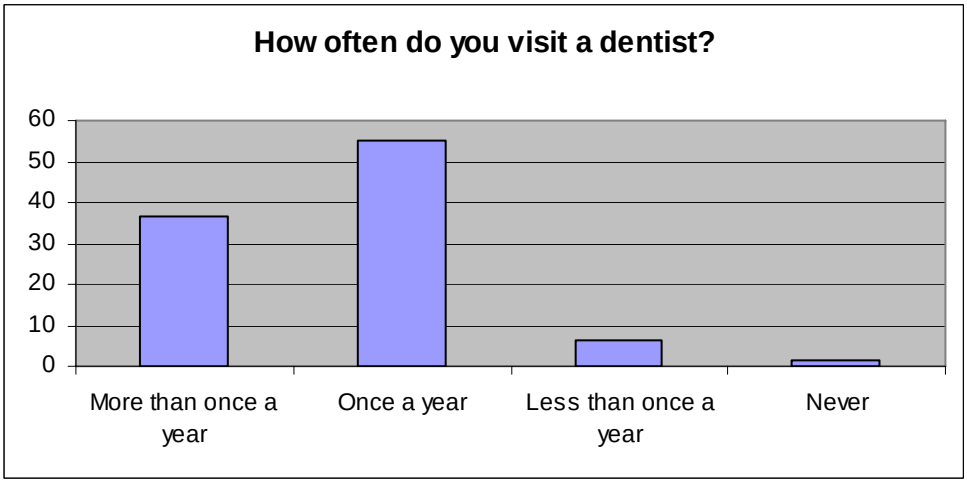
Respondents were asked the following three questions:

1. How often do you visit the dentist?
2. How can we encourage more adolescents to use oral health services?
3. Do you have any other comments about oral health services?

QUESTION 1
How often do you visit the dentist?

The on-line survey received 215 responses. The majority of those who responded to the survey (92%) visited a dentist once, or more than once, a year. 6% of respondents visited less than once a year, and 1% never visited a dentist. Therefore it should be noted that the results of this survey largely reflect the views of those adolescents who are already using dental services.

Figure 8: Bar chart of responses to Question 1



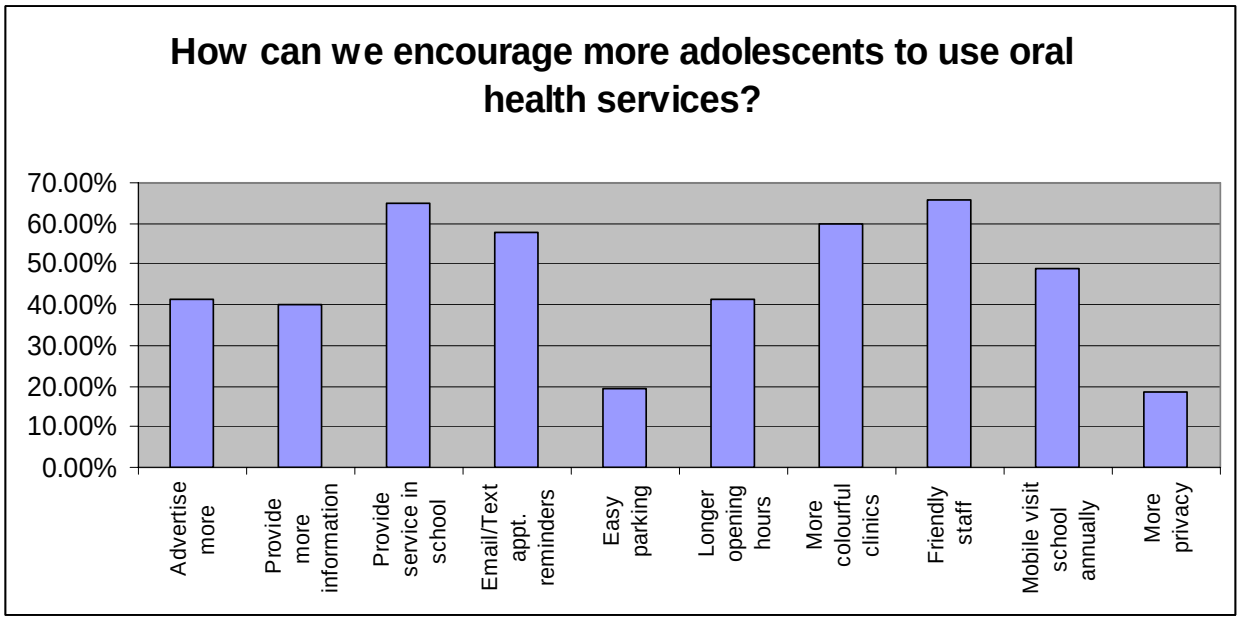
QUESTION 2
How can we encourage more adolescents to use oral health services?

The most commonly suggested means of making oral health services more attractive to adolescents were the provision of oral health services within high schools and having friendly staff on the dental team, both selected by 65% of respondents. This was followed by offering more colourful clinics (60%) and providing email/text appointment reminders (57%).

Almost half of the respondents (48%) felt that an annual visit to high schools by a mobile dental service (bus) would also encourage more adolescents to use the service.

Around 40% of respondents selected more advertising and information about the service, along with longer clinic opening times, as a way of encouraging a higher use of the service. Less than 20% of respondents selected easy parking or more privacy within clinics as important factors.

Figure 9: Bar chart of responses to Question 2



QUESTION 3
Do you have any other comments about oral health services?

137 (approximately two thirds) of the questionnaires included comments that, on the whole, suggested ways in which the oral health service could be improved to make it more relevant and attractive to teenagers. An analysis of the comments identified the following key themes:

Advertising / Service image:

The majority of these comments highlighted a need for the service to promote itself by advertising more widely, not only within high schools but also through radio, TV and the Internet. Creative forms of Internet advertising and social marketing techniques were also suggested.

> *"Using technology is the key - Use the Utube© on the internet go promote your messages, also use a bebo © page – this is where we are all on these web pages. All I can say is - Technology – Technology"*

> *"Use Music to attract us, maybe a hip hop group like "Neisian Mistik" that promoted that vaccination Menz B"*

In terms of the messages to be promoted, respondents felt there was a need to inform young people that the service was free and to stress the importance of looking after oral health. The need to counteract the 'scary' image of dental services was also recognised.

> *"Inform us of what we are entitled to receive once we become high school students. At primary school we know we see the Dental Nurse every six months, and we don't pay anything. At high school, how do we know how often we go, and what, if anything, we have to pay for?"*

> *"Dentists are seen as scary so I think if you did some work around getting good messages out there, people would be more likely to engage. Also more need to know that oral health is actually really important, most young people don't think it is"*

Incentives:

A range of incentives that may encourage young people to use the service were suggested. These included giving away 'freebies' such as toothpaste, toothbrushes and dental floss. Other ideas included competitions, quizzes and rewards for regular attendance.

> *"I got told to floss, but haven't got round to buying any. So free floss might be nice"*

> *"Giveaway perhaps free toothbrushes, toothpastes etc. with the dental clinics phone number on"*

> *"Advertise in schools and maybe offer a deal thing through the school like: New Plymouth Boy's High students will receive a $5 voucher every 5 visits or something"*

Clinic Environment:

Most comments about the clinic environment suggested ways in which the clinic building, waiting areas and consulting rooms could be made more attractive and enjoyable for young people. Ideas included having comfortable chairs, cool posters on the wall, teenage magazines, televisions and modern music. A few comments

also related to the importance of allowing young people to bring someone (usually a friend) into the clinic with them for support if they were nervous.

> *"Background music (radio) while you are getting your teeth checked. Not old music, more new music"*
>
> *"That the building or Bus be painted in such a way that it doesn't appear to be a 'Dental Clinic', maybe some 3D Art"*
>
> *"Maybe put TV's up on the ceiling to be entertained while you are getting your teeth done. Or you could put up cool posters and stuff, just something so it isn't boring to go to the dentist"*
>
> *"If they made a youth dental centre like Waves I would feel more comfortable going there"*
>
> *"Maybe being allowed to have a friend present would help with my nerves"*
>
> *"Take groups of friends at a time to go so there is someone there with you that you and trust and rely on if you need to get something done i.e. an injection for fillings"*

Appointments / Clinic opening times:

A range of issues relating to appointment times and opening hours were identified. These included a need for more frequent appointments, regular reminders, shorter waiting/consultation times, extended opening hours, and greater use of cell phones and emails for appointment booking. Some respondents felt the school dental service needed to be more proactive in making contact and booking appointments.

