Page 2: Information about the person or organisation completing this submission survey

Q1 This submission was completed by:

Name	**Joyce Ireland**
Company/organisation	[redacted]
Position	[redacted]
City/town	[redacted]
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Q2 Are you making this submission survey

on behalf of a company or organisation ,

If group, company or organisation, please specify::
New Zealand Institute of Dental Technologists

Q3 Please tell us which part of the sector your submission survey represents

a registered clinical dental technician ,

a registered dental technician

Page 3: General question about recertification

Q4 Do you think the Dental Council needs to make changes to its current recertification framework?

Yes - but only minor changes ,

Please give your reasons::
We believe the concept of CPD can be an effective tool in maintaining knowledge and even as an indicator of problems, but how it is currently implemented means it is less effective than it could be.

Page 4: Area for change one: public assurance

Q5 Each of the seven statements below are equally important components of good oral health care. We want to identify where there are gaps or weaknesses in the way our oral health practitioners serve the public.Please rank the components from 1-7, with one being the component you think needs the most improvement and seven being the component you think needs the least improvement:

Patients are confident their practitioner will not harm them	**6**
Patients receive the appropriate treatment for their oral health concern or issue	**4**
Patients receive appropriate information about their treatment and care	**3**
Patients needs and concerns are discussed and addressed with their practitioner	**2**
Patients feel they are treated with dignity and respect at all times	**5**
Patients feel confident their practitioner has the knowledge and skills to treat them	**1**
Patients know how to complain about treatment they have received from their practitioner	**7**

Q6 Do you think the Dental Council needs to equip patients and the public to recognise poor practise?

No,
Please give your reasons::
We believe the public can already recognise poor practice and for the Dental Council to do so would be a huge, unreasonable education undertaking that will ultimately not guarantee public understanding. However the simpler task of making people aware of where they can go if they have a problem is more important.

Page 5: Area for change two: right-touch risk-based regulation

Q7 Do you feel you have adequate information about the Dental Council's approach to regulation?

Yes

Q8 A risk pyramid illustrates the connection between the desired actions and/or behaviours of a practitioner and the differing level of responses a regulator can use to encourage and/or achieve the desired action and/or behaviour.Do you think the Dental Council should develop a risk pyramid/matrix to explain the types and levels of risk and corresponding regulatory responses?

Yes,
Please give your reasons::
We have mixed feelings on this. However if the goal is to be proactive, ambulance at the top of the hill, then, if done right, we are tentatively open to the concept in good faith. At this point we cannot think of suitable alternatives to achieve the goal. A big positive the Dental Council promoted, and we feel is a positive for the risk identification process, is that the Dental Council's goal is not to punish identified practitioners, but to educate them and help them become positive members of the dental community. We hope that the structures around this will be robust enough to ensure all following administrators of the Dental Council will have the same value set and not be subject to individual influences. Provided a few things are

subject to individual influences. Provided a few things are changed on how the criteria standards are set and how the resulting analysis is used then it could be a tool that highlights problems before they affect the public. However we recommend some changes. Changes we recommend are that a more balanced and broadened approach to the base indicators be employed than those suggested by the Dental Council so far. Balance indicators. Current indicators raised by the Dental Council are limited and based on negative feedback. Any analysis system needs balance otherwise it can unfairly taint a person. We feel the proactiveness of the practitioner should be taken into account. If a practitioner is actively involved with peer to peer contact and ongoing education etc then this should be a mitigating factor. Being a member of an association is also a good indicator as it means they are interested in their dental community - eliminating isolation, is inclusive and encouraging. An association offers a great vehicle by which a practitioner can keep proactive and be a positive, safe member of the dental community. If the Dental Council was to have recognised accredited CPD providers, like universities, dental companies and associations they would provide the instant infrastructure needed in providing the proactive activities needed to help ensure practitioners are current and provide patient safety. The Dental Council controls, or conditions of accreditation, would be a communication report type dialogue. Accredited providers would have to report back on who attended (The Dental Council would then use this as another potential indicator) or even give guidance to accredited providers areas the Dental Council sees as weak and want improvement on. Possible course structures. We think that in general we have to accept that if a practitioner learns something they will take it into practice with them, or at least use it in making decisions. If we cannot then it makes a joke of the term ‘professionals’. If we agree that practitioners will gain from knowledge and ultimately apply this to their practice and the safety of the public, we just need to assure they gain good current knowledge and thinking. To achieve this the Dental Council can have two standards of courses. Standard 1. Professional, latest ideas and techniques, hands on, peer to peer, etc; Otago University ongoing education etc, and Standard 2. New product information, usually for promotion by dental companies etc. How NEW CPD works. People would have to prove they have retained information presented on the course and this is how the CPD is gained. It is attached to gained knowledge. As an example Standard 1 could have no CPD for just attending. Or alternatively, a base attendance CPD level could apply that is similar to Standard 2. For standard 1 a test at the end could be applied. This would ensure CPD is attributed to knowledge gained, not for simply turning up which is where the current system fails. Standard 2 has attendance CPD only. Standard 2 will have a low amount of CPD applied. This will mean it is harder to achieve the CPD cycle

