

**TO** Hospital Advisory Committee

**FROM** Kate Aplin  
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## MEMORANDUM

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**SUBJECT** Business Case for Investment in Child and Adolescent Oral Health Services

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### 1. Purpose

The purpose of this report is to seek MidCentral District Health Board (MDHB) support for a new configuration of child and adolescent oral health services utilising funding from the Ministry of Health (MoH). MDHB support is sought to make an application to the MoH to access this funding. The previous summary paper dated 6 November 2007 is superseded by this paper.

### 2. Background

#### 2.1 National Context

In August 2006 MidCentral District Health Board received the MoH Child and Adolescent Oral Health Service Improvement Guidelines. The MoH then released The Strategic Vision for Oral Health in New Zealand 'Good Oral Health for All, for Life'. This vision underpins the work of MDHB over the next five years.

The MoH strategy focuses on the following principles:

- Improving the oral health status of disadvantaged people.
- Oral Health is an integral part of general health and well being.
- DHBs have the primary responsibility for ensuring high quality health services are available.
- A strong preventative programme complements examination and treatment.

- A robust and appropriately trained workforce provides a high quality service.
- Evidenced based oral health services require comprehensive information collection and ongoing research.

In 2004, prior to the release of the guidelines and vision, the MoH completed a national review of oral health services. This was followed in 2005 by each DHB completing a 15-year oral health service Asset Management Plan (AMP). As a result of both of these national reviews, the MoH released the Community Oral Health Service Guidelines and Business Case Guidelines for Investment in Child and Adolescent Oral Health Services in August 2006 to support the implementation of the national strategy. Capital funding has been tagged by the MoH for implementation of the strategy in recognition of DHB's financial position. The guidelines define the process by which all District Health Boards can access the \$10.2m per annum operating funding increase and the \$100m capital funding over the five years to 2011. This initiative is targeted at the reorientation of services for the 0–18 year old population. The funds are available only for the implementation of this strategy and cannot be used elsewhere within the DHB.

The following table identifies the current situation in New Zealand for dental care for 0–18 year olds, and the proposed future situation, as described by the MoH.

**Table 1. Current and Future Service Provision**

<b>Now</b>	<b>Future</b>
An emphasis on treatment	An emphasis on prevention and early intervention.
A division between oral health and general health	Oral health is integrated into general health frameworks.
DHBs provide service	There is a mix of service providers, including DHBs, Māori and Pacific providers, and NGO.
School-based dental services for children	Community-based dental services for children, with the potential to expand to adolescents and low income adults.
Separate funding for child and adolescent oral health services	Funding that allows flexibility of service programme design.
An emphasis on primary school years	An emphasis on preschool and early primary school years.
Clinicians work in isolation	A team-based approach to oral health – dentists, dental therapists and dental assistants work together.
A small Māori and Pacific oral health workforces	A workforce more representative of ethnic diversity in NZ.
Pressure on secondary services	Greater capability at the primary care level, with secondary services focused on patients who cannot be managed by primary care.

The MoH requires detailed business cases for future investment proposals relating to the reconfiguration of dental services for the 0–18 year population.

Funding for day-to-day operational items are not to be included in business case requests for capital expenditure, nor are requests relating to information systems, as these items are deemed to be an operational cost that the DHB should be already funding.

## 2.2 MDHB Context

The MDHB District Strategic Plan 2005 - 2015 identifies oral health as one of ten priority areas to be addressed.

MDHB District Annual Plan 2007/08 initiative number 5 is

*“Child and Adolescent Oral Health Service Improvement Project is progressed in line with the Ministry of Health’s strategic vision, “Good Oral Health for All, for Life”, including reorientation of service and a new model of service delivery being introduced over the next five years”, with the goal of the first phase of implementation of this occurring in September 2008.*

While MidCentral Health has not developed a formal oral health plan, service development is guided by the MDHB Oral Health Service Plan 2005, MDHB Primary Health Care Strategy 2004 and the MDHB Child Health Strategy 2005.

The total population eligible for examination and treatment (0–18 year olds) is anticipated to be 33,102 in 2011, which is an increase of 25% from the 2007 School and Adolescent Dental Service contracted volumes. Of the 33,102, 30% are anticipated to be high risk, that is requiring up to 6 monthly recalls, and 10% of this number are anticipated to be of very high risk requiring greater than 6 monthly recall. The total appointments anticipated to be required per annum are 43,926. Please note that the population for Otaki are not incorporated in the table below due to them being captured in a different region in census data.

**Graph 1. MDHB Population Projection to 2026**

	2001	2006	2011	2016	2021	2026
0 to 14 years (incl.)	34300	32300	30000	28100	26800	26300
15,16,17 y o (est.)	6588	6432	6300	6216	6324	6276
Total 0-17 years	40888	38732	36300	34316	33124	32576

Oral Health Services for children and adolescents within MDHB are provided through two main contracts:

- MidCentral Health School and Adolescent Dental Services for those aged between 2½ and 13, with some service provision for 13–18 year olds (adolescents). Services for adolescents in Otaki are solely provided by the MCH School and Adolescent Dental Service due to there being no private Dentists in Otaki holding Community Dental Contracts.
- Community Dental Contracts with 30 private dental providers for those aged 13–18. These services are provided from the private facilities.

The School and Adolescent Dental Services provided through MidCentral Health are paid according to the national pricing schedule which results in a deficit position annually. This deficit is anticipated to grow even if the service remains as it is as. This is detailed in Section 5, along with analysis of status quo and break even positions.

Examination and treatment is provided by 25.5 Full Time Equivalent (FTE) Dental Therapists and 7.2 FTE Dental Therapist Assistants. Professional oversight is provided by a 0.8 FTE Clinical Director/Principal Dental Officer. A survey of existing Dental Therapist and Dental Therapy Assistants in 2007 indicated that there would be 55% leaving the workforce by 2013.

Recognition is given to the efficacy of the Adolescent Oral Health Coordinator role that commenced in 2004 over which time the MidCentral DHB Adolescent Utilisation rate has increased from 61.4% to 76.3% which is the greatest increase nationally. This position, along with greater leadership within the School and Adolescent Dental Service, has proven the need to continue to strengthen coordination and leadership in the future. The proposed service reconfiguration model incorporates this.

Services are predominantly provided from 41 fixed single chair clinics owned and maintained by the Ministry of Education. Funding for the clinics located on school property, occupied by health providers, will be changed in 2008, when the DHB will pay a peppercorn rental of \$10 per annum for each building tenanted, with all maintenance responsibilities transferring to the tenant.