> *"I think that definitely extend the opening hours……because I always have things on at school or basketball practice and things like that on after school!"*
>
> *"Use our cell phones to get reminder appointments & when we are due for another appointment"*
>
> *"Send more than one reminder as young people don't remember things very well"*
>
> *"I only have one visit a year, I think it would be better if I had more visits".*
>
> *"If the dental clinic contacts me about appointment rather then me phoning up"*
>
> *"When people ring up and leave a message in the hopes of organising an appointment, call back quickly!"*

Cost:

Comments relating to cost focused on the need for dental services to be cheaper, and for specific items (particularly braces) to be free or subsidised. A number of respondents also suggested free dental care be extended beyond 18 years of age.

> *"Make it cheaper"*
>
> *"If the free dental care was extended to possibly 20 rather than 18"*
>
> *"Wish I could get funds to pay for braces - I am 13"*

"…my parents still are worried about paying for the braces, however they want me to have them and to have the best teeth possible. It is like this for many others, I think that it would be a great help braces were even partly funded, like dental surgery is"

Education/health promotion:

Comments relating to oral health education and promotion mainly focused on the importance of informing teenagers of the negative effects of not looking after your teeth and gums. Such presentations could be given within schools but need to be interesting and easy to understand in order to get the message across.

"Maybe coming to schools and show what happens when you don't take care of your teeth, but not a boring person to tell us, a funny, young person that will make high school kids remember that the dentist is good for you"

"Show kids how their teeth could be! and tell them how damaged their teeth could be if they don't get dental treatment"

"Keep the message simple & to the point"

Communication with therapist:

The importance of good communication between dental staff and young people was highlighted as a means of helping young people to feel more comfortable when using dental services. Once again, text and email was identified as an important communication method for young people.

"Get the staff to talk to the students during most of the time they are there so they don't feel uncomfortable"

"If the dental staff were a bit more friendly and soft that would make difference or just if they found a way to make it fun and a great place to go"

"I use email quite often, but hate speaking on phones, especially to people I don't know. If it was possible to make an appointment via email, I would definitely be more inclined to do so"

Clinic location:

Local or on-site clinics were seen as being most convenient for young people. Some respondents stated that lack of transport, or needing to rely on parents for transport, made access difficult. Providing more easily accessible clinics, or a transport service, was seen as a means of improving access to the service.

"If there was one closer to where I live (Okato). I have to travel for 30 minutes (to new Plymouth) just to get to the dentist for a check up"

"Maybe a transport service that students could book to take them to their appointment"

"Could there be a mobile bus at Ahititi School so we didn't need to travel to Mokau School"

"Having a clinic at High school like the one we had at Highlands. That way you don't have to rely on parent's transport it's hard to get to the dentists when your parents are working"

"Make sure the clinics are located in places which young people can easily access, as many young people won't make the effort if it is too hard to get there"

Service specific issues:

Issues relating specifically to dental care focused on the availability of pain relief, more treatment options, water fluoridation and having an on-site orthodontist.

"Gas for pain relief"

"Perhaps have a dental service particularly for teenagers, with an orthodontist there too"

Positive comments about service:

A few respondents found the service already met their needs, was easy to access and very efficient.

"The appointments are easy to make and all you have to do is turn up! It's really good I cannot see how people would not make the most of this service!!"

"The service is pretty efficient. I started at Devon Intermediate in June this year after moving from Brisbane and I had a check up at the clinic early in third term. I thought that was very good"

Dealing with complaints:

A couple of comments related to the importance of responding to young people's concerns or complaints about the service.

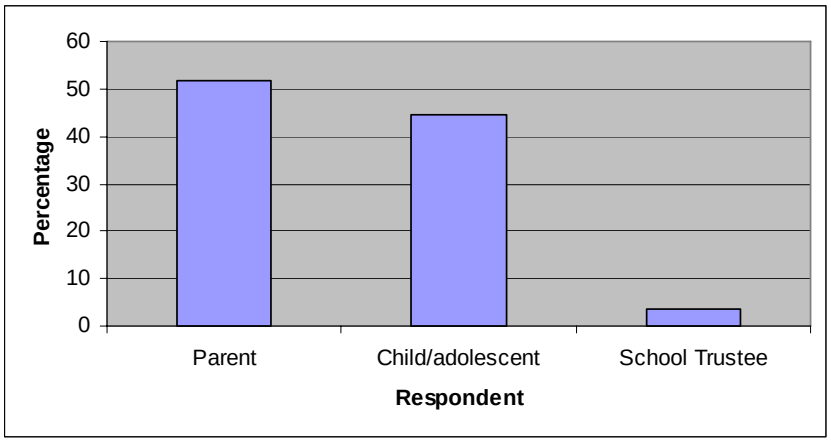
"Some one we can talk to about poor service we have had or getting from our dentist. I feel us younger ones don't get treated right by the dentists. I have just experienced a very bad visit with one. It's off putting"

4.4 On-line General Survey

Demographic Profile of Respondents:

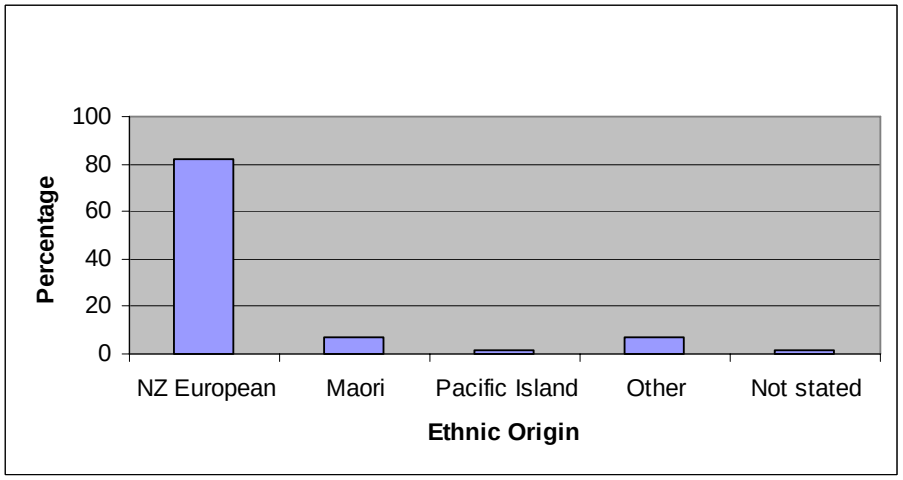
The Full On-line Survey received 56 responses in total. 29 of these responses were from parents, 25 from children/adolescents and two from School Trustees. Two of the parents who completed the questionnaire also stated they worked as health professionals.

Figure 10: Bar chart of respondent types



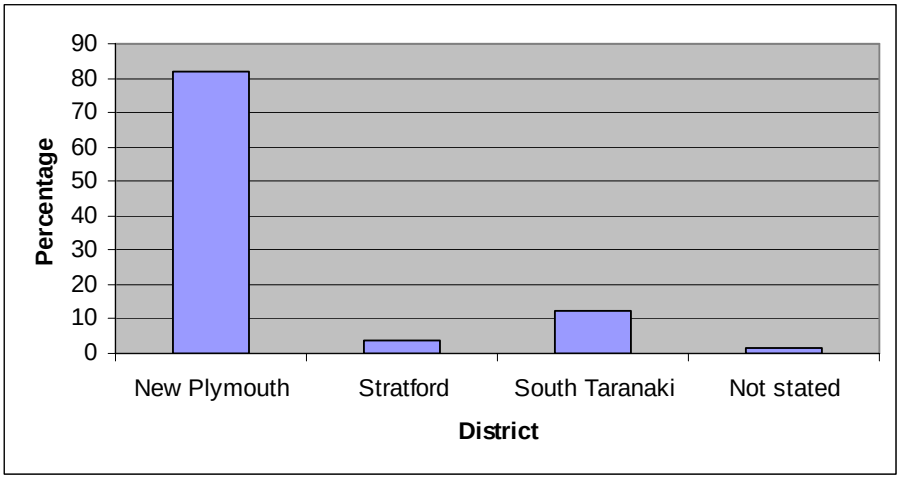
The majority of respondents (46) were NZ European. The remaining 9 included Māori (4), Pacific Island (1) and 'Other' (4). Those selecting 'other' defined themselves as Australian, American, British and Arab/European. One respondent did not state their ethnic origin.

Figure 11: Bar chart of respondents' Ethnic Origin



The majority of respondents (46) were from the New Plymouth District, seven were from South Taranaki and two were from Stratford. One respondent did not state their location. Unfortunately the small sample size, particularly for South Taranaki and Stratford, makes it difficult to make any meaningful comparisons between survey results from different districts. Hence it should be noted that the findings from the on-line survey largely reflect the views of respondents living within New Plymouth District.

