A summary report of submissions

Key themes from phase one consultation

A discussion document on recertifying our oral health practitioners: thinking about the future

(February 2018)

RECERTIFICATION REVIEW

Dental Council
Te Kaunihera Tiaki Niho

Purpose of this summary report

Introduction

On 27 June 2017, we issued *A discussion document on recertifying our oral health practitioners: thinking about the future* for consultation. The discussion document had three purposes. To:

- share the work we had done to date on the review
- set out a number of issues and opportunities we identified to improve our current recertification framework
- begin a conversation with our practitioners and stakeholders about recertification—its strengths and weaknesses and how we could improve it.

To facilitate discussion, we invited participation in an online survey we developed using SurveyMonkey. We held 10 face-to-face forums (from Whangarei to Dunedin) and two webinars to further encourage people to share their views and experiences of recertification with us. We also developed a dedicated web page containing background information, research and literature and other documents relating to the review.

On 30 September 2017, consultation on the first phase of the review closed. At the end of the three-month consultation phase, Council had:

- received 246 submissions (which can be accessed here) via the online submission survey (survey)[1]
- received 10 free-form written submissions (which can also be accessed here) that answered some of the survey questions and/or only covered issues the respondent wished to address specifically[2]
- engaged in discussions with approximately 500 practitioners and stakeholders through the forums and webinars.

This report provides a summary of the main themes and sub-themes, which emerged, firstly from the written submissions and secondly from the discussions[3] that took place during this first phase of consultation.

Some of the themes and sub-themes were more easily identified because they were influenced by a specific survey question or cluster of survey questions. Other themes emerged because they were frequently mentioned, discussed or addressed within individual submissions.

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1 The vast majority of online submissions were made by registered oral health practitioners (93.5%). For the online submissions, 67.89% were made by either a registered dentist or dental specialist; 10.16% by a registered dental hygienist; 14.63% by a registered dental therapist; 6.91% by a registered clinical dental technician; 5.28% by a registered dental technician and 1.22% by a registered orthodontic auxiliary.

2 Council received two written submissions from one organisation. The difference between the two submissions was that one submission responded directly to some of the online survey questions and the second was a free-form submission. Council has considered the information in both submissions, but for the purposes of analysis, has counted both responses as one submission.

3 By discussions, Council means the qualitative responses derived from notes taken by staff whom attended the forums and webinars and comments taken from people who completed participant feedback forms at the forums and webinars.

Limitations of this summary report

A concerted effort was made to engage practitioners and stakeholders in the first phase of consultation. We especially acknowledge the efforts of those individuals and branch members of professional associations who shared information on our behalf and encouraged their peers and colleagues to participate in this review.

In addition to the methods used to identify the themes, the following issues should also be noted:[4]

Submissions were not weighted	• All submissions were read and considered equally • No additional weighting was given to submissions prepared by groups, professional associations or sector groups
SurveyMonkey analytics include complete and incomplete submissions	• No assumptions were made about the reason/s why all/some of the questions were completed • If one or more questions were completed, excluding questions about demographics, the submission was included in the analytics
There are gaps in perspectives and views obtained	• There were low participation levels from the public • There were lower participation levels for some professional groups than others

These issues resulted in some limitations about the conclusions, which can be drawn from this summary report.

Analysis of the submissions

We received and heard a broad range of comments and concerns from people who participated in the consultation process.

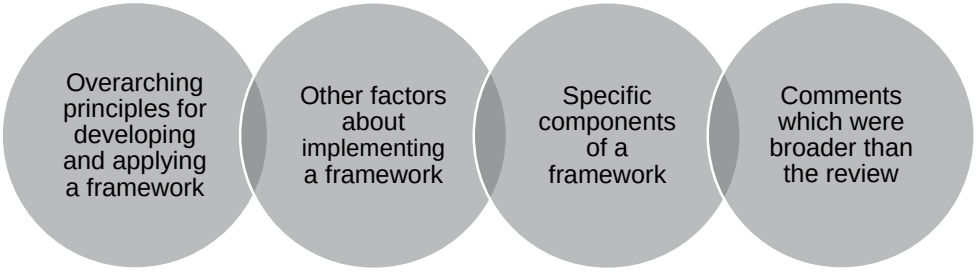
Some of these responses were:

- quantitative in nature—responses to closed-ended questions in the survey
- qualitative in nature—responses to open-ended questions in the survey, as well as comments shared during forums and webinars and within the free-form written submissions.

[4] All respondents who started, but did not finish their submission, were sent an email on 30 October 2017 advising their partially completed submission had been uploaded to our website and collated for consideration by all Council members.

We have organised the qualitative responses into four main themes and sub-themes.

The four main themes are:



In addition to these themes and sub-themes, this summary report also includes a breakdown of the quantitative responses to the questions in the survey (see Appendix one).

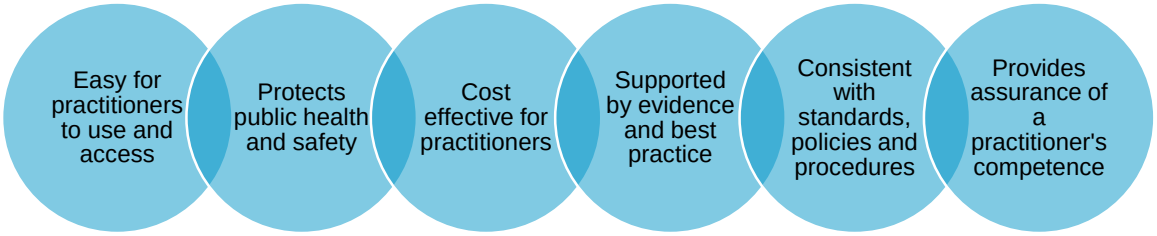
Overarching principles of a framework

Many of the comments we received were about how and what we should consider if a new (or altered) recertification framework was to be developed. Other comments focused on how the framework should be applied to practitioners.