Required standards for infection control, disability access, and workplace safety have altered over the 60 years that the buildings have been in existence resulting in significant work needing to be undertaken to alter the buildings to meet the current standards. Sixteen school dental clinics were closed in 2004 following identification of significant work and upgrade costs.

Three single chair mobile dental clinics are also used by the School and Adolescent Dental Services where the mobile dental clinic is able to park at different schools around the region to provide an on-site service. One of these mobile dental clinics is dedicated to the Adolescent Dental Service.

School and Adolescent Dental Services are provided for 40 weeks per annum during the primary school year. Services are not available during school holidays, or after hours due to the service configuration, funding model, and also employment contracts of existing staff. Emergency situations – for example; relief of pain – that occur during the holiday periods are dealt with by either the Hospital Dental Unit or a private provider.

Dental Therapists work predominantly in isolation, resulting in significant clinical time being taken up by non-clinical work, e.g. cleaning of equipment and administrative tasks. Peer support is not available as a result of the isolation, and therefore risks to the Dental Therapist's professional safety arise due to allegations around malpractice or poor behaviour, which are not easily mitigated without independent verification.

Parents/caregivers are able to choose to take their 2½–12 year old children to their family dentist, however the family pays for this privately. Once the child commences secondary school they can still attend the same dentist with the cost of the visit being covered by the Community Dental Contracts, as long as the chosen dentist holds a contract with MDHB.

MDHB has taken a proactive approach to asset replacement for the School and Adolescent Dental services over the past four years, resulting in minimal equipment upgrades being required as part of this current business case. The MoH has stated that they will not be providing additional funding through this process for “business as usual” items that should already be included in DHB funding packages.

There is no integrated information system for oral health services, and the School and Adolescent Dental Service has a paper based system. Investment in information technology for this service has been tagged in the MDHB Information System Strategic Plan (ISSP) for 2007/08. This investment will be held until confirmation of the new service delivery model has been received. Funding for information systems is another item excluded by the MoH and therefore is not included in this business case.

Table 2 identifies that MDHB children have marginally better oral health status recorded than the national average. Caries-free is defined as children who do not have signs of dental caries (dental decay) recorded at age five, and at Year 8 (12-13 years old). DMFT relates to the number of Decayed, Missing, and Filled Teeth as a result of dental caries, present in the mouth of children at the age of five and Year 8.

**Table 2. MDHB Oral Health Status Compared to National Position**

MDHB Rates	2004	2005	2006	National 2006 Rates
<b>% caries free 5 year olds</b>	55.1%	51.4%	53.88%	52%
<b>% year 8 (12 and 13 year olds) caries free</b>	45.3%	46.4%	45.36%	44.3%
<b>5 year old mean DMFT</b>	2	2.27	2.13	2.24
<b>Year 8 mean DMFT</b>	1.6	1.6	1.63	1.67

Table 3 identifies that the oral health status for Māori and Pacific Island is worse than all other groups. Table 3 also shows good oral health for the “other” group. (*Other is defined as those who do not identify as Maori and Pacific Island as indicated in census returns.*)

**Table 3. Ethnicity/Fluoridation MDHB Oral Health Status**

MDHB 2006	5 year old mean DMFT	5 year old % caries free	Year 8 mean DMFT	Year 8 % caries free
All children	2.13	53.88	1.63	45.36
All fluoridated	1.97	56.56	1.66	44.13

All non-fluoridated	2.4	49.24	1.59	47.32
Maori fluoridated	3.14	40.32	2.54	28.6
Maori non-fluoridated	3.79	26.76	1.98	32.9
Pacific Island fluoridated	3.69	27.08	2.33	39.49
Pacific Island non-fluoridated	5.1	35	1.57	47.6
“Other” fluoridated	1.44	64.12	1.39	48.6
“Other” non-fluoridated	1.67	59.9	1.41	53.6

There are 120 primary, intermediate and kura kaupapa schools within MDHB of which 34% (41 schools) have a dental clinic on site, with a 36% utilisation rate. Forty-eight schools, or 40%, are visited by the three mobile dental clinics, with the remaining 24.4% (28 schools) travelling to either a school with a clinic or where the mobile clinic is at any given time, for examination and treatment. The latter are known as contributing schools.

**Table 4. Service Provision Locations**

	<b>Number of schools</b>	<b>Number of dental chairs</b>	<b>% of total</b>
Schools	120*		
School with clinic on site	41	41	34%
School visited by mobile	48	1 dedicated for adolescents 2 general population	40%
Contributing school	28		24.4%

\* note that 3 of these schools are serviced by mobile dental clinics from Whanganui

MidCentral School and Adolescent Oral Health Service is contracted to provide 22,161 completed treatments for the 2½ to 12 year olds, and 2,751 for adolescents. The *Oral Health in New Zealand 2006* report released by the Ministry of Health in October 2007 indicates that 76.3% of all eligible adolescents are enrolled with an oral health service provider.

### **3. MDHB Process**

#### **3.1 Project Structure**

Sponsorship for the Child and Adolescent Oral Health Service Improvement project is through the MDHB Executive Management Team.

Two working teams were developed to support the development of the Business Case:

- i) Project Team: This team was tasked with “doing the work” required to complete the Business Case and consisted of the Project Manager, Business Leader for MCH Dental Services, and a Performance Analyst from the Performance Planning Unit.
- ii) Reference Group: Provided advice, guidance and technical expertise on the local context. This group had representation from MCH School and Adolescent Dental Service staff, MDHB Funding Division, Compass Health, Iwi representation, and Child Development Services.

#### **3.2 Engagement**

Engagement with key stakeholders during the development phase of the Business Case occurred. Key stakeholders were identified as:

- i) Existing MCH School and Adolescent Dental Service Staff.
- ii) MCH School and Adolescent Dental Service management.
- iii) MDHB Funding Division, in particular Primary Health Care and Child Health portfolio managers.
- iv) Private Dental providers.
- v) Primary Health Organisations.
- vi) MDHB Oral Health District Management Group (DMG).
- vii) Neighbouring DHBs.
- viii) Iwi representatives
- ix) Pacific Island representatives.
- x) Well Child providers.
- xi) School Principals.
- xii) School Boards of Trustees.
- xiii) MoH Oral Health Directorate.
- xiv) Ministry of Education Network Planning Directorate.

Engagement occurred through presentations to groups and individuals, by providing written information, by e-mail and phone conversations, and workshops.

Following gaining support from MDHB, and subsequently the MoH to fund the implementation of the proposed model, wider community engagement will occur (refer Table 13 for further implementation detail).