Figure 12: Bar chart of respondents' location



***Analysis of Questionnaire Responses*:**

Respondents were asked the following seven questions:

1. What are the benefits of a central oral health clinic?
2. What are the disadvantages of a central oral health clinic?
3. What are the benefits of the mobile oral health clinic?
4. What are the disadvantages of the mobile oral health clinic?
5. How can we make oral health care a better experience for you and your family/whanau?
6. How can we make it easier for you and your family/whanau to access the oral health service?
7. What would encourage more young people to use the oral health service?

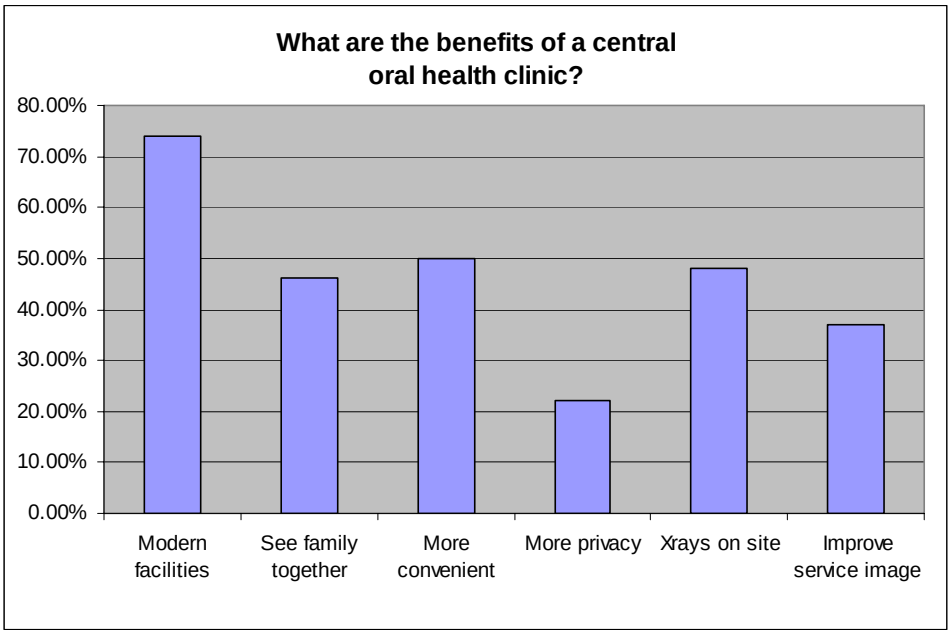
For each question the results are reported by TOTAL population. Analysis was also carried out to compare results between children/adolescents and parents as well as between different ethnic groups. Where noticeable differences were found these have also been reported.

A thematic analysis of comments within the questionnaire was also carried out to identify key themes and issues.

QUESTION 1
What are the benefits of a central oral health clinic?

Having modern facilities was selected by most respondents (74%) as a benefit of a central oral health clinic. Half of the sample (50%) felt the central oral health clinic would be more convenient. Almost 50% of the sample felt having x-rays on site would be another benefit of the central clinic.

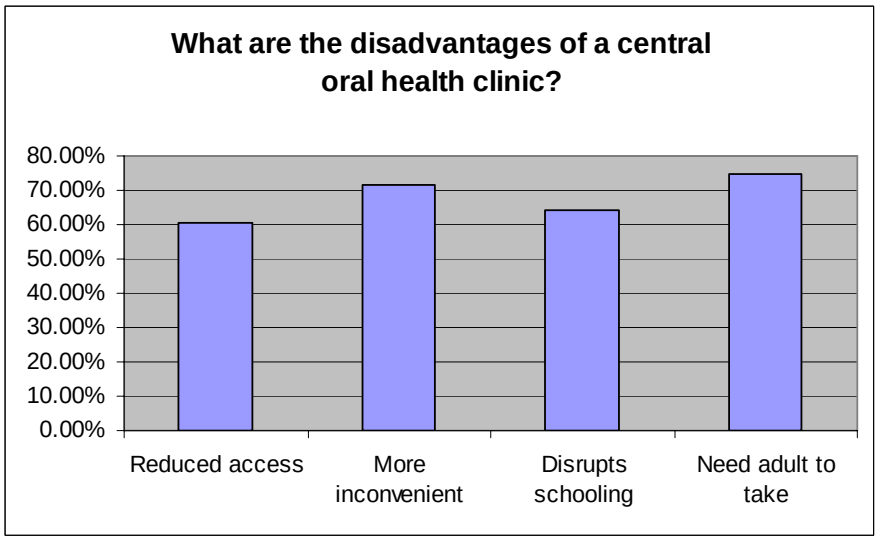
Figure 13: Bar chart of responses to Question 1:



QUESTION 2
What are the disadvantages of a central oral health clinic?

The need for an adult to be available to take children to the central oral health clinic was selected by three quarters (76%) of respondents as a disadvantage. Disruption to schooling and inconvenience was also identified by over 50% of the sample as a disadvantage (61% and 63% respectively).

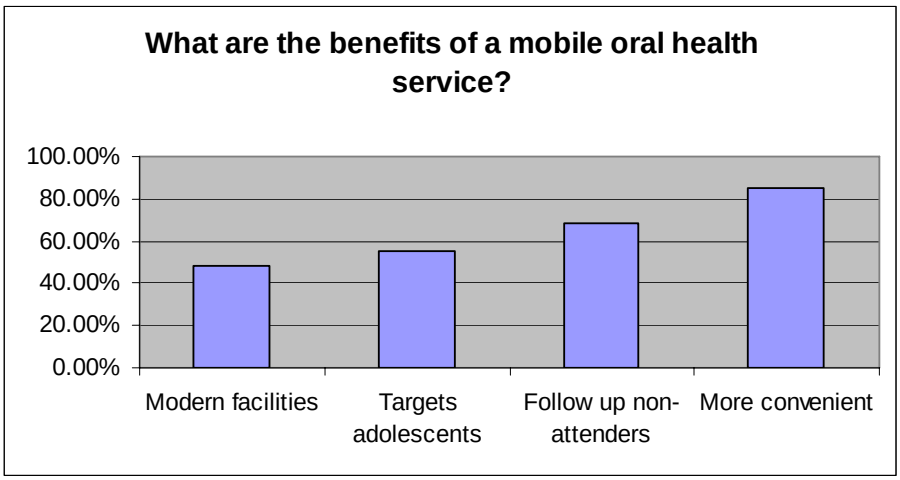
Figure 14: Bar chart of responses to Question 2:



QUESTION 3
What are the benefits of the mobile oral health clinic?

85% of respondents felt the convenience of the mobile oral health clinic would be a benefit. 68% of respondents felt that following up non-attendees was another benefit of the mobile service. The mobile service's ability to target adolescents was seen as a benefit by over half of the respondents (55%)

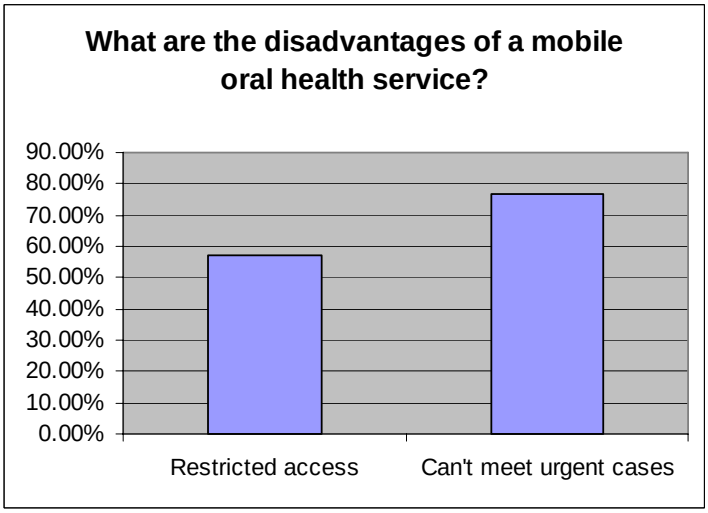
Figure 15 – Bar chart of responses to Question 3:



QUESTION 4
What are the disadvantages of the mobile oral health clinic?

Most respondents (76%) felt not being able to respond to the needs of urgent cases was a disadvantage of the mobile oral health clinic. Over half (57%) also identified restricted access to the service as a disadvantage.