This will mean it is harder to achieve the CPD cycle requirements for clinical dental technicians. The Dental Council would also be able to monitor what standard of CPD practitioners are doing. Standard 2 is better suited for dental technicians (but not limited to) and is why we recommend a lower CPD amount per cycle later on. How we see CPD applied to knowledge. Firstly there is no failing, just more or less CPD accredited. Let's say a test has 5 questions, and each question is worth 2 CPD. If a practitioner answers 3 correctly they get 6 CPD for the course. Number of questions would be specific for the course. The Dental Council could also collect CPD obtained from the course and monitor the CPD attained by a practitioners. The Dental Council could also use this data in conjunction with registration as another identifier. Concerns on how the Accumulated Data is used. We are of the understanding this tiered system of identification is designed to highlight 'at risk' practitioners, so the majority of 'good' practitioners are targeted less often by audits etc. This would also mean expensive audits are focused primarily (but probably not solely) on the 'at risk' practitioner instead of being lost on compliant practitioners. However if an 'at risk' practitioner is found compliant and safe, that practitioner should have that weighted heavily as a positive indicator and be removed from the 'at risk category'. Time frame subjective but anywhere from permanently to 10 yrs maybe. To save costs audits could be performed at two levels. 1. Initial probe, quick and lower cost so many more practices can be audited. If from these 'light audits' further investigation is indicated, then a second more time intensive, and ultimately more expensive, 'full audit' could be done. The full audit could include, depending on recommendation, education or live patient test or mixture of both. After a full audit a light audit should follow to ensure the practitioner has implemented the guidance/help. Associations have their own internal mediation and resolution processes, and these are currently underutilised by the Dental Council. These would provide the Dental Council with good indicators for potential problem practitioners. There are some issues we have to work around with this but we are sure it should serve well for patient safety.

Page 6: Area for change three: risk identification

Q9 Which (if any) of these tools and mechanisms do you think the Dental Council should be using to identify and manage risk?

Practice audits ,

Practice questionnaires ,

Inquiries such as those under section 36 of the Health Practitioners Competence Assurance Act 2003 ,

Risk factors for practitioners,

Course of instruction ,

Supervision, counselling and/or mentoring

Q10 Are you aware of any other tools or mechanisms the Dental Council should be using to identify and manage risk?

Yes,
Please tell us about other tool/s or mechanism/s you are aware of::
Internal resolution and complaints systems that are in place, and currently being used within dental associations. Activity within the dental community. Highlighting/recording areas of practice that tend to yield the greatest number of complaints so education programs can target these areas and help prevent further occurrences.

Q11 Do you think any of these risk tools or mechanisms are more effective than others?

Yes,
Please give your reasons::
The use of associations, university and dental companies to provide ‘on the ground’ infrastructure to help the Dental Council ensure patient safety. Having an accreditation system for CPD providers means the Dental Council still has control of quality and content if needs be. For the Dental Council to build and increase their infrastructure to provide what the industry already has in place would be difficult if not impossible to implement. It would also have high maintenance costs which would impact negatively on registration fees and ultimately the industry and affordable patient care.