All of these comments seemed to be describing “big picture” ideals and values that lent themselves to the notion of having some overarching principles to guide both the development and application of a recertification framework.

Theme: overarching principles for the development of a framework

Six overarching principles for the development of the framework emerged from the comments we received about recertification. These six principles focused on the need to have a framework:



Sub-theme: easy for practitioners to use and access

Respondents wanted a recertification framework that was simple, achievable and relevant to their scope of practice. Respondents believed the simpler the process, the more likely it was it would be complied with. Suggestions for a simpler process included:

- making compliance documents and procedures easier to complete and submit for Council’s consideration
- having policy and procedural documents that use clear and concise language
- having diagrams and/or guidelines to explain processes and procedures
- having information clearly setting out the steps, actions and consequences that would be taken when specific requirements were not met.

Respondents were also keen to embrace technological opportunities, especially if these included the development of a web-based recertification system so practitioners (and the public) could have access to:

- simpler documents and forms which took less time to complete and submit (particularly at annual practising certificate (APC) renewal time) for Council’s consideration
- online platforms which encourage the development of collegial (i.e. peer-to-peer) spaces for practitioners to share information and better support one another

- online tools to facilitate communication (e.g. webinars and Skype) and easier payment options for fees (e.g. PayPal or credit card payment platforms).[5]

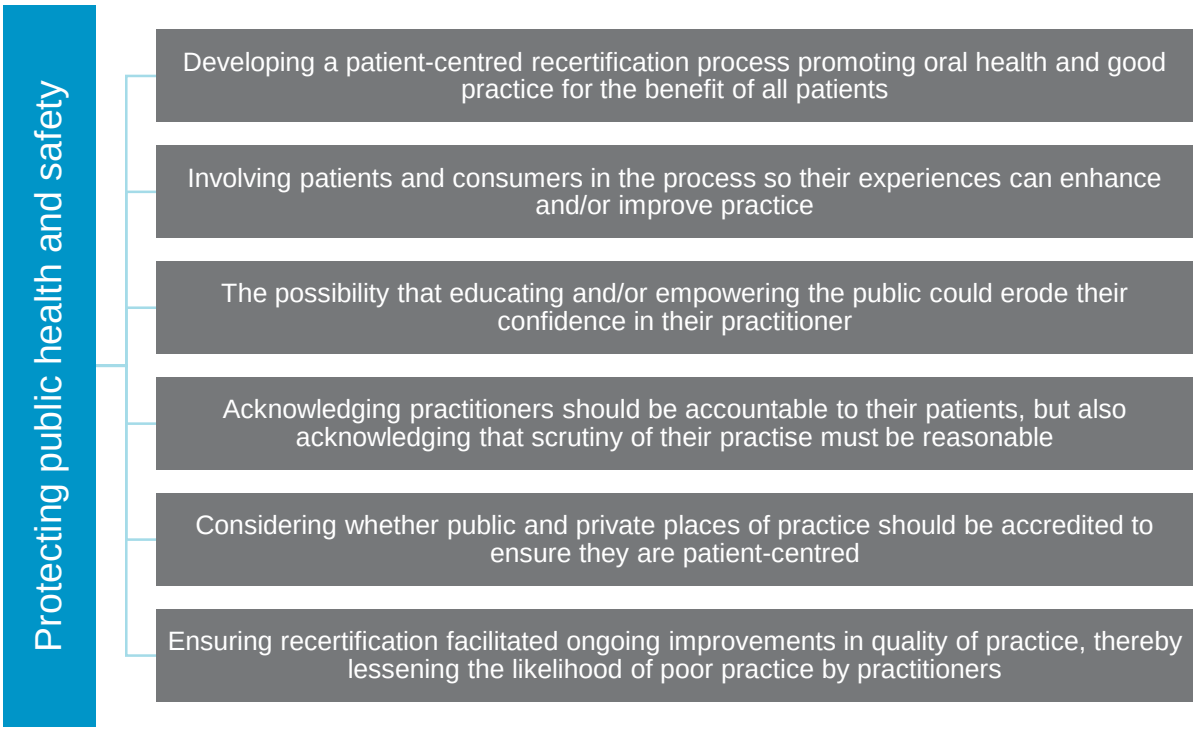
Finally, respondents wanted a recertification process that ensured access to support and remedial systems at the earliest opportunity.

Sub-theme: protects public health and safety

Protecting the health and safety of the public was a key consideration in many of the submissions. Respondents thought the public should expect the best care possible and have confidence that high quality service was being provided by their oral health professional.

Respondents felt that knowing recertification requirements were being monitored by Council and maintained by practitioners enhanced public confidence in their oral health professionals. Respondents also felt (although there were mixed views on this point) that the public should be empowered to know when they were receiving good care and, if necessary, know how to report poor practice to the appropriate authorities.

Other issues raised by respondents about public health and safety included:



Sub-theme: recertification is cost effective for practitioners

The issue of financial costs/impacts was also a key issue for respondents. However, this issue was divided into two categories—the costs associated with recertification (e.g. APC fees) and the direct and indirect costs (e.g. those associated with fulfilling the requirements of APC renewal) for practitioners.