#### **3.3 Engagement Outcome**

Fourteen scenarios were developed through the engagement process. Of these, five were identified as preferred service delivery models for Oral Health

services for the 0–18 year old population of MDHB, and these were developed as options. A status quo option, with the addition of the \$10 per annum peppercorn rental and maintenance costs imposed by the Ministries of Health and Education, was also analysed. A financial analysis of the options was undertaken, as well as a Health Equity Assessment Tool (HEAT) analysis, to identify the preferred option.

### Service Exit

The possibility of exiting the provision of dental services was proposed however this would only be an option for the School Dental Service, not MDHB overall, as the provision of a service, whether through a contract with MidCentral Health or an alternative provider, is the responsibility of the DHB therefore further exploration of this has not occurred.

### Options Developed

All options, with the exception of the status quo, included the introduction of double chair clinics, a reduction of single chair clinics, increased mobile dental clinic provision, and workforce development components. The preferred option was chosen as it met the greatest number of essential criteria, these being:

- Re-orienting child and adolescent oral health services.
- Reducing inequalities in oral health outcomes and access to oral health services.
- Promotion of oral health.
- Building linkages with Primary Health Care.
- Building the oral health workforce.

The preferred option has been benchmarked against the status quo position, and also with Capital and Coast, Hutt Valley, Hawkes Bay, Nelson Marlborough, and Whanganui DHBs options with favourable outcomes.

**Table 5. Service Configuration Options**

<b>Options</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
<b>Total number of chairs</b>	20	21	21	21	21	20	46
<b>Number of mobiles</b>	4	6	8	11	13	3	3
<b>Number of fixed clinics</b>	8	5	3	0	0	17	41
<b>Number of co-located clinics (note these are fixed but tenanted)</b>	0	2	2	2	0	0	0
<b>Hours of availability</b>	50 weeks, 8 hours per day	50 weeks, 8 hours per day	50 weeks, 8 hours per day	50 weeks, 8 hours per day	50 weeks, 8 hours per day	47 weeks, 8 hour day	40 weeks, 7 hour 35 minute day

#### 4. MDHB Preferred Option and Comparison

The configuration of the proposed model is Option 3 in the table above:

- Three double chair clinics owned by MDHB and sited at schools in areas of high need.
- One single chair clinic and one double chair clinic co-located in primary health owned facilities in Palmerston North and Feilding as tenants, dependant upon the feasibility study into co-located primary health practices being undertaken by MDHB over mid- to late-2007 being viable.
- Four new double chair mobiles and one new single chair mobile in addition to the existing three single chair mobile dental clinics. All mobile dental clinics will be owned by MDHB.

Table 6 identifies the key differences between the current and future service configuration relating to clinic and chair numbers, and chair utilisation rates, i.e. the number of hours per year that each chair is used as a percentage of the available hours. The available hours are influenced by the school population that a clinic serves, and Dental Therapist availability to provide a service, i.e if a school has a roll of 200 children the clinic will be used for 8 weeks of the year to ensure that all children are able to be seen annually. A Dental Therapist will provide the service from the School Dental Clinic for the 8 weeks required for the population and then will relocate to another School Dental Clinic to attend to that population. Although efforts have been made to have portable equipment that is able to shift with the Dental Therapist there remains some equipment, for example, the dental chair and compressor, that are not able to be portable by nature of the industrial and ergonomic requirements for these items therefore they remain in a clinic even when the clinic is not in use, reducing the chair utilisation rate.

**Table 6. Clinic Comparison for Status Quo and Preferred Option**

	Number of fixed clinics	Number of fixed chairs	Number of mobile clinics	Number of mobile chairs	Percentage chair utilisation
Current	41	43	3	3	36%
Preferred Option	5	9	8	12	81%
Variance	- 36	- 34	+5	+9	+ 45%

A change to the model of care will also occur to involve inclusion of oral health assessments for toddlers and children as part of their scheduled well child checks, provided through the primary health sector.

An integrated clinical record, accessible to all those providing health care for an individual or family, will be developed.

The primary health sector would be notified when children are discharged from secondary health services without an identified primary health provider in order for the primary sector to identify a primary health provider. The

primary care provider takes responsibility for the co-ordination of overall health of the individual or family within their care.

Development of a risk assessment tool will occur ensuring that those at high risk of poor oral health, and subsequent poor general health, are identified early in order for a focussed package of care to be developed, utilising a multi-disciplinary, multi-agency approach when appropriate.

Increasing service mobility while retaining fixed clinics at some schools will enable greater numbers of schools with small populations to have a service provided on site. Co-location of dental chairs with combined primary health care facilities will enable those attending for a well child check to have their oral health check at the same time, and also allow greater access for the adolescents who have left school. Access to specific groups will improve due to greater mobility – for example, to a church site for Pacific Island people. The proposal increases mobile options by 75%.

Table 7 provides detail for how the MDHB current position and proposed solution compare with the MoH strategy. The requirement is for DHB's to provide an oral health service to the population that it serves. An analysis of each option rated against the proposed solution is available in Appendix 4.

**Table 7. Current/Future Comparison**

<b>MDHB Current Configuration</b>	<b>MoH Strategy</b>	<b>MDHB Solution</b>
Targets, financial and volume, are related to completions, i.e. completed treatment	An emphasis on prevention and early intervention.	Incorporating oral health checks with the Well Child schedule.  Targeted intervention according to need.
The School and Adolescent Dental service is siloed	Oral health is integrated into general health frameworks.	Incorporating oral health checks with the Well Child schedule.  Co-location with Primary Health providers.
The School and Adolescent Dental service is siloed	There is a mix of service providers, including DHBs, Maori and Pacific providers, and NGO.	Flexibility of service configuration to allow services to be provided from a range of sites with potential for more non-DHB providers.
41 clinics and 3 mobile dental clinics provide treatment from school sites  Service available during school term and school hours only	Community based dental services for children, with the potential to expand to adolescents and low-income adults.	Increase mobile services by 75% to enable service provision in more locations.  Co-location with primary health providers.  Three fixed clinics at schools where the school is seen as the community.  Service available for 50 (to accommodate public holidays) weeks of the year with flexible

		operating hours.
Funding for School and Adolescent Dental services is separate from all other funding	Funding that allows flexibility of service programme design.	Reconfigure funding to enhance implementation of the proposed model.
An emphasis on primary school years	An emphasis on preschool and early primary school years.	Integrate Oral Health checks with the Well Child schedule.  Provide a service in the locations closer to preschoolers.
Clinicians work in isolation	A team-based approach to oral health – dentists, dental therapists and dental assistants work together.	Introduction of double chair clinics and chair side assistants, with a community dentist and a clinical educator to provide a support service delivery.
Two Māori and no Pacific Island Therapists within MDHB	A workforce more representative of ethnic diversity in NZ.	Incorporate cultural safety programmes into Therapist competencies while encouraging Māori and Pacific Island secondary school students to see oral health as a career, and utilise available scholarships.
Increased waiting lists for FSA and General Anaesthetics	Greater capability at the primary care level, with secondary services focused on patients who cannot be managed by primary care.	Early detection and monitoring of at risk children and families allows greater preventative measures to be undertaken, reducing the need for secondary intervention.  Employment of a community dentist enhancing the scope of work that is able to be undertaken in community settings.