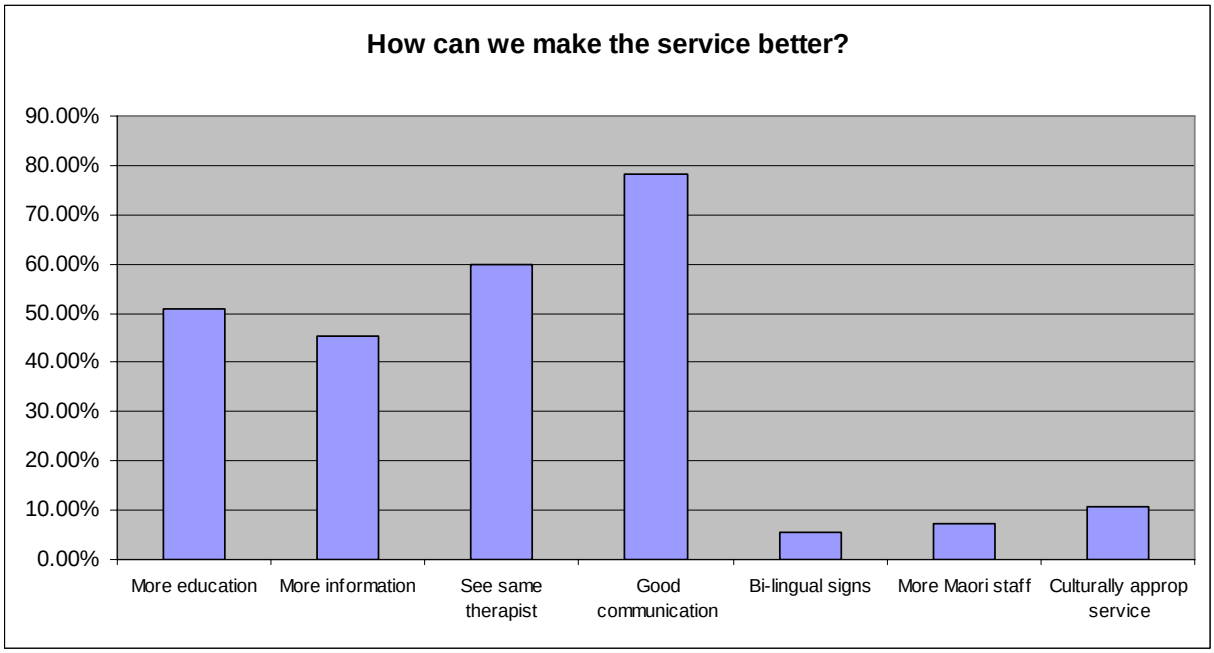
Figure 16 – Bar chart of responses to Question 4:



QUESTION 5
How can we make oral health care a better experience for you and your family/whanau?

Good communication between school and dental service was most commonly selected (78%) as a means of making oral health care a better experience, followed by seeing the same therapist (60%) and more oral health education (50%).

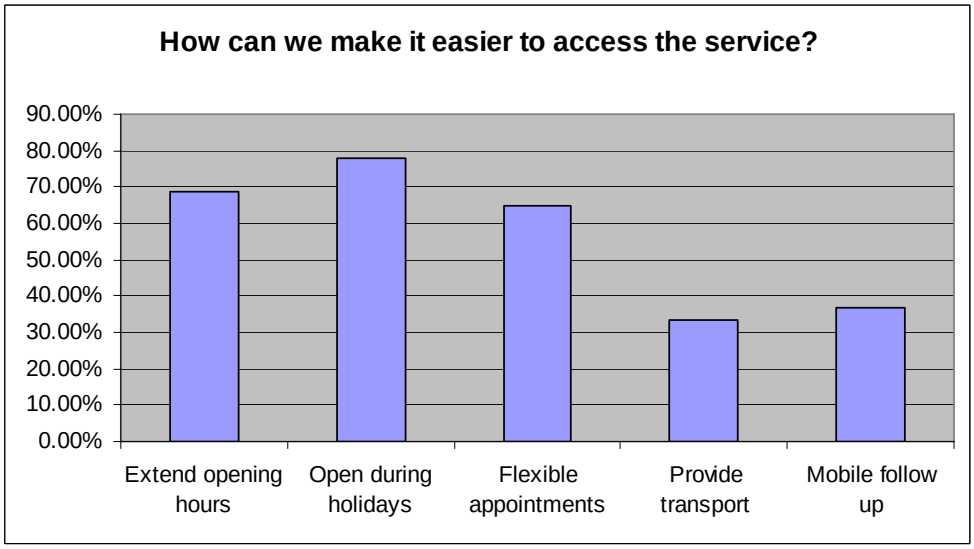
Figure 17 – Bar chart of responses to Question 5:



QUESTION 6
How can we make it easier for you and your family/whanau to access the oral health service?

Most respondents (77%) felt that opening the service during school holidays would make access to the oral health service easier. This was closely followed by extending opening hours (68%) and offering flexible appointment times (64%).

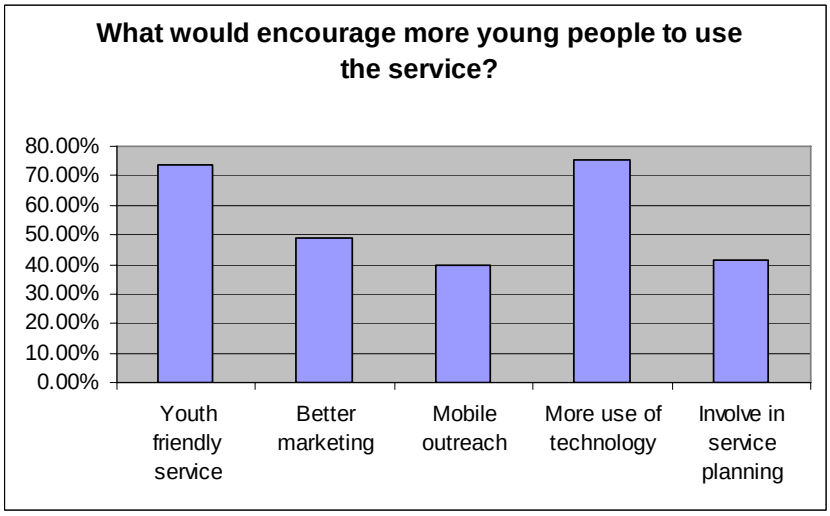
Figure 18 – Bar chart of responses to Question 6:



QUESTION 7
What would encourage more young people to use the oral health service?

Greater use of technology and provision of youth friendly services were most commonly identified by respondents as a way of encouraging more young people to use oral health services (75% and 73% of respectively).

Figure 19 – Frequency of responses to Question 7:



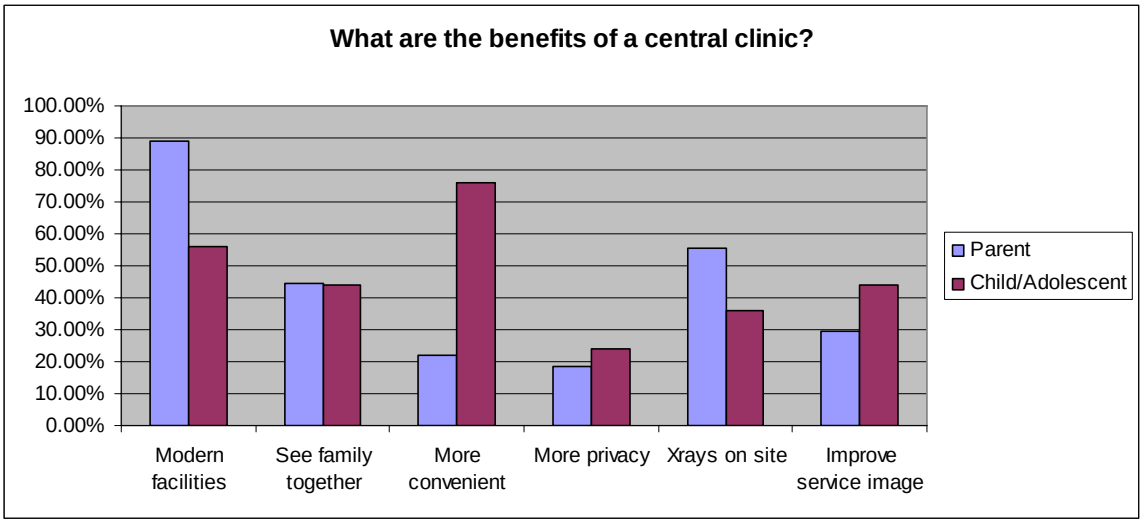
Comparison of results for children/adolescents and parents:

51% of the sample identified themselves as parents, while another 44% identified as children/adolescents. Responses to each on-line survey question were analysed to identify any noticeable differences between the responses from parents and children/adolescents. Differences were particularly apparent in Question 1 and 7:

QUESTION 1- What are the benefits of a central clinic?

The key differences in Question 1 related to the two groups views about modern facilities and more convenience being a benefit of the central clinic. While almost 90% of parents felt modern facilities would be a benefit of the new central clinic, this view was shared by only 55% of the children/adolescents. In contrast, over 70% of children/adolescents felt the central clinic would be more convenient compared to 20% of the parents.