Other comments related to this sub-theme included Council:

- keeping the costs for administering and implementing a framework as low as possible

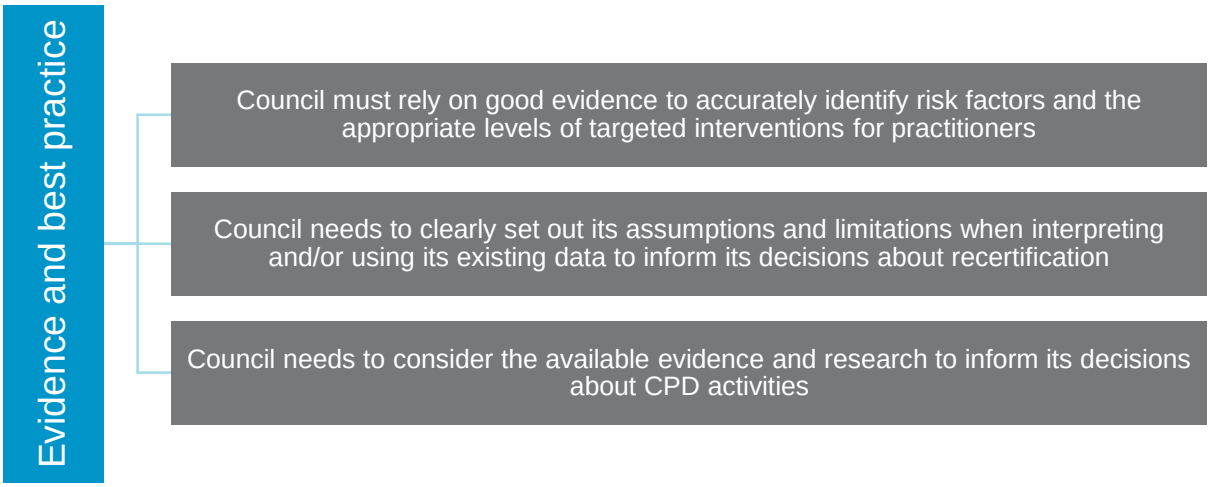
[5] The issue of fee payments spread over 12 months was also raised by some respondents.

- being more aware of the impact of compliance requirements and how this can have flow-on effects for practitioners (e.g. prohibitive cost for some CPD activities)
- considering the use of economic rewards (e.g. lower APC fee and/or disciplinary levy) as a means of encouraging compliance
- being pragmatic and focused on deploying its limited resources where they are most needed and likely to be most productive and/or effective for the public and practitioners.

Sub-theme: supported by evidence and best practice

Developing a framework that is supported by evidence and best practice about recertification and the oral health sector was important to respondents. The need for robust evidence applied not only to the development of the framework, but also the individual components that would form the complete framework.

On the issue of evidence and best practice, respondents had the following comments:



Sub-theme: consistent with standards, policies and procedures

Respondents had three key points about the development of a recertification framework. These were that:

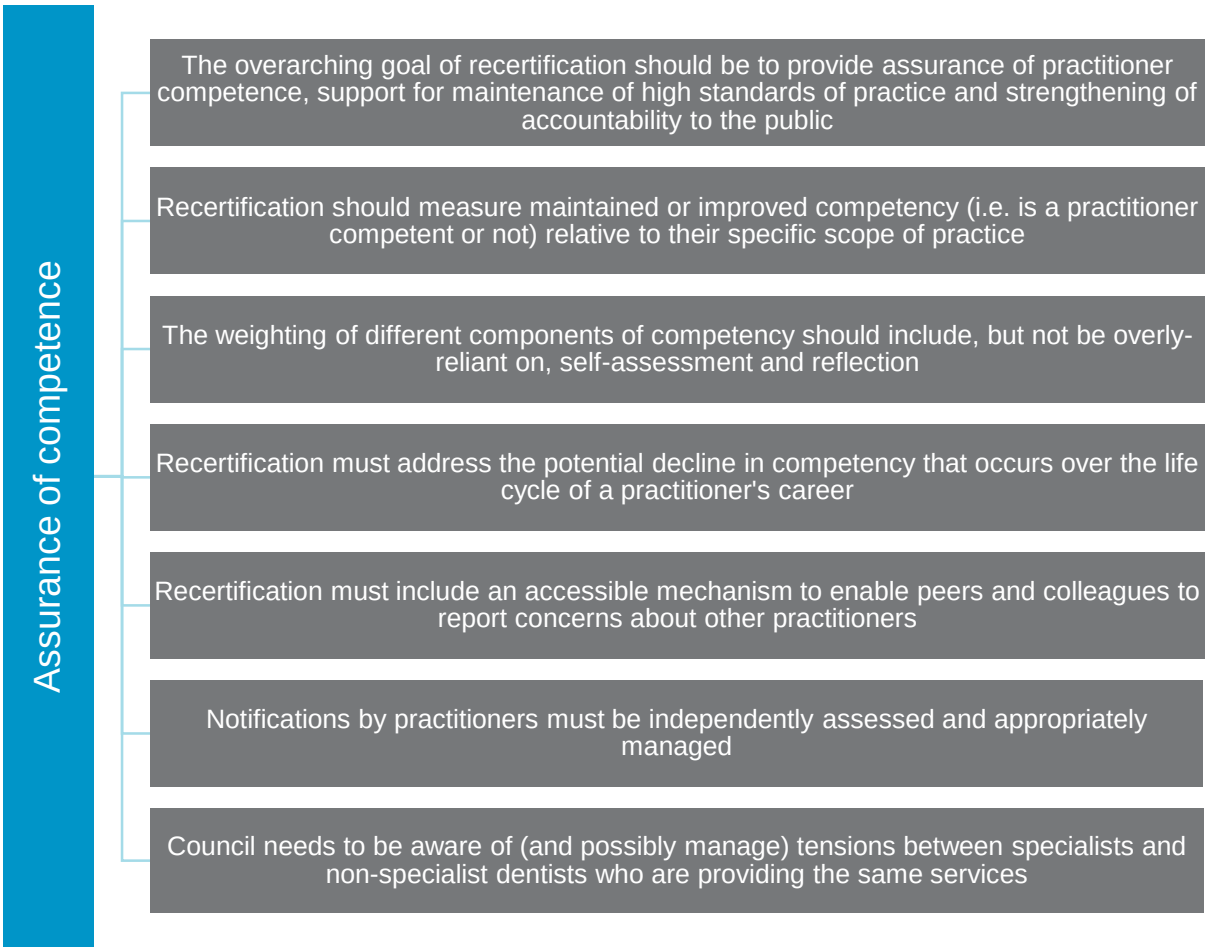
- recertification needed to include and be consistent with current practice standards
- recertification provided an opportunity to ensure current practice standards were clear, concise and transparent for everyone
- a recertification framework must also meet New Zealand's Trans-Tasman statutory obligations.