Table 8 compares the current staffing requirements to the proposed future requirements.

**Table 8. FTE Comparison for Status Quo and Preferred Option**

	Current	Preferred Option	Variance
Service Manager	1	1	0
Clinical Director/Principal Dental Officer	0.6	0.2	- 0.4
Community Dentist	0	0.5	+ 0.5
Service Coordinator	0	0.5	+ 0.5
Clinical Educator	0	0.5	+ 0.5
Dental Therapist	25.5	21	- 4.5
Dental Assistant	7.87	13	+ 5.13
Administrator	0.8	0.6	- 0.2
<b>Total</b>	<b>35.77</b>	<b>37.3</b>	<b>+ 1.53</b>

## 5. Financial Analysis

An analysis of the current service followed by development of a new service model was completed prior to determining the number of dental chairs and facility configuration. Five variations of a new model of service delivery have been costed together with the status quo and an option based on attaining a minimum compliance level across 17 fixed chair clinics. The operational implementation is due to commence in 2009/10 following development and approval of an implementation plan. In preparing the financial estimates presented in the accompanying tables, a number of assumptions have been made which are detailed in Appendix 1. The financial information presented needs to be read in conjunction with the information presented in Appendix 1.

The analysis is high level, prepared with the intention of providing anticipated costs for the provision of service under the different options.

### 5.1 Capital Expenditure

Capital Expenditure of \$5.584 million over five years is requested from MoH capital funding pool to implement the preferred model. The cost of capital has been calculated at 8% and is included in the financial analysis. The request is above the \$119,000 identified for each year of operation for replacement of day-to-day clinical items identified in the Asset Management Plan (AMP), and therefore identified as a regular running cost for MDHB rather than being able to be put forward as an additional capital expenditure request to the MoH.

**Table 9. Forecast Capital Expenditure**

	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>
	<b>09/10</b>	<b>10/11</b>	<b>11/12</b>	<b>12/13</b>	<b>13/14</b>
	<b>F'cast</b>	<b>F'cast</b>	<b>F'cast</b>	<b>F'cast</b>	<b>F'cast</b>
	<b>(\$,000)</b>	<b>(\$,000)</b>	<b>(\$,000)</b>	<b>(\$,000)</b>	<b>(\$,000)</b>
Buildings	\$455,126	\$843,804			
Vehicles	\$1,538,305	\$1,092,727	\$506,479		\$119,405
Clinical Equipment	\$88,172	\$374,330	\$81,137	\$56,109	\$58,657
Furniture and Fittings		\$32,782			
	<b>\$2,081,603</b>	<b>\$2,343,643</b>	<b>\$587,616</b>	<b>\$56,109</b>	<b>\$178,062</b>

### 5.2 Operational Performance

Estimates used in the forecast statement of operating performance prepared for each option are based on the proposed model of care and service delivery model.

The analysis shows that irrespective of the option chosen, other than the status quo, operating expenditure is likely to exceed revenue. Also shown is the fact that the greater mobility of service the higher the ongoing operating

costs. Although mobility of service increases access it is more expensive to sustain e.g to the costs of transporting the unit from site to site, costs of staff travel to the location, and higher depreciation costs than fixed facilities.

Given that the greater capital expenditure is expected to be phased across 2009/10 and 2010/11, Year 3 of the forecast statement of operating performance provides the best indicator as to the likely financial performance of each option. It is expected that the capital expenditure spend in Years 1 and 2 will result in an increase in the depreciation expense and cost of finance and a reduction in maintenance costs.

Key ratios and funding comparisons are shown in Table 10. The assumption that the preferred model of service delivery will deliver an efficiency gain of 27% is fundamental to this business case – refer to Section 5.3 for a sensitivity analysis.

A detailed statement of operating performance containing forecast information for the first five years and Year 10 of the project for the preferred option is presented in Appendix 2.

**Table 10. Comparative Setup**

	<b>Option 1</b>	<b>Option 2</b>	<b>Option 3</b>	<b>Option 4</b>	<b>Option 5</b>	<b>Option 6</b>	<b>Option 7</b>
	<b>4 mobile 8 fixed</b>	<b>6 mobile 5 fixed, 2 co-located</b>	<b>8 mobile 3 fixed, 2 co-located</b>	<b>11 mobile 2 co-located</b>	<b>13 mobile 0 fixed</b>	<b>Minimum Compliance</b>	<b>Status Quo</b>
<b>Year 3 Clinical and Personnel Plans</b>							
Volumes (completed treatments/client cases)	38,912	38,912	38,912	38,912	38,912	38,912	24,912
Fixed Clinics	8	7	5	2		17	41
Mobile Clinics	4	6	8	11	13	3	3
<b>Clinics</b>	<b>12</b>	<b>13</b>	<b>13</b>	<b>13</b>	<b>13</b>	<b>20</b>	<b>44</b>
<b>Chairs</b>	<b>20</b>	<b>21</b>	<b>21</b>	<b>21</b>	<b>21</b>	<b>20</b>	<b>46</b>
Shore facilities	7	15	30	30	45		
<b>FTEs</b>	<b>36.30</b>	<b>37.30</b>	<b>37.30</b>	<b>37.30</b>	<b>37.30</b>	<b>41.30</b>	<b>35.77</b>
<b>Year 3 Forecast Statement of Operating Performance (2011/12)</b>							
	<b>F'cast (\$,000)</b>	<b>F'cast (\$,000)</b>	<b>F'cast (\$,000)</b>	<b>F'cast (\$,000)</b>	<b>F'cast (\$,000)</b>	<b>F'cast (\$,000)</b>	<b>F'cast (\$,000)</b>
Revenue	\$3,956	\$3,956	\$3,956	\$3,956	\$3,956	\$3,956	\$2,864
Personnel Costs	\$2,490	\$2,570	\$2,570	\$2,570	\$2,570	\$2,714	\$2,048
Clinical Supplies	\$256	\$256	\$256	\$256	\$256	\$256	\$223
Infrastructure & Non-Clinical	\$1,076	\$1,297	\$1,492	\$1,737	\$1,937	\$1,146	\$896
Overheads	\$378	\$380	\$385	\$388	\$396	\$379	\$244