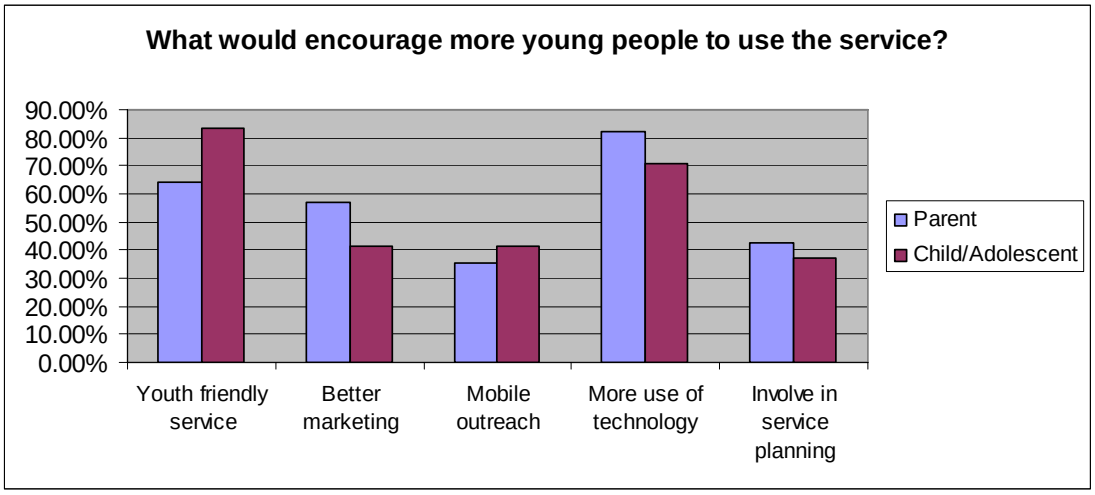
Figure 20 – Bar chart comparing parents and child/adolescent responses to Question 1:



QUESTION 7 - What would encourage more young people to use the oral health service?

To encourage more young people to use oral health services, most parents (82%) felt that the service should make more use of technology (e.g. cell phones, email). While many young people agreed with this (70%), the most important issue from their perspective was the provision of a youth friendly service (selected by 83% of young people).

Figure 21 – Bar chart comparing parents and child/adolescents responses to Question 7



Comparison of results for different ethnic groups:

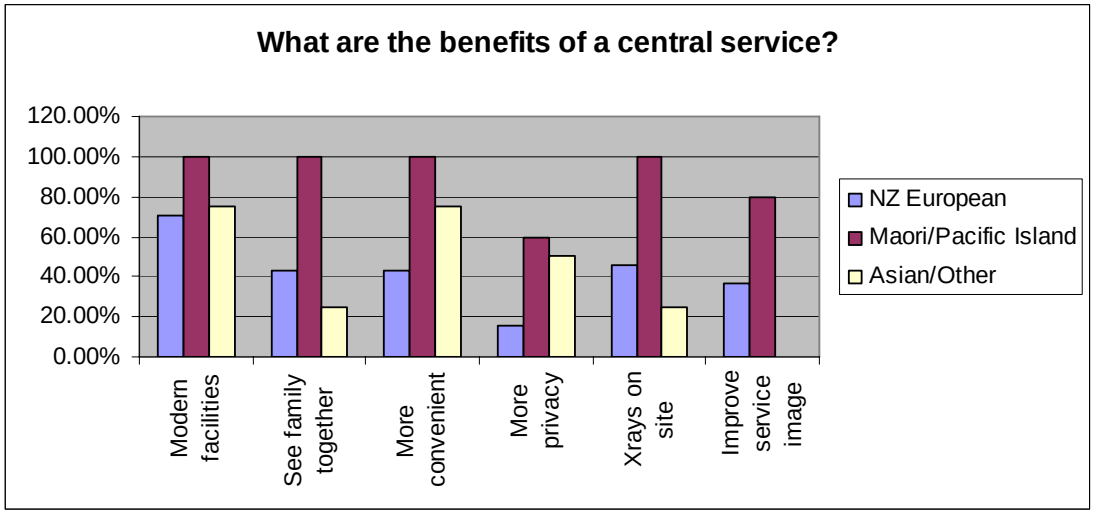
As with the comparisons between responses from parents and children/adolescents, responses from different ethnic groups were analysed. Respondents were separated into three groups – NZ European, Māori/Pacific Island and Asian/Other.

However, as the numbers in the Māori/Pacific Island and Asian/Other group were very small (five in each group), the results should be treated with caution. With this in mind, there are some interesting comparisons between the results of different ethnic groups for two of the questions (Question 1 and Question 5).

QUESTION 1- What are the benefits of a central oral health clinic?

41% of NZ European respondents identified being seen together as a family as a benefit of the central oral health clinic compared to 100% of Māori/Pacific Island respondents. The results are similar for responses to 'more convenient' and 'provision of x-ray facilities on site'.

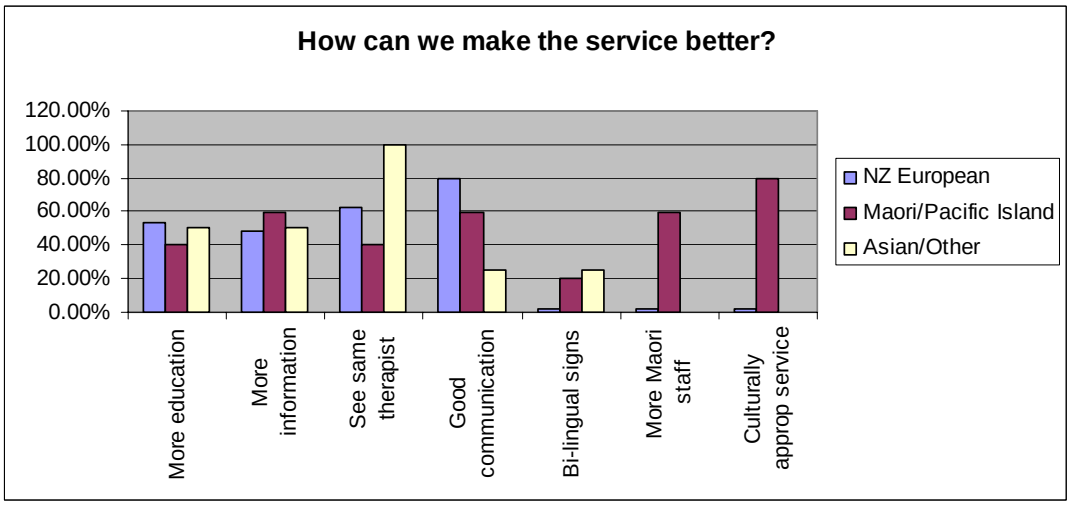
Figure 22 – Bar chart comparing responses to Question 1 by Ethnic Group:



QUESTION 5 - What would make oral health care a better experience for you and your family/whanau?

Differences in the responses to this question were most noticeable in the categories of 'bi-lingual signage', 'more Māori staff' and providing a 'culturally appropriate service' as a way of making oral health care a better experience. 20%, 60% and 80% of Māori/Pacific Island respondents selected these categories respectively, compared to 0% (zero) of NZ Europeans.

Figure 23 – Bar chart comparing responses to Question 5 by Ethnic Group:



Analysis of Comments from On-line General Survey:

25 of the on-line survey questionnaires included written comments that focused mainly on access issues and possible limitations of the new service, along with a range of suggestions about how these may be overcome. When analysed, the comments were found to reflect a number of key themes:

Access:

Concerns about access mainly related to the difficulty in transporting children to central clinics if school-based clinics closed. These concerns included practical difficulties of transporting large numbers of students off site and individual concerns about parking, traffic congestion, petrol costs and travel time. Two parents were concerned that having to be present for children's dental examinations would cause distress for them and their child.

> *"Stratford Primary School role currently 442. State condoned truancy in transporting this many pupils off site … Retain new clinic at Stratford primary School"*
>
> *"Big commitment of time and petrol to get to appointments, by both children and parent or who ever is taking child"*
>
> *"As the children get older I see access as more of a problem. I hope parking is taken care of at the new clinic!"*
>
> *"I have trouble getting my young child there if it is not on the school grounds. She freaks out and is much better if I am not there"*

Appointments:

The majority of the comments on appointments related to opening hours and the difficulties faced by working parents. Lack of communication (between school dental service and parents), short notice and inconvenient appointment times (often during school hours) were seen as barriers for some parents. Suggestions for improvements included extended opening hours and more proactive appointment booking by the dental service.

