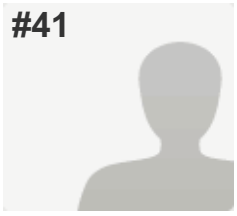

COMPLETE

[redacted]

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

Q1: This submission was completed by:

Name	Dr C Brooks
Company/organisation	[redacted]
City/town	[redacted]
Email address	[redacted]

Q2: Are you making this submission survey	as a registered practitioner
Q3: Please tell us which part of the sector your submission survey represents	a registered dentist or dental specialist

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: Ensuring compliance with CPD requirements and recertification time-frames are met by practitioners.

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	3
Patients receive the appropriate treatment for their oral health concern or issue	2
Patients receive appropriate information about their treatment and care	4
Patients needs and concerns are discussed and addressed with their practitioner	1
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	7
Patients know how to complain about treatment they have received from their practitioner	6

Q6: Do you think the Dental Council needs to equip patients and the public to recognise poor practise?	No, Please give your reasons: All practitioners make mistakes it is a part of general practice, most practitioners feel regret and guilt when this happens and work hard to rectify these situations for patients. Ensuring adverse events are recognised by the practitioner and communicated with the patient is imperative. The focus should be on enabling the patient and practitioner to work together towards a solution when mistakes happen. Maintaining communication is more likely to allow a suitable resolution to an adverse event

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?	No, Please tell us what additional information you think you require: There is a lot of information it is however not in a user friendly format.
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: This will help practitioners understand risk more and encourage appropriate response to adverse events

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, 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: Competence Review
Q11: Do you think any of these risk tools or mechanisms are more effective than others?	Yes, Please give your reasons: Competence review allows Council to be advised and guided by suitable peers of a practitioner. The non judgmental process usually ensures cooperation to any investigation.

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: Data around these issues should only be used as a guide, there will always be outliers to the data. However focusing purely on a risk profile will inevitably lead to some complacency in groups not targeted once the profiles become known. Also purely profiling may impact more on rural based 50 something male practitioners whilst overlooking those of a similar demographic working in an urban conurbation may restrict access to services in some areas as the workforce moves region to reduce the risk of being profiled.

PAGE 8: Area for change five: compliance

Q13: Do you think the Dental Council should explore the use of incentives to encourage practitioner compliance?	No, Please give your reasons: Provision of suitable healthcare should not require incentives. Everybody makes mistakes that adversely effect patients during their career council should be encouraging the recognition and responsibility that accompanies such events. Making mistakes does not render a practitioner incompetent, incentives do not make them competent
Q14: What do you think the Dental Council could do differently to encourage practitioner compliance with its recertification requirements? Please explain:	Clarification of process, ensuring a dedicated line of communication for practitioners to a council adviser

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?	No - the hours are about right, Please tell us what your preferred increase/decrease in hours is and why: The hours are about right in comparison with many other professions. More regulation of what qualifies for cpd may provide the reassurance that learning is achieved.
Q16: Do you think the Dental Council should change the current length of its education and learning opportunities (CPD) cycle?	No - the cycle length is about right, Please tell us what your preferred increase/decrease in cycle is and why: a four year cycle is right.

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

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

Yes - but only minor changes or improvements ,

Please tell us what other changes or improvements should be made and why:
Ensure that courses and meetings have a learning outcome by having practitioners rate the course attended confidentially to NZDA or DCNZ

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?

Respondent skipped this question