<b>Operating Surplus(Deficit)</b>	<b>(\$244)</b>	<b>(\$548)</b>	<b>(\$747)</b>	<b>(\$995)</b>	<b>(\$1,204)</b>	<b>(\$540)</b>	<b>(\$548)</b>
<i>Direct Cost/Volume</i>	\$98.23	\$105.97	\$110.98	\$117.27	\$122.40	\$105.79	\$127.15
<i>Additional funding above status quo</i>	\$788	\$1,092	\$1,291	\$1,540	\$1,748	\$1,084	
<i>Additional funding to achieve breakeven</i>	\$1,336	\$1,640	\$1,840	\$2,088	\$2,296	\$1,632	\$548
<b>Ten Year Capital Expenditure Plan</b>							
Nominal Expenditure	\$4,811	\$5,128	\$5,584	\$5,911	\$6,754	\$4,994	\$3,271
Discounted Expenditure @ 8%	\$4,372	\$4,653	\$5,127	\$5,522	\$6,437	\$4,464	\$2,814

### 5.2.1 Break Even Scenarios

The financial statements presented in the business case show that under Option 7 (Status Quo) an operating deficit of \$548k is forecast for the 2011/12 financial year. The status quo option is based on continuing the service in its current format, but with provision for a limited upgrade to each dental clinic as envisaged in the 2005 Asset Management Plan.

The challenge is how can the service deliver a breakeven result? What are the challenges and compromises that this presents.

The scenarios in Appendix 3 are based on what would be lost in levels of service to deliver a cost structure that fits within the available revenue, i.e how can variable costs be exited, and what risks does this present, financially and operationally, for the future of the service.

i) Scenario 1 shows that maintaining the status quo, while undertaking limited improvements to infrastructure, will result in an annual operating deficit of \$548k. This is equivalent to the revenue received from 17% of the annual throughput. Reducing volumes by 17%, while maintaining existing levels of funding, will result in the forecast operating deficit reducing by \$311k. Elimination of the full forecast deficit would require a 26% reduction in volumes to exit the required level of variable costs to meet breakeven.

ii) Scenario 2 forecasts what would happen if the status quo was maintained, and no clinic upgrades occurred. This scenario does however include annual building maintenance and utility costs of \$200k, as per the agreement between the MoH and Ministry of Education. Under this variation volumes would need to reduce by 18%, while maintaining revenue at current levels, for a breakeven result to be achievable.

To achieve a breakeven result under Scenario 1 and 2 the revenue attached to the reduced volumes would need to be used to increase purchase unit prices for both the School and Adolescent Dental Services by 34% (Scenario 1) and 21% (Scenario 2). Reducing Dental Therapist numbers and continuing to fund the service on a completion basis using existing prices will lead to a widening of the deficit, given the loss in contribution from the resulting reduction in service throughput.

In summary, the strategies to reduce costs are:

- Reduce the level of staffing
- Undertake no facility upgrades
- Reduce levels of building maintenance

The key risks that these present to the oral health services across MDHB are:

**Table 11. Risks for a Breakeven Result**

<b>Factor</b>	<b>Risk</b>				
<b>Access</b>	<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>Scenario 1</th> <th>Scenario 2</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">41%</td> <td style="text-align: center;">44%</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>• Mobile services resourced to provide examination and treatment to 35% of schools within the region</li> <li>• Significant deterioration in the oral health status of people within MDHB, resulting in a deterioration of overall general health</li> <li>• No service available during school holidays</li> <li>• Relief of pain during school holidays through private Dentists with contracts or the Palmerston North Hospital Dental Unit</li> </ul>	Scenario 1	Scenario 2	41%	44%
Scenario 1	Scenario 2				
41%	44%				
<b>Model of care</b>	<ul style="list-style-type: none"> <li>• Examination and treatment for those at primary school</li> <li>• No health promotion</li> <li>• Limited scope for primary provider involvement</li> <li>• Reactive versus preventative service resulting in a significant increase in moderate to long term expenditure due to high cost interventions needing to be undertaken</li> </ul>				
<b>Safety</b>	<ul style="list-style-type: none"> <li>• Dental Therapists continue to work in isolation</li> <li>• Building and equipment deterioration resulting in an unsafe environment for Dental Therapists and children</li> </ul>				
<b>Staffing</b>	<ul style="list-style-type: none"> <li>• Inability to become a learning environment due to single chair clinics</li> <li>• Support for Dental Therapy interns is inefficient</li> <li>• Reduced morale due to lack of peer support and a work environment below that of other DHB's</li> </ul>				
<b>Chair utilisation</b>	32%				

All of the risks identified in Table 11 have a significant negative impact on the ability for MidCentral Health to recruit and retain appropriately qualified and skilled staff. A 55% turnover of existing staff is projected by 2013.

### 5.2.2 Status Quo v Option 3 (Preferred Option)

The financial result for each option assumes payment for additional volumes only. The residual deficit shown is indicative of the additional support required over and above the revenue value of volume increases in order to make each option financially sustainable for MidCentral Health.

- **Status Quo**

The deficit of \$548k presented for the status quo is the projected deficit based on the projected cost increases that will occur as a result of likely required capital investment/clinic ownership. This is not the current service deficit, which for 2006/07 was \$183k.

This deficit issue is one that the DHB will consider, if the option not to proceed with service reconfiguration was taken.

- **Option 3 (Preferred)**

This provides additional \$1.092m revenue to MidCentral Health from additional volumes, and \$1.291m of additional cost – increasing the the projected deficit from the \$548k under status quo by \$199k to the \$747k deficit presented. Key points to note are:

- The preferred option of expanding the service and volumes provides a marginally reduced bottom line result, if the DHB is able to fund those volumes per the current funding model.
- It is assumed that revenue for additional volumes will be made available to the MDHB Funding Division from the MoH, to enable the business case to proceed. This will then pass across to the provider as per the current contracting process at the national price.