> *"Be proactive and offer appointments through school rather than relying on parents to contact the service"*
>
> *"Must be easy to get appointments at suitable times. (Not like at the doctors where you have to wait at least 2 days when your child is sick)"*
>
> *"We currently have to attend clinic at another school. It has sometimes been difficult to schedule appointments for our children when both parents are working out of town and clinic has only been open during school hours. Opening outside of school hours would be easier for working parents and not so disruptive to the school day for children"*

Service related issues:

Comments on the dental service related mainly to equipment, privacy and the experience/training of staff. Other concerns focused on there being enough staff to meet the needs of the new service and being able to see the same dental therapist at each visit.

> *"I would hope staff are better trained to have all the up to date equipment"*
>
> *"I would like more up to date equipment and privacy for the child. They should not have treatment in a room that has someone else in it. We don't as adults neither should they"*
>
> *"Will all children be able to get an appointment every year? Will there be enough staff to ensure a good service is provided?"*

One parent also expressed concern that schools would lose interest in the dental service if it were moved off site:

> *"Will schools be interested in the school dental service if it is removed from school grounds. Out of sight and not their responsibility"*

Positive comments about new service:

A range of positive comments were expressed about the new service, including improved access (as a result of the mobile service) and greater convenience.

> *"[The mobile clinic] meets promises made when rural clinics were closed"*
>
> *"Less schooling lost by child and less time and costs to parents"*
>
> *"Hopefully better able to monitor this service and ensure the current people missing out gain regular consultation"*

No issues with current service:

These comments highlighted the positive aspects of the current service, which it was felt met parents' needs very well:

> *"We currently attend Highlands and I have been very pleased with the care and attention from staff. I do think people have to take responsibility for themselves"*
>
> *"Currently I am VERY pleased with all aspects of having a dental clinic AT school for both my children and I. The facilities need modernising but all other aspects of the visit would get a tick in the above criteria! We have no problem with the experiences we have had with our dental care through the school clinic"*

Youth friendly services:

These comments highlighted the importance of the dental service and its surroundings being more friendly and comfortable for young people.

> *"Have the dentist place more friendly such as not being so quiet like having some music on maybe."*

"Make environment more adult like and modern appearance. A bit of colour so they don't feel like they are in a little child's environment."

Limitations of mobile service:

These comments expressed concerns that the mobile service could not meet the needs of those who required urgent care. The fact that the mobile service would only visit occasionally also raised concerns about routine appointments being missed if children were absent from school when the bus visited.

"What about emergency dental care - how will that be managed/available? What happens if can't make it on the day the service is in the area?"

"Depends on how often the bus visits. If only once a year, some children will miss it. Needs to be more than once a year"

Education / health promotion:

The importance of early education in establishing good oral health in the long term was commented on. Schools and colleges were recommended as an appropriate setting to continue providing oral health information and education to groups of young people.

"Dental Education for both the kid's and parents. If they are used to going to the dentist on a regular basis when they are young, then they will probably continue as they get older"

4.5 Formal Submission Process

A total of 16 responses to the formal submission process were received. These comprised 14 submission response forms, one letter and one email.

Most of the material within the submission was in qualitative form, apart from a small amount of quantitative demographic data gained from Q1-3 on the submission form (respondent's occupation, representative organisation and ethnicity).

Although analysis was made easier by the structure provided in the submission template, the questions were quite generalised and encouraged respondents to provide broad comment on the proposed service changes. The data was analysed to identify key themes and issues.

Demographic Profile of Respondents:

Occupation/Role of Respondents*

Occupation/Role	Number
Principal / Teaching staff	1
Dental Therapist	13
Dental Assistant	2
Parent	3

Dental Association	1
Dentist	1

*Total are more than 16 as some respondent's ticked more than one box.

Representative Organisation*

Service	Number
School with on-site dental clinic	4
School with no on-site dental clinic	1
School Dental Service	13

*Total are more than 16 as some respondent's ticked more than one box.

*Ethnicity**

Ethnicity	Number
NZ European	12
Māori	3
Other	1 (South African)
Not specified	1

*Total are more than 16 as some respondent's ticked more than one box.

Analysis of Questionnaire Responses:

Respondents were asked the following six questions:

1. The new service would see oral health services for children and adolescents up to 18 years old, delivered from central modernised fixed site clinics, supported by dental buses serving smaller and rural communities. What are your views on these proposed changes?
2. What do you feel would be the most effective method of delivering oral health messages to families/whanau, particularly of babies and young children?
3. What do you see as the main impact from these changes on children, adolescents and their families/whanau?
4. What suggestions do you have to increase enrolments for teenagers once they leave primary and intermediate school?
5. What is important for schools and teaching/support staff that should be thought about before making any of the proposed changes to the Taranaki Oral Health Service?
6. Do you have any other comments that you would like to make about the proposed changes to the Taranaki Oral Health Service to help inform our future planning?

Responses to the questions fell into four general areas:

- Negative impacts of the proposed service changes on dental staff, schools and service users
- Positive impacts of the proposed service changes on dental staff and service users
- Suggestions for more effective ways of delivering oral health education and oral health services to families/whanau with babies and children

- Suggestions for more effective ways of attracting adolescents to use oral health services

Negative impacts of the proposed service changes on dental staff, schools and service users:

Access difficulties:

Concerns were expressed about the impact of moving the service from smaller school-based clinics to central clinics supported by a mobile service on access, particularly for 'at risk' groups and those without transport. There were concerns making access harder would lead to some families and whanau becoming even less likely to use the service, leading to further disparities in access.

> *"My concern is that the proposed changes will create larger disparities by basing clinics centrally and relying on parents/whanau to get their children to clinics whereas traditionally having school based clinics the access has been easier"*
>
> *"…whanau will opt out if the service is not appropriate to them and accessible"*
>
> *"The more parents/caregivers perceive access to dental clinics as being difficult the less likely they are to get their children to them"*
>
> *"By moving clinics from the school grounds is only making access for the most vulnerable harder. Many children's parents do not bring them due to the clinic being at the school and the children are 11/12/13 years old"*
>
> *"Access is so important. Target groups must be catered for most importantly as the people that can afford it will take their children to dental treatment anywhere and will pay if necessary"*

Respondents stressed the importance of siting the fixed facility in a location that would target lower socio-economic groups, particularly those not being visited by the mobile service. The need to use 'free' locations was seen as a potential limitation in choosing the best location and two respondents expressed concern that the central clinic would not offer central access if located on current DHB sites (Hunter Road in Hawera, Westown in New Plymouth) and alternative (central) sites were suggested.

Some respondents felt the mobile service could help to improve access for particular target groups, at low decile schools. However, others expressed concerns about the inability of a mobile service to meet urgent care needs and the practical difficulties in running a mobile service (e.g. who drives the bus, etc.)

> *"Has it been considered that a mobile bus could be used for whole whanau – not just kids?"*
>
> *"My concern is how children will access treatment when the bus is not in Patea. There are many families in Patea who don't have access to transport and there is no public transport system"*

Some respondents suggested that transport (bus or taxi) be provided for those families who needed it, particularly in low decile schools, to take children to the clinics.

"Attendance of low decile families with transportation problems and a lack of priority for their children's oral health, these families tend to only surface when acute problems arise"

Negative impacts on Dental Therapists:

Two main issues were identified relating to the negative impact of the changes on dental therapists – the effect on relationships between therapist and clients, and the broader issues relating to change management. Regarding the impact on the relationship between dental therapist and clients, this relationship was felt to be important to both therapist and families, particularly in building up trust and support, and concern was expressed that this could be lost in the new service.

"I am concerned that Therapists will be working like an assembly line and may lose contact with the clients, relationships are important in Dentistry"

In terms of the broader impacts of the changes on the profession, a small number of dental therapists raised concerns about difficulty managing change, job insecurity, lack of job satisfaction and potential high staff turnover as a consequence.

"High turnover of Dental Assistants possible if job satisfaction is not achieved. Decrease in job satisfaction of Dental Therapists not having a stable, fixed job any longer"

The importance of managing service change by keeping staff, schools and parents informed was highlighted. Dental therapists asked that they be kept up-to-date and allowed to have their say so that personnel concerns could be discussed and compromises reached. They acknowledged the importance of their role in ensuring the projects' success and the need to maintain vision and go forward positively.

"Continue to keep us up-to-date with progress, we need to have our say as we are the workers which will ensure what is planned works"

"Taking on board all personnel's concerns etc. and thrashing them about to come out with something 99% in favour with all. As with all change – easy to be negative/critical but we need to get behind the concept and go forward positively"

Other issues raised included the possibility of more 'down time' for therapists due to missed appointments and some therapists lacked the skill, or desire, to treat adolescents. One respondent also commented that the consultation document failed to recognise the advanced dental needs of many children and did not address these.

