Andrew Devine – DT and CDT, [redacted]

I agree that the current system does not guarantee competence but I think this could be solved by changing the auditing and CPD systems.

DTs should be treated quite differently to CDTS as their risk to the public is significantly less. "Being a right-touch risk-based regulator means making decisions and responding in a way that is proportionate to the risk or problem".

Currently CDTs fill out an APC form and work survey, do 60 CPD hours over a four year cycle and are required to hold a current Dental Modular Certificate Level 4.
I propose that when a CDT first registers he must compile a file of all policies required by law e.g. privacy and confidentiality, sexual harassment, cultural respect, cross infection control, medical emergencies etc. Once these are in place a commercial auditor would visit the practice and check whether the policies and systems are appropriate. If yes the CDT would be signed off, if not the auditor would discuss any deficiencies and allow the CDT time to come up to scratch. To save money the commercial auditor could organise to do CDT audits in one area on the same day.
Of course these policies can be found online but who actually takes the time to have them on file in-house and have read them. Perhaps the auditor could also ask questions about the different policies.

Once a CDT has done his first audit I don't see a need for further auditing unless a problem occurs. On the APC form CDTs should note any upgrades or changes to their policies and systems.

Still agree with CPD points. Should be split in to three areas:

a) A third for lectures – 20 hours
b) A third for hands-on workshops – 20 hours
c) A third for peer group study meetings. Twice in the four year cycle CDTs would do a 30 minute presentation with a 15 minute discussion on a case study or research project from beginning to end not just before and after or conclusions/summaries – 20 hours

I believe this type of programme would show that CDTs are continuing to be educated and maintaining their competency because they will need to demonstrate their work. This could be achieved through Zoom meetings for those who cannot easily attend peer group meetings in person.

Research can improve practice.
Research-based features include:
• Beginning with a problem or question;
• Following a rigorous and prescribed scientific inquiry process or methodology;
• Collecting, analysing, and interpreting data;
• Permitting critical review from peers and experts in the field; and
• Adhering to standards of the field.

Research can be reviewed by teams of colleagues
• Each team member reads and summarizes one article for the team and makes a brief presentation to the team on the article.
• Team members read the same article reporting on research related to their content area and discuss the implications for their practice.

• Team members read research abstracts and determine which articles merit more in-depth reading.
• Team members read a variety of different research studies on one topic that the team is interested in studying in depth.

DTs should be audited in the same way as CDTs because they perform two restricted activities i.e. shade taking and the repair of dental prostheses. However I think there is no need for DTs to do CPD hours because dental appliances and restorations can and are supplied by other providers on-shore and off-shore who are not required to register or do CPD. This is permitted by the DCNZ because dentists/dental specialists prescribe and oversee the fitting of the restorations. Market forces will maintain competency for DTs.

If the DCNZ approved the type of CPD system I'm recommending then I believe the NZIDT could be licenced to facilitate, co-ordinate and organise these CPD events. The NZIDT executive could do this themselves or employ people to provide this service to NZIDT members and non-members.

If the NZIDT Mediation & Complaints Committee shared information with the DCNZ about practitioners at risk this early intervention may help and support these practitioners.