### 5.3 Sensitivity Analysis

**Table 12. Annual Impact – Based on Year 3 Financials (first year of full impact) All amounts in (\$,000)**

Sensitivity 1	Scenario 3 (Preferred)	A	B	C
Productivity Gain	27%	20%	10%	0%
Impact on presented Scenario	\$0	(\$153)	(\$365)	(\$577)
Rate of change		20%	49%	77%
Sensitivity 2	Scenario 3 (Preferred)	D	E	F
Cost Growth > FFT of 3%	3%	4%	5%	6%
Impact on presented Scenario	\$-	(\$60)	(\$122)	(\$185)
Rate of change		8%	16%	25%
Sensitivity Index - Variable a to b		2.54	2.99	3.12

Net result(Deficit) - Scenario 3	(\$517)
% of Service Revenue	-13%

#### 1 Net Result – Productivity gain achieved, cost growth risk materialises

Cost Growth	4%	5%	6%
Revised Deficit	(\$808)	(\$869)	(\$932)

## 2 Net Result – Productivity gain not achieved, no cost growth

Productivity Gain	20%	10%	0%
Revised Deficit	(\$900)	(\$1,112)	(\$1,324)

## 3 Net Result – Mix

3a	10% efficiency, 4% cost growth		
	Deterioration	(\$425)	
	Result	(\$1,173)	
3b	20% Efficiency, 5% cost growth		
	Deterioration	(\$275)	
	Result	(\$1,022)	
3c	20% Efficiency, 4% cost growth		
	Deterioration	(\$213)	
	Result	(\$960)	

This project is significantly more sensitive to the productivity gain assumptions. The impact of not meeting these targets is more significant than the cost of exceeding FFT (3% baseline assumed). This is due to the high fixed cost nature of the service, where reduced volumes will have a full revenue impact and be much less influential in reducing costs. This does not impact the overall level of funding needed to meet breakeven, but shifts this from volume based revenue to an effective subsidy. Slight deterioration on both variables would result in a \$233k deterioration in result (3c).

## 5.4 Productivity Assumption

The 27% efficiency gain is the result of further increasing the positive impact that additional Dental Therapy Assistants have had to date. This is as a result of the internal efficiencies gained from the new model of care regarding effective use of staff time.

Volumes per Dental Therapist have increased by 16.9% over the last four years as Dental Therapy Assistants have been introduced. This rate of improvement has been factored in to continue, as well as the additional 27% gain.

This issue links with the workforce issues discussed in the business case, which further explore the risks and mitigation strategies for the workforce.

## 6. Next Steps

Following MDHB support and sign off, the Business Case for Investment in Child and Oral Health Services will be presented to the MoH in February 2008. All business cases must be submitted to MoH by 31 March 2008 at the latest. The MoH as part of this funding application requires confirmation from MDHB on the following:

Management confirms:

- a) That in developing the Investment in Child and Adolescent Oral Health Services Business Case, the following were considered:
  - Redevelopment of existing facilities
  - New development and build opportunities
  - Relocation of services into an existing building which requires redevelopment
  - Number of mobile dental clinics required
  - Do nothing
  - Achieve breakeven.
- b) Agree that the option chosen is the best option for improving access and reducing oral health inequalities in the MDHB region.
- c) Note that the preferred option is consistent with the health priorities and service delivery options in the MDHB Strategic Plan and District Annual Plan.
- d) Note that the preferred option will deliver a high and acceptable level of clinical quality and a modern delivery of oral health services.
- e) Note that the project design and costs have been developed with, and confirmed by, the DHBs health planners and Commercial Support Services.
- f) Agree that the complete project budget, including all consequential financial impacts will be \$6.875 million (combined total of requested capital, and operating expenditure for 1 year) which will be accessed from the Ministry of Health funds.
- g) Note that the project will result in increased annual operating costs of \$1.291 million subject to at least matching annual revenue being provided by the Ministry of Health.
- h) Note that the investment requires the introduction of new models of care.
- i) Agree to the establishment of a change management programme to promote modern models of care and set credible targets.
- j) Note that taking into account the net cost impact of this project, the DHB will continue to achieve a breakeven result.
- k) Note that the Business Case development is now complete.
- l) Note that an Implementation project will commence on acceptance and commitment from the Ministry of Health to support preferred model of care and service delivery.

Upon acceptance by the MoH of the MDHB Business Case and commits to funding the requested capital and operational expenditure, MDHB will undertake an implementation project for which a project plan will be developed inclusive of the components set out in Table 13.

**Table 13. Indicative Implementation Plan**

Completion of Terms of Reference and project scope	May 2008
Appointment of Project Sponsor	May 2008
Appointment of Project Implementation Manager (funded through the operational budget as identified in Appendix 1 Key Assumptions)	June 2008
Development of detailed implementation and change management plan	June 2008 – August 2008
Engagement, including community, about specific facility location	June 2008 – August 2008
Submission of the detailed plan to MDHB	August 2008
Commence implementation of identified Phase 1 (Formal staff change management commences, purchase of additional mobiles, consultation with Ministry of Education and Boards of Trustees to locate facilities, site analysis, contract tender)	October 2008 – October 2009
Conclude implementation of Phase 1	October 2009
Commence Phase 2 (continuing staff change management, procurement and placement of portable facilities, exit existing clinics, occupation of collocated facilities)	December 2009 – June 2011
Conclude Phase 2	June 2011
Post occupancy review	September 2011 December 2011

## 7. Recommendation

It is recommended that

- *the proposed new service configuration for child and adolescent oral health services be approved as detailed in the paper dated 14 January 2008*
- *capital investment of \$5.584 million be approved and that this be sought from the MoH*
- *following the decision from the Ministry of Health, the proposal will be represented to MDHB for full approval*
- *following the decision from the Ministry of Health and full approval from MidCentral District Health Board a comprehensive community engagement process will be undertaken*
- *MidCentral District Health Board provides the following confirmation to the Ministry of Health in respect of the DHB's funding application:*

- a) That in developing the Investment in Child and Adolescent Oral Health Services Business Case, the following were considered:
- Redevelopment of existing facilities.
  - New development and build opportunities.
  - Relocation of services into an existing building which requires redevelopment.
  - Number of mobile dental clinics required.
  - Do nothing.
  - Achieve breakeven.
- b) Agree that the option chosen is the best option for improving access and reducing oral health inequalities in the MDHB region.
- c) Note that the preferred option is consistent with the health priorities and service delivery options in the MDHB Strategic Plan and District Annual Plan.
- d) Note that the preferred option will deliver a high and acceptable level of clinical quality and a modern delivery of oral health services.
- e) Note that the project designs and costs have been developed with, and confirmed by, the DHB's health planners and Commercial Support Services.
- f) Agree that the complete project budget, including all consequential financial impacts will be \$6.875 million (combined total of requested capital, and operating expenditure for 1 year) which will be accessed from the Ministry of Health funds.
- g) Note that the project will result in increased annual operating costs of \$1.291 million subject to at least matching annual revenue being provided by the Ministry of Health.
- h) Note that the investment requires the introduction of new models of care.
- i) Agree to the establishment of a change management programme to promote modern models of care and set credible targets.
- j) Note that taking into account the net cost impact of this project, the DHB will continue to achieve a breakeven result.
- k) Note that the Business Case development is now complete.
- l) Note that an Implementation project will commence on acceptance and commitment from the Ministry of Health to support preferred model of care and service delivery.