"A significant proportion of 0-12 school dental service population will require advanced dental services at some stage. The need for these services is poorly recognised"

Negative impacts on rural communities:

A small number of comments related to the impact of the changes on rural communities, both in terms of children/adolescents accessing services and the knock-on impact of clinic closure on the wider community. These comments related particularly to Patea, Waverley and Manaia. There were concerns that the Hawera Intermediate dental clinic currently served children who travelled by school bus school from areas such as Patea and Manaia, and there would be difficulty transporting these children to a new central clinic for their treatment.

Other concerns focused on the impact of removing the school dental service from Patea. The school dental service operates from a clinic that is shared by a private dentist. Two respondents were concerned that removing the school dental service from the clinic would render it economically unviable to run (particularly if the DHB decides not to upgrade the ageing facilities) leaving the wider Patea community with no private dental service. One respondent suggested that each small town should have a fixed dental clinic, as the costs of equipping these facilities would outweigh the long-term costs of poorer oral health care.

> *"As Waverley and Patea communities both have Dentists I would hate to see them lose their adolescent patients to the School Dental Service as this could seriously impact on their practices"*

> *"If Patea does become serviced solely by the mobile bus what is to happen to the existing clinic? …The equipment is already 15-20 years old and will need replacing in the near future. No dentist is going to set up a practice for one or two days a week and yet this regular service is extremely well supported and appreciated by the local community. At least with the school dental service operating out of the same clinic the equipment has a dual function and makes replacement more economical and viable"*

> *"People in the small communities are always the victims of well meaning bureaucrats who fail to realise that what may work in the cities doesn't necessarily have the same positive effect in the rural areas"*

Negative impact on schools:

A number of comments related to the negative impacts of the changes on schools, particularly the longer amount of time spent out of school travelling to and from dental appointments.

> *"Concern about appointment times affecting school subjects/sports"*

Other concerns included worries about the safety of children leaving the school site to attend appointments, the fact that school staff should not be expected to be responsible for children attending their dental appointments and the lack of wheelchair access to the mobile bus.

> *"If children and adolescents leave school grounds to attend appointments their safety is of concern. Even though parents/caregivers may deem them mature enough to attend on their own will they return on time and safe?"*

Positive impacts of the proposed service changes on dental staff and service users:

Service improvements:

A number of service improvements that would result from the proposed changes were identified, including the provision of new equipment and materials, an improved service image, more choice and the targeting of services to areas of need. One respondent commented the proposed changes would also provide opportunities to offer a 'holistic approach' to oral health care.

"An opportunity to work with whanau in a holistic approach to whanau oral health care…we would improve oral health outcomes for the whole population"

"Fresh bright and inviting facilities will help improve image and hopefully attendance"

Positive impact on dental therapists:

Some respondents commented the service changes would have a positive impact on dental therapists and their working environment, particularly in addressing professional isolation and providing an environment for clients that was more modern, private and safe.

"Great to see us moving into 21st Century – we will be able to provide a far better service. Goodbye to cottage dental service!"

"Modern purpose built clinics are well overdue, for too long we have been working in buildings that are quite unsuitable…working sole charge is also unsatisfactory, professional isolation can and does cause problems for Dental Therapists"

Suggestions for more effective ways of delivering oral health education and oral health services to families/whanau with babies and children:

Improving service delivery:

Many of the respondents suggested new or improved models of service delivery to attract families/whanau with young babies/children, particularly those that allowed one-to-one discussion with dental therapists, Plunket nurses, kaiawhina etc. Suggestions included home visits, whanau-based care and visits to kindergartens and kohanga reo centres.

"In our area (Waitara) home visits are most effective. Face-to-face contact"

Concerns were expressed that the proposed service changes focused extensively on the need to increase adolescent enrolments, but did not give significant weight to the need to improve access and care for the pre-school population whose enrolment numbers are also low. For this population group, respondents highlighted the importance of education and prevention work with parents focusing on the role of diet, fluoride and oral hygiene strategies in preventing decay. Oral health education within schools was also seen as important, with one respondent suggesting an oral health professional be employed solely to visit schools and deliver preventative education.

"Our school dental therapists are our most important tools for promoting prevention"

"Dietary patterns appear to be set in early childhood, the failure of this DHB to recognise this aspect of care is a significant concern"

Other suggestions relating to improved service delivery included dental therapists specialising in particular treatment areas and enabling the service to become more proactive in managing client details and booking appointments (e.g. through a central database).

Information and communication:

Some comments focused on the importance of giving up to date information that was easy to understand. Respondents stated that, in order to achieve this, dental therapists need to be kept up-to-date and need to pass on consistent messages in simple language when clients are most receptive. The use of social marketing techniques and local/national advertising was also suggested.

> *"Therapists would need to know what is being said and done so that everyone is giving the same message"*
>
> *"Advertising nationally would be beneficial, it is tough competing with TV advertising of snack or unhealthy foods"*
>
> *"Basic language and bullet point type leaflets, not lots of words or waffle"*

More partnership working:

A few respondents suggested the school dental service work with other health providers, such as PHO's and Māori Health Care Providers, through the networks already in place. Working with Māori Health Care Providers was suggested as a means of working more effectively with whanau. Using Health Promoting Schools as a resource, as well as linking in with schools existing systems of communicating with families, was also suggested.

> *"Whanau based care. I like the idea of casting our nets wide and working with PHO/Māori Providers etc "*
>
> *"Perhaps setting up a liaison with schools and linking in with their reporting to families system"*
>
> *"It is important that parents as first role models have access to oral health services and to be positive dental health models to their children. Therefore we recommend that you look to strengthen the ability of Māori health providers to provide these oral health services to parents and whanau"*

Suggestions for more effective ways of attracting adolescents to use oral health services:

Promote continuity of service:

Some respondents suggested that the school dental service promote continuity of service either by automatically enrolling students who are not registered with a private dentist, or by offering students the choice of remaining enrolled with the school dental service when they leave intermediate school/enroll at high school in Year 9.

> *"Offer them the school dental service as a choice for continued care when GDB enrolment done in Year 8"*
>
> *"Keeping in contact with children after they have left Intermediate if they indicated that they're not going to see a private dentist"*

Advertising and promotion:

Respondents also highlighted the need for the school dental service to advertise and promote its service through schools and dental services, particularly to inform adolescents/families what the service offers and that it is free. The use of age appropriate resources, and advertising campaigns specifically aimed at teenagers, were suggested.

> *"It is important to educate teenagers/high school children to the fact that they can still visit their dental clinic for all their oral health needs and that it's a free service till the age of 18"*

Service improvements:

Some service improvements were suggested that could be used to increase adolescent enrolments. These included visiting high schools with the mobile service, providing a culturally sensitive and friendly service and flexible opening hours, including school holidays.

> *"Flexible appointment times to fit around school timetables and family commitments, possible appointment offered in school holiday…could be achieved by job-sharing positions or flexi hours for dental therapists/assistants"*

> *"Friendly staff/culturally sensitive and age appropriate resources"*

Service limitations:

A small number of respondents expressed concerns about service limitations that make increasing adolescent enrolments difficult. The first of these concerns related to dental therapists' workloads. Therapists are often fully booked and the increased workload associated with treating 0-18 year olds could prove difficult given current workforce availability.

> *"What is your strategy to cope with increases in workload of treating 0-18 year olds when there is a potential problem with workforce availability?"*

The other concern related to accessing updated client data to manage enrolments, particularly as the school dental service moved away from the school setting. A central database, updated annually, was suggested as a potential benefit for both the school dental service and private dentists. Another suggestion was for a centralised communication service that could advise on clinic availability and out of hours care, along with more use of text and email communications.

> *"Primary school rolls in many rural schools change every year by 30% to 40%…When the School Dental Service moves away from the schools will their access to current school rolls be reduced? We recommend that the new oral health service have access to the education database and that relevant information also be passed on to the relevant adolescent dentists"*

Communication between school, dental service and families/whanau:

A number of respondents highlighted the importance of maintaining good relationships between the dental service and schools, and the need for good communication to promote enrolment and attendance at the new clinics. Support from schools in encouraging children to use the service was seen as essential.

"Positive buy in from schools, actively supporting and encouraging children to take up a free health service"

"Keeping the community WELL informed. Reassuring them that the service will be improved not diminished"

5.0 Reducing Māori Health Inequality

5.1 Model of Service Delivery Recommendations from the Māori Health Care Providers Working Group

- The model of service delivery be re-oriented to a whanau ora service. This has been defined for this project as: "*Wellness and wellbeing of the whanau as a whole. A holistic approach to health which includes oral health."*

- The new Taranaki Community Oral Health Service should co-locate and provide joint care with Non-Government Organisations (NGO's). A whanau ora approach would see the inclusion of all age groups being treated from one location.

