[redacted]

Page 2: Your demographics

Q1 Your details

Name	**Imogen Scott**
Company/organisation	[redacted]
City/town	[redacted]
Email	[redacted]

Q2 Your submission is in the capacity as

dentist or dental specialist

Page 3: The proposal

Q3 Do you agree or disagree with the proposal to remove the 18-year age limit for restorative activities from the OHT scope of practice including: accredited, gazetted programmes allowing oral health therapists to perform restorative treatment on patients 18 years and older an exclusion, such as "Restorative treatment on patients 18 years and older", being placed on oral health therapists' scopes of practice until they complete an accredited adult restorative programme which will allow them to apply to have the exclusion removed (noting that the activities registered oral health therapists can currently perform within their scope of practice remain unchanged).

Strongly disagree

Page 4: Your support

Q4 Please describe why you support the proposal

Respondent skipped this question

Page 5: Your concerns

Q5 Please describe your specific concern/s with the proposal

My primary concern with regard to the commencement of OHTs in adult scope is that the needs of paediatric patients will continue not to be met. This has been a concern of mine for a long time, and I have seen more cause for concern given the number of children requiring dental treatment at ADHB. Nationally, the demand for paediatric dental care is growing rapidly, so to restrict this provision seems barbaric.

Where will this treatment for adults be provided? To provide treatment for adults in dental clinics intended for children would be neglectful of our young and vulnerable population.

It is my understanding, following discussion with OHTs, that they are limited in their provision of restorations by the anatomy of the carious disease. Hence, they can provide occlusal and interproximal restorations in permanent dentition measuring less than 1/3 of the bucco-lingual anatomy of the tooth and less than half of the dentine. This seems ridiculous considering that one never truly knows the dimensions of the final preparation prior to commencing treatment. How does one discriminate with certainty clinically or radiographically which carious lesions would fit into these boundaries of practice? There are many clinical situations that will be borderline for the OHT scope - who makes this call?

There will be confusion for public because the restorative scope for OHTs is very narrow. In addition, it is very likely that the scope will not cover all of the patient's restorative needs. Deep, complex or indirect restorations will not be provided by the OHT. There is no consideration of the concepts of occlusion, hence, full mouth rehabilitation cannot be provided by OHTs.

Furthermore, if a restoration is presumed to fit within these boundaries and, after preparation, does not (whether this be due to extension of dimensions of the preparation, extensive loss of tooth structure, pulp exposure, insufficient bonding etc) who takes responsibility for completion of this care? This will lead to increased cost, confusion, frustration and use of the patient's time.

Will this truly be cheaper for the patient? It is true that the OHTs scope will provide treatment for a small sector of adult oral health needs, but most treatment plans are more complex than only simple restorative treatment, particularly those for whom provision of care is intended through this extended scope, ESPECIALLY the elderly.

A concern is also raised by the proposition that OHTs will provide more affordable care. Theoretically, baseline cost of a simple restoration should be the same in terms of materials, sterilisation and staff. The cost to the patient will change dependant on the clinician - which is often determined by time, experience and difficulty. I am concerned that providing patients with a "cheaper" treatment, may in fact provide a "poorer quality" restoration. Have there been long terms studies into the difference in survival of restorations placed by OHTs vs those provided by Dentists?

It seems that there will be insufficient workforce to cover both paediatric and adult treatment demand. DHBs already struggle to get enough Dental Therapists working - particularly in our rural communities. One can understand why, given that working within the Hygienist scope for OHTs is much more lucrative than in Dental Therapy. Working with children can be very difficult, which I am sure any clinician will attest to. Working under another, likely more lucrative scope of OHT to steer clear of treating children will create a greater void in the Dental Therapy scope of practice.

Ultimately, if the aim of the DCNZ/Ministry of Health is to increase the access to care for a broader range of people, then a much more appropriate solution for the patient and the profession would be for SALARIED POSITIONS FOR NEW GRADUATE DENTISTS TO PROVIDE SUBSIDISED AND UNRESTRICTED care rather than OHTs.

Page 6: Details about OHT scope, qualifications and competencies

Q6 Do you have any specific feedback on the proposed amendments to the OHT scope of practice, prescribed qualifications or competencies as set out in appendices 1 & 2?	**Yes**

Page 7: Specific comments on the proposal

Q7 Please provide us specific comments related to the OHT scope, qualifications and competencies.

Do not apply the adult scope. If adult scope is applied to the OHTs, there MUST be an outline of the relationship between Oral Health Therapists and the Dentist. This relationship should be similar to that of the Hygienist and the Dentist currently, where OHTs (practitioners with a limited scope) must not see patients unless they have previously been examined by their supervising dentist.

Page 8: Anything else

Q8 Do you have any further comments on the proposal?	**No**

Page 10: Last thoughts

Q9 Please provide us your feedback	**Respondent skipped this question**