Page 7: Area for change four: early intervention

Q12 Do you think the Dental Council should explore the use of risk analysis and risk-profiling to identify poor practise sooner?

Yes,
Please give your reasons::
Advanced warning or potential 'at risk' practitioners is a positive move if done correctly. It will not only help promote the safety of the public, but will also help individual practitioners better themselves and ultimately the industry in general.

Page 8: Area for change five: compliance

Q13 Do you think the Dental Council should explore the use of incentives to encourage practitioner compliance?

Yes,
Please give your reasons::
Practitioners that demonstrate good compliance will be less likely to be regularly audited.

Q14 What do you think the Dental Council could do differently to encourage practitioner compliance with its recertification requirements? Please explain:

Continue to build trust and communication with the dental industry. If the Dental Council can demonstrate that they would rather identify a risk early so they can direct resources to help them, we think this will alleviate some of the negativity the Dental Council is sometimes seen with. A reduction in registration fees, or the new changes not increasing registration fees would also go a long way.

Page 9: Area for change six: ongoing education and learning opportunities

Q15 Do you think the Dental Council should change its current amount of prescribed hours and peer activities?

Yes - the hours should be , decreased
Please tell us what your preferred increase/decrease in hours is and why::
Clinical Dental Technicians: CPD obtained should be a combination of lectures, Hands on, and peer to peer study groups. Dental Technicians: Have less of an influence on public safety as their work is monitored by the prescribing dentist, specialist, etc. In many ways market driven. We should not lose sight of the fact dental work coming in from overseas has no regulations applied to it from New Zealand. We should also try and avoid placing further obstacles that may force them to deregister. However they do carry out some restricted activities such as repairs and shade taking so some CPD is warrantable, but at much lower requirement level. Under the cross infection code of compliance the same cross infection processes are required as they do for clinical dental technicians and dentists with their own in house lab areas. Patient records to a lesser extent, but still a requirement that needs assessing.

Q16 Do you think the Dental Council should change the current length of its education and learning opportunities (CPD) cycle?

Yes - the cycle length should be , decreased
Please tell us what your preferred increase/decrease in cycle is and why::
We believe a two (2) year cycle is a better time frame that ensures regular course attendance but still allows for a practitioner to self regulate if they had a busy year or significant time off.

Q17 Please rank the following statements (with one being most important and eight being least important) according to the following question:Which actions should the Dental Council prioritise when considering its approach to ongoing education and learning opportunities?

Changing the current amount of prescribed hours and peer activities	**5**
Changing the current length of the education and learning opportunities (CPD) cycle	**4**
Permitting practitioners to set their own hours of education and learning opportunities and quantity of peer activities	**6**
Removing the requirement to have verifiable education and learning activities	**7**
Requiring practitioners to maintain an accurate record of their education and learning activities	**8**
Permitting practitioners to choose some of their education and learning opportunities from prescribed categories	**3**
Permitting practitioners to choose all of their education and learning opportunities from prescribed categories	**2**
Setting some mandatory education and learning opportunities based on the Dental Council's Practice Standards	**1**

Q18 Do you think the Dental Council needs to make any other changes or improvements to the ongoing education and learning process?

No - it works well as it is

Page 10: Final thoughts and comments

Q19 Do you have any other comments, suggestions or information you want to share with the Dental Council about recertification?

If overseas educators come to New Zealand to provide short courses, there are currently no systems in place that will allow them to practice in any restricted activities. This can limit the educational value to participants, but more importantly negate the legitimacy of the course and knowledge gained because the overseas educator is technically practicing illegally in New Zealand. We propose such overseas educators get temporary registration specific for the course being run. Qualification for the temporary registration would need to be approved and a number of systems should be used for this assessment. Qualification, place of qualification, and country of practice could all be considered. The list of qualifying countries/qualifications over time will become easier as previous acceptance could be used as precedents. Alternatively the overseas practitioner would be required to provide proof of good standing with their regulating body and that the educational activities in NZ will be supervised by registered NZ practitioners