Sub-theme: provides assurance of a practitioner's competence

Like protecting public health and safety, providing assurance of competence was also a key issue for many respondents. Respondents wanted a clear definition of competence included in a recertification framework.

Some respondents also thought quality control was needed to address all aspects of professional competency. Other respondents thought competence needed to be connected to the initial registration process for practitioners.

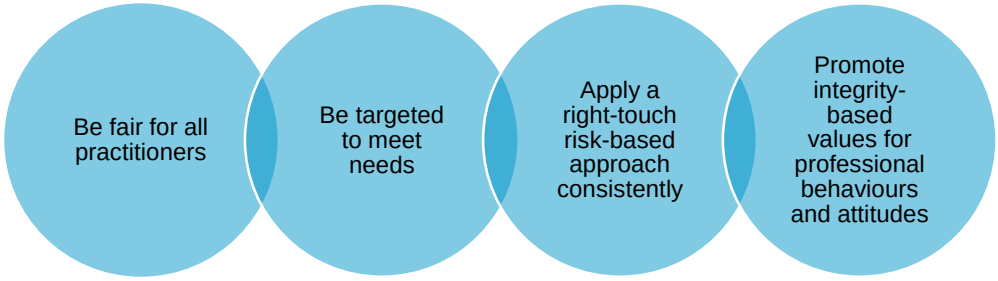
Respondents also thought:



Theme: overarching principles for applying a framework

In addition to comments about principles to guide the development of a framework, respondents also considered the application of a framework to practitioners to be an important issue.

Four overarching principles emerged from the submissions. To adhere to these principles, the recertification framework should:

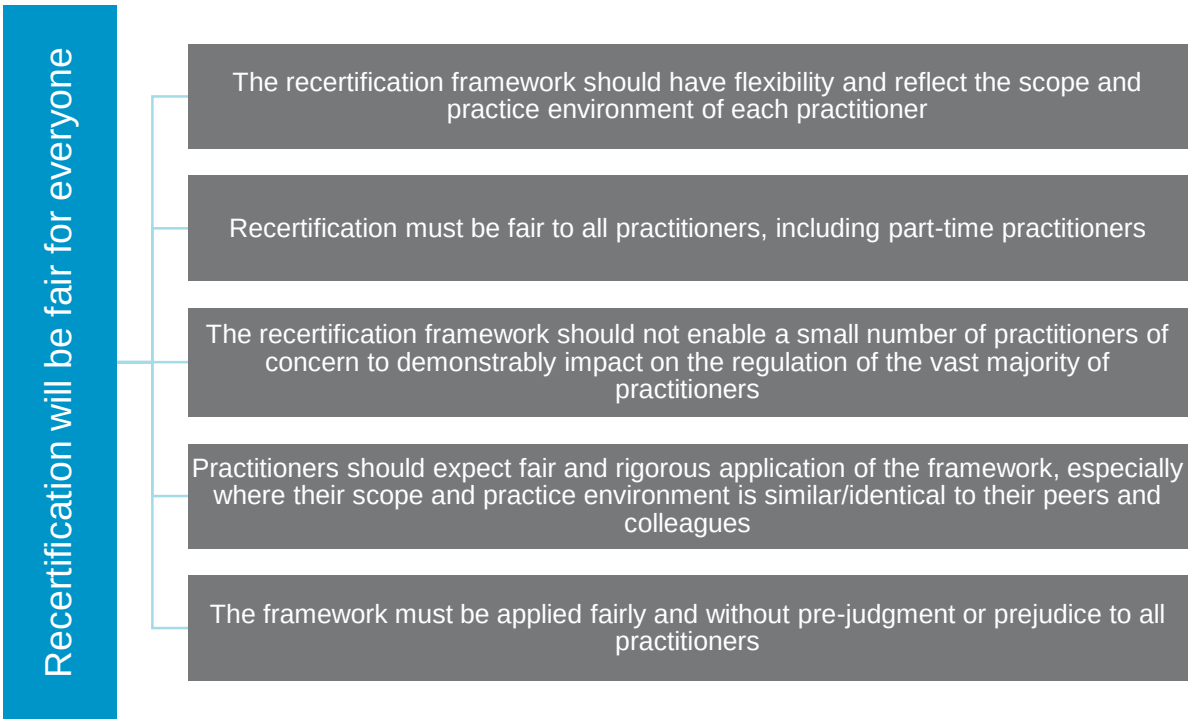


Sub-theme: recertification will be fair for all practitioners

The idea of fairness for all practitioners was mentioned frequently in submissions. Some respondents expressed frustration because they felt our current approach did not recognise the differences between scopes of practice and/or a person's practising environment.