Muriel Hanratty  
**Group Manager**  
**School and Adolescent**  
**Dental Services**

Dr Philip Marshall  
**Clinical Director**  
**Dental Services**

Kate Aplin  
**Project Manager**  
**Child and Adolescent**  
**Oral Health**

## **Key Financial Assumptions**

### **Capital Expenditure**

The assumptions used in determining the level and timing of capital expenditure include:

- Capital costs for each clinic have been based on a construction cost of \$2,500 per square metre.
- Sizing of clinics is based on 39 square metres (single chair fixed clinic), 62 square metres (two chair clinic).
- Costs for single and double chair mobile clinics are as per the Ministry of Health (MoH) recommendation – \$450k for a single chair and \$500k for a double chair.
- Other building costs include \$25k for planning, 10% for project management and a contingency of 20% to recognise factors such as the timing of the project.
- The capital cost also includes provision for an upgrade of radiography equipment.
- It has been assumed that the cost of all fittings and clinical equipment is included in the above prices for mobile clinics. To this end the clinical plan presented relates only to the proposed fixed clinics.
- An allowance of \$10k for fittings per fixed clinic has been made.
- A replacement mobile will be purchased in Year 3 of the project, and the two existing mobiles will be refurbished in Year 5.

In order for the preferred option to be progressed \$5.584 million of capital expenditure will be required over a period of 5 years. This will be used to fund the building of three two chair clinics and the purchase of a further five mobile clinics. Space for a further two clinics will be rented as part of a co-location with Primary Health Providers.

### **Operating Performance**

Key assumptions underlining the accompanying financial analysis include:

- A 3% increase in revenue and operating costs where applicable to allow for expected price increases, including in the case of personnel step changes. Three percent represents the average future funding track adjustment received over the past two years.
- An assumption that all additional volumes will be funded. This amounts to 9,000 additional treatments and client cases.
- Personnel costs are calculated based on the current Multi Employer Collective Agreement. In the case of all options other than Option 7 (status quo) personnel

costs have been determined on the basis of 2,080 working hours per annum for both Dental Therapists and Dental Therapy Assistants, compared to the current 'school term'. To accommodate this, rates for Dental Therapists and Dental Therapy Assistants have been adjusted accordingly.

- Volumes and revenue are consistent with the existing agreement with the MDHB Funding Division. The employment of Dental Therapy Assistants to provide support to Dental Therapists should result in an increase in chair productivity and service standards compared to the status quo. Whilst this could lead to an increase in revenue for the service this remains to be confirmed.
- The cost of capital has been calculated at the current rate of 8%. Expenditure on new facilities and upgrades in excess of the current depreciation expense will result in an increase in equity and a further cost to the DHB.
- No provision has been made for the repayment of amounts received from the MoH to fund capital expenditure.
- Depreciation has been calculated at rates used by MidCentral DHB – Buildings (2.5%), Vehicles (10%), Clinical Equipment (8%) and Fittings and Furniture (8%).
- Maintenance costs include the cost of maintaining mobile dental clinics as well as the cost of maintaining buildings. Building maintenance has been calculated at the rate of \$45 per square metre.
- Clinical supplies have been taken as constant across all options and consistent with current levels of use. While some differences may result depending on the option chosen, this is not likely to be material.
- Rental costs in respect of clinics collocated with PHOs have been calculated using a rate of \$300 per square metre. In the case of clinics located on Ministry of Education property an assumption of a peppercorn rental has been made.
- Consistent with analyses of this type, it has been deemed prudent to include a contingency equal to some 10% of direct costs other than personnel in the analysis.
- Overheads have been calculated based on existing DHB policy and methodology. An amount equal to 8.3% of revenue, adjusted for the expected increase in the cost of insurance by adding 1% of the cost of fixed assets, has been used

**APPENDIX 2**

<b>Option 3 - Forecast Statement of Operating Performance</b>						
<b>(2 Co-located / 3 fixed / 8 mobile)</b>						
	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>	<b>Year 10</b>
	<b>F'cast</b>	<b>F'cast</b>	<b>F'cast</b>	<b>F'cast</b>	<b>F'cast</b>	<b>F'cast</b>
<b>Financial Year</b>	<b>0910</b>	<b>1011</b>	<b>1112</b>	<b>1213</b>	<b>1314</b>	<b>1819</b>
	<b>(\$,000)</b>	<b>(\$,000)</b>	<b>(\$,000)</b>	<b>(\$,000)</b>	<b>(\$,000)</b>	<b>(\$,000)</b>
<b>Revenue</b>	<b>\$3,729</b>	<b>\$3,841</b>	<b>\$3,956</b>	<b>\$4,075</b>	<b>\$4,197</b>	<b>\$4,865</b>
<b>Expenditure</b>						
<b>Personnel</b>	<b>\$2,422</b>	<b>\$2,495</b>	<b>\$2,570</b>	<b>\$2,647</b>	<b>\$2,726</b>	<b>\$3,160</b>
<b>Clinical Supplies</b>	<b>\$242</b>	<b>\$249</b>	<b>\$256</b>	<b>\$264</b>	<b>\$272</b>	<b>\$315</b>
<b>Infrastructure and Non Clinical</b>						
Cleaning	\$64	\$66	\$68	\$70	\$72	\$83
Uniforms	\$18	\$19	\$19	\$20	\$20	\$24
Depreciation	\$135	\$254	\$363	\$411	\$412	\$429
Maintenance	\$182	\$164	\$104	\$107	\$110	\$127
Rental	\$	\$6	\$40	\$41	\$42	\$49
Security	\$26	\$53	\$54	\$56	\$57	\$67
Waste	\$34	\$36	\$37	\$38	\$39	\$45
Electricity	\$34	\$36	\$37	\$38	\$39	\$45
Water	\$2	\$2	\$2	\$2	\$2	\$3
Vehicles	\$27	\$73	\$106	\$109	\$112	\$130
Computer Costs	\$41	\$43	\$44	\$45	\$47	\$54
Telecommunications	\$14	\$14	\$15	\$15	\$16	\$18
Stationery and Postage	\$25	\$26	\$27	\$28	\$29	\$33
Cost of Finance	\$188	\$362	\$380	\$351	\$333	\$189
Other	\$4	\$4	\$4	\$4	\$4	\$5
Contingency	\$119	\$173	\$195	\$200	\$200	\$195
	<b>\$914</b>	<b>\$1,328</b>	<b>\$1,492</b>	<b>\$1,534</b>	<b>\$1,533</b>	<b>\$1,496</b>
<b>Overheads</b>	<b>\$342</b>	<b>\$373</b>	<b>\$385</b>	<b>\$391</b>	<b>\$400</b>	<b>\$453</b>
<b>Total Expenditure</b>	<b>\$3,920</b>	<b>\$4,444</b>	<b>\$4,703</b>	<b>\$4,836</b>	<b>\$4,931</b>	<b>\$5,424</b>
<b>Surplus(Deficit)</b>	<b>(\$191)</b>	<b>(\$604)</b>	<b>(\$747)</b>	<b>(\$762)</b>	<b>(\$734)</b>	<b>(\$559)</b>