- That TDHB provide tikanga and Treaty training / education for all current and future oral health staff. This will aid in addressing the clinical mainstream feel of the current School Dental Service, identified as a barrier for Māori.

- That all current and new oral health staff participate in tikanga and Treaty of Waitangi training provided by TDHB.

- The Taranaki Community Oral Health Service include a cultural competency component in the biannual clinical appraisals of oral health clinicians.

- All oral health staff provide evidence of applying the principles of the Treaty of Waitangi in their individual practice.

- That TDHB takes the opportunity when employing Dental Assistants for the new Community Oral Health Service, to target young Māori for these positions. This would address the issue of appropriate staff working with the clinicians for both the adolescent patient group and Māori communities. It is also a proven workforce development tool as those people who show an interest in the oral health professions can then be supported to further their education at either AUT or Otago University.

- The Dental Assistant positions be widely distributed to Iwi, Hapu and Māori Health Care Provider networks.

- The plans for the new facilities must include space for whanau to support the patient receiving oral health care.

- The new oral health clinics be located in high deprivation areas.

- That more Taranaki resources are developed with key oral health education and promotion messages and that they are translated into Te Reo Māori.

- That Māori Health Care Providers are considered first and adequately resourced to be able to deliver Oral Health education, promotion and early enrolment for oral health care.

- That all future oral health consultation contains an ethnicity question.

- The mobile oral health surgeries provide oral health care on Marae, Kura Kaupapa Māori, Whare Kura and Te Kohanga Reo grounds or at events that are frequented by Māori and high needs communities.

6.0 Discussion

6.1 Limitations of Consultation Methodology

The consultation was an immense undertaking involving the distribution of around 40,000 consultation questionnaires, information newsletters and postcards to Taranaki families through Primary and Intermediate Schools, Kura Kaupapa Māori, Early Childhood Centres and Kohanga Reo. In addition to this the consultation included a number of stakeholder interviews, focus groups, project working groups, on-line surveys as well as the usual formal submission process that often accompanies DHB consultations.

The use of these multiple consultation methods reflect the commitment of the DHB to enabling participation by as many different groups as possible. The diversity of responses – from parents, young people, health care providers, oral health professionals and others – reflects this. However, it should be noted that approximately 600 consultation responses were received, representing a very small percentage of the overall population with a direct interest in oral health services, either as service users or providers. As with all consultations we should not only consider the consultation findings but also ask ourselves “whose voice has not been heard?”

All consultation processes have inherent limitations within the different methods and approaches used that can inadvertently serve to exclude the participation of certain groups, promote the participation of others or distort the actual data that is collected and analysed. These limitations should be noted and used to inform future consultation planning.

As the majority of the consultation data was generated from questionnaires and on-line surveys, the limitations of these method are considered below along with recommendations for improving future consultations.

Questionnaires:

To encourage as many parents to respond as possible it was decided that the questionnaire should be kept as short as possible. For this reason the respondents’ location or ethnicity was not asked for on the questionnaire.

Lack of ethnicity data from these questionnaires means that it was not possible for us to break down the analysis of the data to compare responses between Māori and Non-Māori.

Similarly, a general lack of information regarding location also limited the ability to analyse data by location. Although some questionnaires were returned in envelopes with a school or clinic address stamped on the back, a significant proportion of the questionnaires were returned from unknown sources.

Other issues relating to the use of questionnaires include the potential for biased results. This may be due to selection bias in the way respondents are selected (or select themselves). For example, questionnaires are less likely to be used by those with lower literacy levels and hence questionnaire results will not include their views. Indeed there is no means of measuring how many of the consultation questionnaires, postcards or newsletters were actually delivered to parents. Further potential for bias is possible through the misinterpretation of questions – for example, what respondents understand by the terms "culturally appropriate service" or "better communication between school and dental clinic". Questionnaires were piloted on a number of parents before being produced but the potential for such bias always remains.

For future consultations an ethnicity question should always be included.

Allowing as much time as possible for the return of questionnaires is advisable. A good proportion of the questionnaires were received well over a month after the official close of the consultation (which was extended as a result). It is possible that more questionnaires would have been returned if the extension to the consultation period was more well known.

It is also important to consider the use of other more participatory (but time-consuming) methods, such as focus groups, to target those who may not be reached by questionnaires.

On-line surveys:

As well as the general issues considered already for on-line surveys, there are some additional limitations of on-line surveys. The first of these is that they rely on computer access. Relying on the results of on-line surveys alone would always be questionable as the results would reflect the views of those with access to computers (possibly the more affluent and more computer literate members of society). A further complication is that there is the potential for the same person to fill in multiple questionnaires, thus biasing the results.

However, on-line surveys can often allow for the collection of more data because they are usually quicker to complete than paper questionnaires (the comments in the on-line surveys were much more extensive than the paper comments). They can also be a good way of encouraging young people to participate in a consultation.

For future consultation it is well worth considering the use of questionnaires, particularly as a means of engaging young people. However, they should not be used in isolation as they will only reflect the views of those who are computer literate and/or have access to a PC. The potential for bias if one person completes multiple questionnaires should also be noted.

7.0 Consultation Recommendations

The views expressed during the consultation have been analysed and the following recommendations are made to the Taranaki Community Oral Health Steering Group to inform service planning and the development of the future model of service delivery:

The model of service delivery is important

- The model of service delivery be re-oriented to a whanau ora service, defined for this project as: "*Wellness and wellbeing of the whanau/family as a whole. A holistic approach to health which includes oral health."*

- Oral health service for adolescents are provided within a model of service that is young people friendly and that adolescents are involved in the planning and development of such services wherever possible.

- The mobile oral health service (bus) be used in creative ways to target high needs populations and to provide a 'back up' service to existing oral health providers at secondary schools.

- The Taranaki Community Oral Health Service takes the opportunity when employing Dental Assistants for the new Community Oral Health Service, to target young Māori for these positions. This would address the issue of appropriate staff working with the clinicians for both the adolescent patient group and Māori communities. It is also a proven workforce development tool as those people who show an interest in the oral health professions can then be supported to further their education at either AUT or Otago University.

- The Māori Health Care Providers are considered and adequately resourced to be able to deliver Oral Health education, promotion and enrolment for oral health care.

- That all oral health workforce vacancies be widely advertised through Iwi, Hapu and Māori Health Care Provider networks.

Continuity of care is important

- The Taranaki Community Oral Health Service ensures that Dental Therapists continue to treat the same patient group on a continual basis and not be rotated around communities – it is strongly recommended that the oral health team should build a relationship with the community they treat as consistency is important.

Access (location) is important

- The new oral health clinics be located in high deprivation areas.

- The new Taranaki Community Oral Health Service co-locate and provide joint care with Non-Government Organisations. This whanau ora approach would see the inclusion of all age groups being treated from one location.

- The Taranaki Community Oral Health Service provide oral health services on site at secondary schools.

- The mobile oral health surgeries provide oral health care on Marae, Kura Kaupapa Māori, Whare Kura and Te Kohanga Reo grounds or at events that are frequented by Māori and high needs communities.

A culturally appropriate model of service delivery is important to address the current oral health inequalities

- That all current and new oral health staff participate in tikanga and Treaty of Waitangi training provided by TDHB.

- The TDHB include a cultural competency component in the biannual clinical appraisals of oral health clinicians.

- All oral health staff provide evidence of applying the principles of the Treaty of Waitangi in their individual practice.

- That more Taranaki resources are developed with key oral health education and promotion messages and that they are translated into Te Reo Māori.

Access (appointments) is important

- The Taranaki Community Oral Health Service ensures maximum access to the oral health service for all clients by extending the opening hours of the oral health clinics, ensuring the oral health clinics are open during school holidays and making flexible appointments times for the patient group and their whanau / families.

- The Taranaki Community Oral Health Service provide the mechanisms for adolescents to be able to have their oral health appointments times and reminders using text to their mobile phones and email.

Promotion of the service is important

- The Taranaki Community Oral Health Service ensures ongoing advertising of oral health services for teenagers using a variety of mediums such as radio, internet and social marketing techniques.

The clinic environment is important

- The plans for the new facilities must include space for whanau / family to support the patient receiving oral health care.

Communication and a team approach is important

- The Taranaki Community Oral Health Service ensures that good communication between schools and the dental service continues as the service moves more to a community base.

- The Taranaki Community Oral Health Service develops and builds a team approach to Oral Health education and promotion between Māori Health Care Providers, Primary Health Organisations, Private Practice Dentists and the TDHB Oral Health Team.