Other respondents wanted a framework that emphasised good behaviours and attitudes. And these respondents favoured a system that could reward or reduce compliance requirements for practitioners who continually exhibited these good behaviours and attitudes (although this view was not shared by all respondents).

On the principle of fairness, respondents made the following observations:



Sub-theme: recertification will be targeted to meet need

Respondents wanted a framework that could identify practitioners who needed additional support and guidance. They also wanted an assurance that appropriate support structures (including those provided by peers, colleagues, employers, professional associations and colleges) could be accessed, if, and when required.

However, the idea of “targeting” raised alarm bells for some respondents. Especially when “targeting” was used in relation to “risk identification” and “risk management”. These respondents wanted Council to be careful to target only those practitioners who required support.

Respondents also sought an assurance that words such as “target” and/or “targeting” were not alternative terms for “witch hunt” or allowing an individual or group to be unfairly singled out as a result of having “targeting” included in a recertification framework.

Other comments included the need for:

- Council to recognise that practitioners are only human, that they can and do make mistakes
- a flexible framework that coped with dynamic changes within each profession as well as innovations across the oral health sector
- a framework that could differentiate between one-off and ongoing difficulties for practitioners

- processes that accounted for differences in practitioner levels of training, experience and practice environments, as well as skills and knowledge
- a robust framework that could identify gaps in a practitioner's knowledge and skills and identify appropriate pathways to facilitate improvements
- guidelines and information clearly setting out when and how a practitioner may be sanctioned and/or required to undertake remedial programme/s or interventions.

Sub-theme: consistent use of a right-touch risk-based approach to regulation

Respondents wanted a recertification framework that could be objectively and consistently applied to all practitioners. This was a salient point for respondents concerned by the potential loss of institutional knowledge about the development and implementation of a recertification framework—especially when there is a turnover of staff or a change of membership within Council itself. Some respondents saw our move to the use of a right-touch risk-based approach to regulation as a mechanism to address this concern.

Respondents also raised the following issues about right-touch risk-based regulation:

Sub-theme: promote integrity-based values for professional behaviours and attitudes

Many respondents used terms such as “professionalism”, “professional behaviours” and “professional attitudes” in their submissions. Other respondents talked about the importance of having value-based ideals underpinning or guiding a recertification framework.

The contexts and examples used in the submissions were often wide-ranging. This included the potential for including integrity-based values in a recertification framework.

Having a values-based approach could support and encourage professional behaviours and attitudes in practitioners. On this issue respondents made the following points:

Additional comments about applying the framework to practitioners

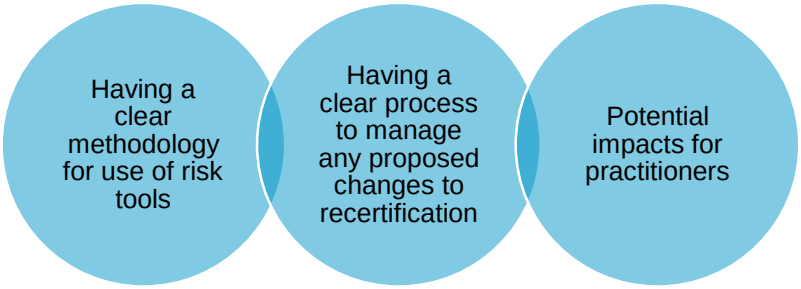
In addition to identifying principles about the application of a recertification framework to practitioners, respondents also made additional comments, which should be considered in this review. These additional considerations were:

- the need to allay practitioner fears they may be unfairly targeted or tainted by risk profiling and targeting as well as being mindful of unconscious bias when using risk-based tools and mechanisms
- that the principles of natural justice and non-discrimination will be protected
- there should be no surprises—practitioners should know what is required and what the likely outcomes will be when these requirements are not met
- considering whether a recertification framework should manage the impact that unreasonable expectations from patients can have on practitioners.

Other factors influencing how a framework will be implemented

In addition to the principles, which could guide the development and application of a recertification framework, there were three additional factors respondents felt would impact on implementation.

These three factors were:

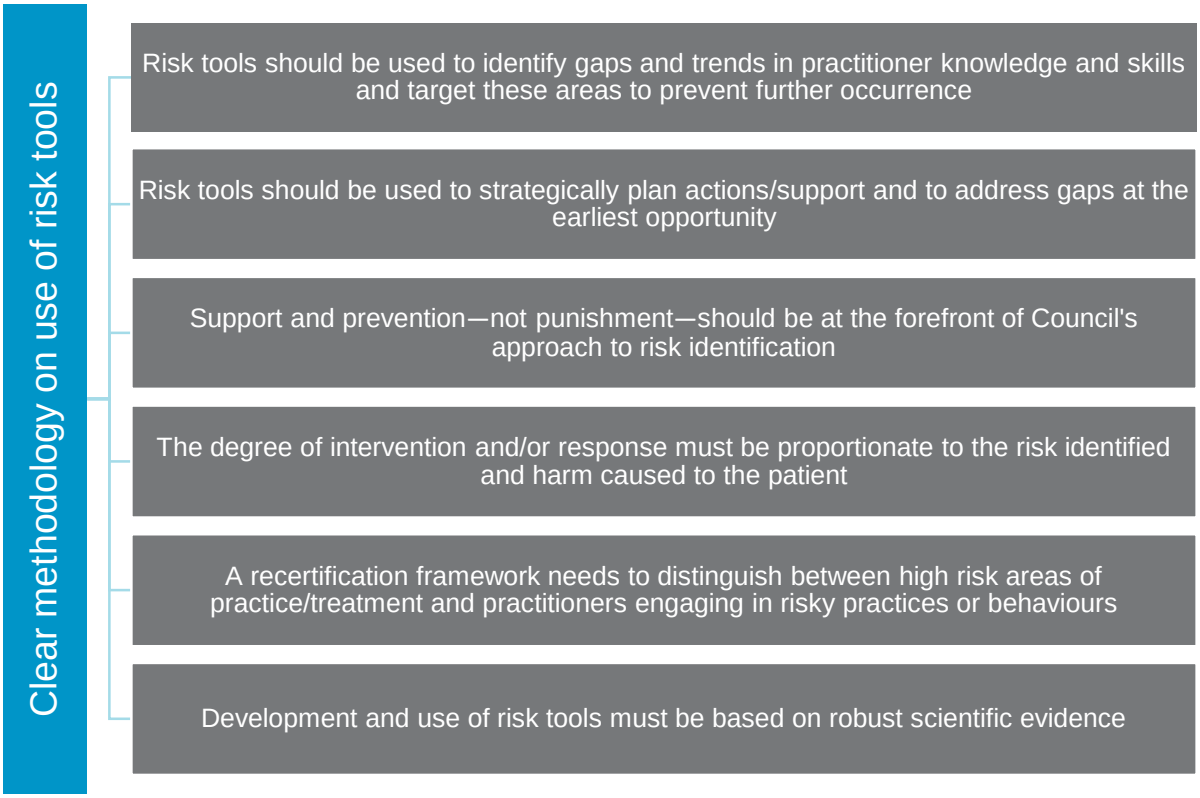


Sub-theme: methodology for use of risk tools

There was no universal agreement on the potential use of tools and mechanisms to identify and manage risk/s for practitioners. We will be giving further consideration to these reasons as work on the recertification review progresses.

What also emerged from respondents' comments was the need for us to have a clear methodology, should we decide to use a range of risk tools—including risk profiling—to identify and assist practitioners in need of additional support.

On the issue of methodology for the development and use of risk tools, respondents had the following comments:



In addition to the comments set out above, respondents also felt:

- the goal of risk identification should be to educate and help practitioners become positive members of the dental community
- it was important that a relevant set of risk indicators/factors was developed as part of a recertification framework
- that having good risk tools will help Council to proactively identify practitioners who are competent and/or compliant, and those who may currently be falling through the cracks
- a recertification framework needs to include an engagement strategy for practitioners who do not want or think they need targeted interventions and support
- Council needed to have good data from multiple sources (i.e. internal and external) in order to develop risk indicators/factors and to appropriately apply these to practitioners
- Council needed to consider how it could utilise existing expertise/experience of people within professional associations who are already involved in mediation/dispute resolution work—as a means of identifying risk factors and trends
- Council must continually review and evaluate its recertification framework to measure the effectiveness of its approach and impacts (positive and negative) on practitioners.

Sub-theme: managing the change process

The possibility of change and the need to have a process to manage potential change was also an important factor for respondents. Comments focused on:

Sub-theme: potential impacts for practitioners

For some respondents, implementing a new recertification framework (or changing the existing framework) prompted comments about the impact this would have on practitioners.

Some of these comments were consistent with concerns raised under other themes in this summary report. These included the positive effect of using data to identify trends (i.e. ongoing incidents of poor practice and/or compliance issues) to proactively manage and support practitioners.

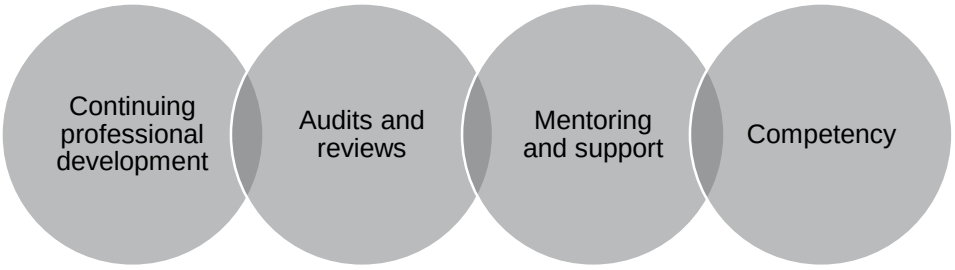
Other respondents called for us to be clearer about compliance with our practice standards and recertification requirements. For some respondents, this meant more effort needed to be put into the development of straightforward information, especially about the consequences of non-compliance.

The issue of fairness (i.e. that recertification requirements will be applied consistently to all practitioners and consideration will also be given to scope of practice and working environments) also featured prominently in submissions. Some respondents expressed frustration their own experiences were more onerous than those of their peers and colleagues. Others believed it would be inequitable and unfair to let the concerns of a small group of practitioners significantly impact on the majority of practitioners (i.e. the development and implementation of a new recertification framework).

Respondents also reiterated their concerns about the use of risk tools, including the possibility this could have the unintended consequence of eroding professional/collegial and peer relationships.

