[redacted]

COMPLETE

Collector: [redacted]
Started:
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Time Spent:
IP Address:

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

Q1 This submission was completed by:

Name	**Arish Naresh**
Company/organisation	[redacted]
Position	[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 dental therapist**

Page 3: General question about recertification

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

Yes - it needs to make substantive changes ,

Please give your reasons::

The current measure of CPD hours is arbitrary and does not promote the concept of continuous learning. It is acknowledged that it is still better than having no measure at all. Auditing of practitioners on a three yearly cycle should be mandatory or having a credentialing process similar to the medical workforce. Audits should not be random but designed in a way that a practitioner has an audit every three years. This may be resource intensive to implement. However, the current random audit system also means that i may never get audited throughout my career. Secondly, practitioners MUST be part of at least one recognized professional association. In the DHB sector, all professionals that are not regulated under HPCA require the applicant to be part of their professional association. Having this requirement would also be in line with our Australian counterparts who have this mandatory from the time registration came in. This can be then added as part of the risk profiling measure.

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	**1**
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	**3**
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	**6**
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?

Yes,
Please give your reasons::
Currently it is seen that there is false or misleading adverts by a small number of practices that may not be inline with the HDC standards. Currently most of these are covered by consumer act that is not looking at practice standards(and it isnt their role) GP practices are affiliated to PHOs and undergo accreditation and so do hospitals. However, dentistry even when it is an expensive experience for the patient does not have minimum standards other than those that become part of APC requirements. Both public and private practices should be accredited through robust processes to ensure the patient is at the center and their rights are upheld.

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::
A risk profiling tool is supported as long as it does not discriminate any practitioner or violate the bill of rights act or the human rights act. Other wise the following could be added to in the risk profiling: 1. APC renewal or the failure to do so 2. Any previous complaints 3. Psychological conditions 4. Failure to maintain practice standards 5.Making false or misleading declaration 6. Practitioners MUST be part of at least one recognized professional association. In the DHB sector, all professionals that are not regulated under HPCA require the applicant to be part of their professional association. Having this requirement would also be in line with our Australian counterparts who have this mandatory from the time registration came in. This can be then added as part of the risk profiling measure.

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,

Competence and recertification programmes ,

Examinations and assessments ,

Practical training/experience for a period of time ,

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::
IRD's risk profiling tool Banks using credit risk profiling before issuing credit DAA audits carried out for hospitals has some useful tools to assess standards. Note: practice questionnaires are the worst measure available as it is subjective and may not provide assurance to DCNZ. It is similar to self rating your business on trip advisor.

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

Yes,
Please give your reasons::
1.audits
2.supervision/mentoring

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::
as discussed previously. DCNZ should also consider provisional registration for new graduates for the first year until a mentoring report is received at the end of the mentoring period. Nursing council has registration exams(plus NETP program), medical council requires 2 years post grad training before a full APC is issued. Oral health is one of the few professions that has no standards around first year of practice or the need for an intern year. Students are struggling for clinical time in most institutions globally and it is advisable to have an intern year or a similar system built in. This should then become part of the risk profiling tool.

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::
Similar to a no claims bonus system. When there are more complaints, everyone's disciplinary levy goes up. This shouldn't be the case. Instead, good practitioners should have this lowered in their APC as an incentive to maintain their standards. Poor performing practitioners should have to pay more APC fees for a certain period of time

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

create a risk profile, and incentivise low risk practitioners

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 increased

Please tell us what your preferred increase/decrease in hours is and why::

The hours should be increased in line with the DCNZ standards and the quality of CPD should also be closely monitored. "Social events" should not count towards peer contact activity or CPD hours. Practitioners should also access CPD outside of their district/region to expand their knowledge.

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

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	**6**
Permitting practitioners to set their own hours of education and learning opportunities and quantity of peer activities	**8**
Removing the requirement to have verifiable education and learning activities	**7**
Requiring practitioners to maintain an accurate record of their education and learning activities	**5**
Permitting practitioners to choose some of their education and learning opportunities from prescribed categories	**1**
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	**3**

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

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