Breakeven Analysis - Status Quo Option				APPENDIX 3			
		Scenario 1		Scenario 2		Scenario 3	
		Breakeven Analysis based on Business Case Status Quo Option (Option 4)		Breakeven Analysis based on Business Case Status Quo Option but with no facility upgrades		Breakeven Analysis based on Business Case Status Quo Option but with no facility upgrades and no building maintenance costs	
		Yr 11/12	Yr 11/12	Yr 11/12	Yr 11/12	Yr 11/12	Yr 11/12
		FY Forecast	FY Forecast	FY Forecast	FY Forecast	FY Forecast	FY Forecast
		(\$0,000)	(\$0,000)	(\$0,000)	(\$0,000)	(\$0,000)	(\$0,000)
<b>Revenue</b>		<b>\$2,780</b>	<b>\$2,780</b>	<b>\$2,780</b>	<b>\$2,780</b>	<b>\$2,780</b>	<b>\$2,780</b>
Personnel		\$1,931	\$1,931	\$1,931	\$1,931	\$1,931	\$1,931
Outsourced							
Clinical Supplies		\$216	\$216	\$216	\$216	\$216	\$216
Infrastructure		\$866	\$866	\$718	\$718	\$518	\$518
Overheads		\$237	\$237	\$237	\$237	\$237	\$237
<b>Total Costs</b>		<b>\$3,250</b>	<b>\$3,250</b>	<b>\$3,103</b>	<b>\$3,103</b>	<b>\$2,903</b>	<b>\$2,903</b>
<b>Surplus (Deficit)</b>		<b>-\$470</b>	<b>-\$470</b>	<b>-\$322</b>	<b>-\$322</b>	<b>-\$122</b>	<b>-\$122</b>
<i>% Revenue</i>		<i>-16.9%</i>	<i>-16.9%</i>	<i>-11.6%</i>	<i>-11.6%</i>	<i>-4.4%</i>	<i>-4.4%</i>
<b>Actions</b>							
<i>Reduce volumes</i>		<i>-16.9%</i>	<i>-25.6%</i>	<i>-11.6%</i>	<i>-17.6%</i>	<i>-4.4%</i>	<i>-6.7%</i>
Corresponding reduction in variable costs							
Therapists		\$233	\$353	\$160	\$242	\$61	\$92
Dental Assistants		\$41	\$61	\$28	\$42	\$11	\$16
Clinical Supplies		\$37	\$55	\$25	\$38	\$10	\$14
Total cost reduction		<b>\$311</b>	<b>\$470</b>	<b>\$213</b>	<b>\$323</b>	<b>\$81</b>	<b>\$122</b>
<b>Revised Surplus (Deficit)</b>		<b>(\$159)</b>	<b>(\$)</b>	<b>(\$109)</b>	<b>\$</b>	<b>(\$41)</b>	<b>(\$)</b>

**APPENDIX 4**

**Options rated against MDHB Preferred Model of Care (% of strategy met)**

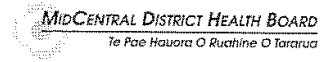
Strategy	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7
Incorporating oral health checks with the Well Child schedule.	100%	100%	100%	100%	65%	20%	20%
Targeted intervention according to need.	100%	100%	100%	100%	95%	30%	45%
Incorporating oral health checks with the Well Child schedule.	100%	100%	100%	100%	65%	0%	0%
Co-location with Primary Health providers.	0%	50%	50%	50%	30%	0%	0%
Flexibility of service configuration to allow services to be provided from a range of sites with potential for more non-DHB providers.	60%	90%	93%	95%	97%	0%	0%
Service available for 50 (to accommodate public holidays) weeks of the year with flexible operating hours.	100%	100%	100%	100%	100%	0%	0%
Introduction of double chair clinics and chair side assistants, with a community dentist and a clinical educator to provide a support service delivery.	50%	90%	90%	90%	80%	0%	0%

**Letter of Support - Group Manager, Commercial Support Services**

**TO** Murray Georgel  
CEO

Lareen Cooper  
GENERAL MANAGER

**FROM** Jeff Small  
Group Manager  
COMMERCIAL SUPPORT SERVICES

**MEMORANDUM**

**DATE** Friday 25<sup>th</sup> January, 2008

**SUBJECT** INVESTMENT IN CHILD & ADOLESCENT ORAL HEALTH SERVICES

I refer to the Business Case for the above services which I have reviewed in conjunction with my contracted Building & Engineering personnel.

- a) Based on the options and associated information, I confirm that the cost estimates in relation to building construction requirements and costs, plus on-going maintenance costs and rental assessments, are realistic and prudent. The contingency allowances are also realistic and prudent.
- b) The maintenance and site specific building management/advisory design requirements are within the scope and capacity of the Board's current Building & Engineering Contract with Spotless Facilities Maintenance.
- c) The maintenance and running costs of the Mobile Dental Units and ability to accommodate movements are also confirmed.
- d) The proposal for DHB wide nationally co-ordinated Project Management and Consultancy services to enable the design of fixed standardised buildings for the national oral health initiative is supported (Ref: CDHB proposal to DHBNZ).
- e) The outline of the Procurement Strategy, Consultant and Construction procurement including Value Management process etc for site specific design is consistent with the standard process managed by Commercial Support Services for the Board's works projects.

  
Jeff Small  
GROUP MANAGER  
COMMERCIAL SUPPORT SERVICES

**Commercial Support Service**  
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