Components of recertification

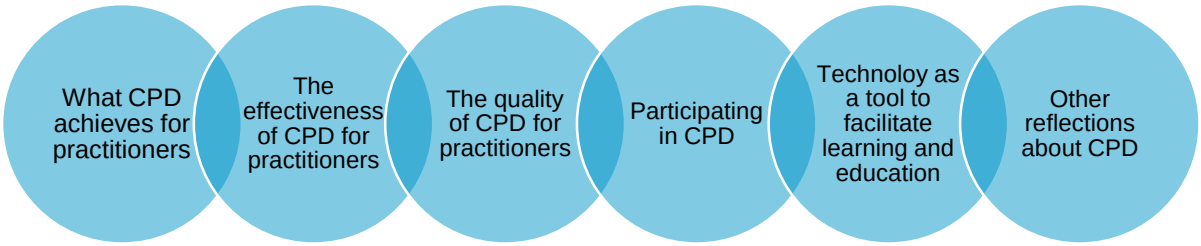
This section of the summary report sets out the issues and comments respondents had about some of the core components of a recertification framework. These comments have been organised under four key themes:



While the majority of comments related to two themes—CPD and audits and reviews—respondents also shared wide-ranging opinions about mentoring and support and competency.

Theme: continuing professional development

Six sub-themes were identified from the comments received about CPD.[6] These comments have been organised under six sub-themes and focus on:



Sub-theme: what CPD achieves for practitioners

Many respondents thought CPD should be educational in nature—with a focus on broad technical and clinical aspects of practice. Many respondents also felt CPD should build on the knowledge and proficiency a practitioner gained while acquiring their tertiary qualifications. Other respondents felt CPD needed to promote the concept of continuous learning and that it could help practitioners to stay up-to-date on innovations within their profession and scope of practice.

Respondents felt CPD could:

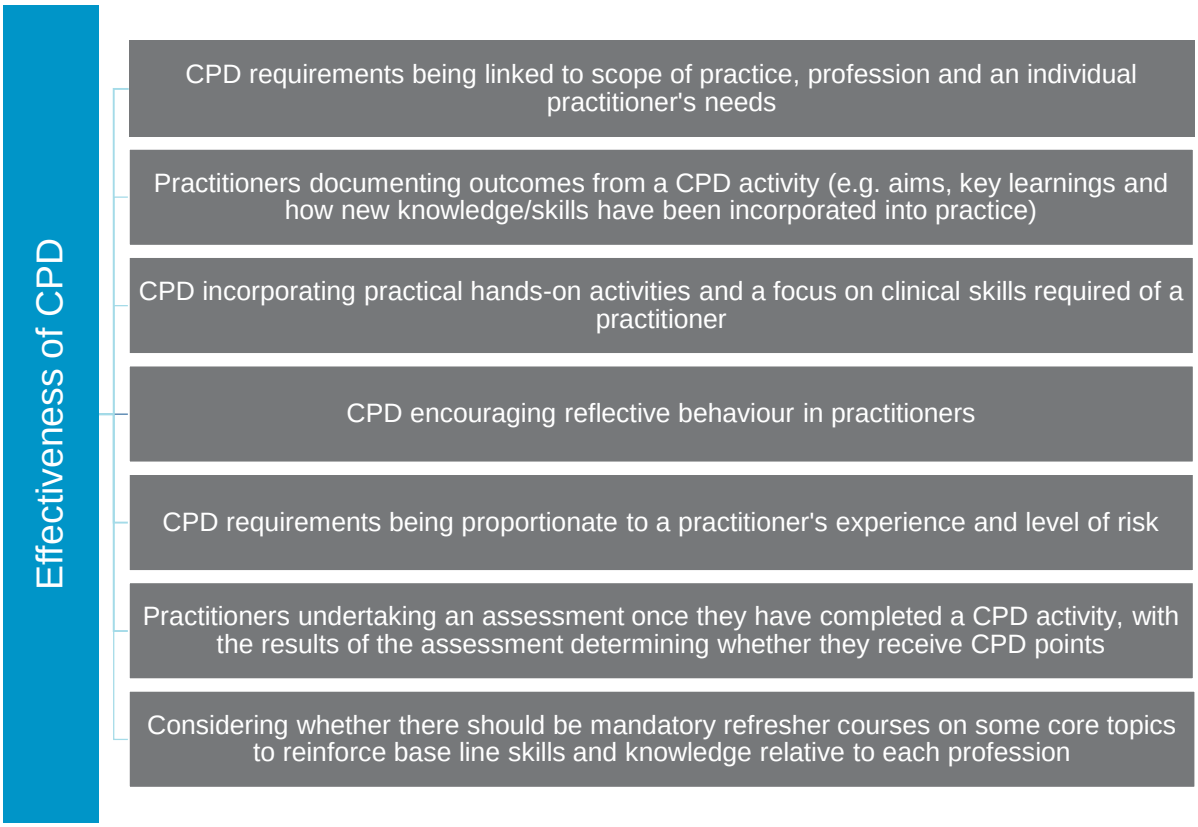
- help maintain knowledge and competence
- help maintain a practitioner's ethical and moral obligations
- ensure every practitioner was maintaining a minimum level of ongoing education and learning
- be an indicator of issues affecting a practitioner's competence.

[6] It should be noted that CPD was also a key focus of discussions for people who participated in the forums and webinars.

Sub-theme: the effectiveness of CPD

Respondents felt CPD must provide the public an assurance that practitioners were maintaining current knowledge and competence. However, some respondents also questioned whether CPD—as it is currently structured and implemented—is as effective as it could be. Respondents also questioned whether collecting CPD points/hours is an actual indication of a practitioner's competence.

Comments about what would improve the effectiveness of CPD included:



Sub-theme: quality of CPD

Respondents queried the value of some CPD courses and activities and believed some CPD was of a poor quality. Respondents felt there should be more rigorous assessments of CPD courses—especially where CPD points were allocated for participation. Furthermore, respondents felt more emphasis needed to be given to evidence-based, dentistry-focused CPD courses.

Respondents thought the person or organisation running CPD courses and activities was an important consideration. Respondents believe there are differences between companies promoting their own products and reputed teaching bodies. Respondents also felt an assessment of the quality of CPD courses should be extended to overseas-based educators providing short courses in New Zealand.

Some respondents suggested:

- having accredited CPD providers would help monitor and maintain course quality and the allocation of CPD points associated with each activity
- CPD providers should consistently seek participant feedback to improve the quality of their CPD courses
- CPD needs to be based on a practitioner's actual work and working environment.

Respondents also expressed annoyance and frustration about the content of "CPD-sponsored" courses. Respondents believed courses provided by industry groups could be biased and misleading. They also felt presenters should have to declare any conflicts of interests or sponsorship deals at least at the beginning of their presentation. Ultimately, respondents thought more needed to be done to limit and/or prevent the availability of these types of courses.

Sub-theme: participation in CPD

We received a lot of comments about the participation barriers some practitioners face when trying to meet their current CPD requirements.

Some respondents provided suggestions about how current CPD requirements could be improved. These included:

- less focus on the need for practitioners meeting CPD requirements (i.e. prescribed hours) and more focus on the benefits associated with participating in CPD activities (i.e. ongoing acquisition of knowledge to maintain and/or improve skills and practice)
- linking participation requirements to risk factors (e.g. number and/or type of notifications or complaints received by a practitioner)
- Council exercising discretion and flexibility if a practitioner has attended all available courses relevant to their profession and scope of practice, but still has a shortfall in meeting their CPD requirements.

Cost was seen as a major barrier for many respondents. For some, the upfront costs of expensive courses and/or CPD activities was prohibitive. Respondents also highlighted the hidden costs associated with participation. These included travel and accommodation, loss of business and/or additional costs associated with cover (i.e. locums) while participating in CPD activities.

Respondents were also concerned that a potential increase in CPD hours would make it even more difficult for some practitioners to meet their CPD requirements. Other respondents said:

Sub-theme: technology as a tool

Capitalising on the use of technology in a recertification framework was a point mentioned in many submissions. In fact, some of the technology-based comments in other parts of this summary report are also relevant to the discussion about CPD.

Respondents could see the advantages of technology as a way of facilitating and enhancing participation in CPD activities. Respondents also saw technology as a tool for promoting interactive learning, reducing costs (such as travel and accommodation expenses) associated with participation and using an online questionnaire to identify ongoing or new learning areas to assist a practitioner's competency.

Respondents saw an opportunity to use technology (e.g. online forums and professional groups) to facilitate information sharing. These same respondents saw technology as a practical way to provide support, including for practitioners requiring peer-to-peer and remedial-based assistance.

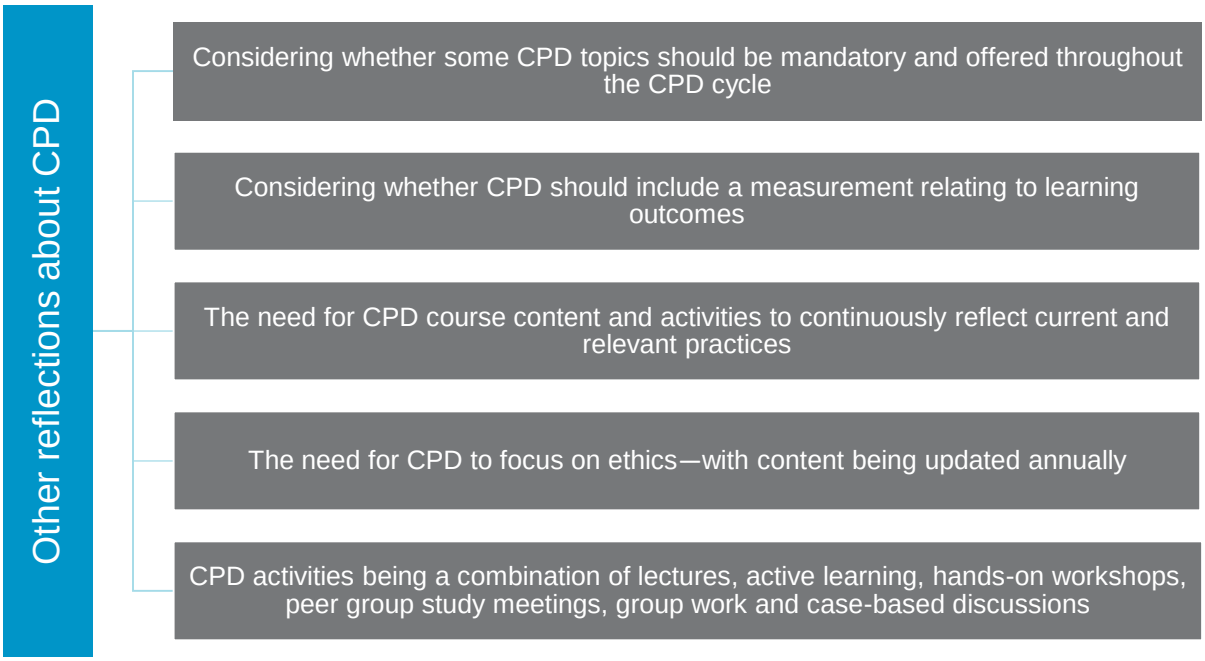
Sub-theme: other reflections about CPD

Some respondents felt recertification should promote ongoing learning and regular participation in activities. They also wondered if CPD could contribute towards an overall goal of optimising good oral health for more people.

Some respondents felt consistent and regular participation would prevent front or end loading of courses or activities just to complete CPD requirements. Other respondents thought CPD needed to help practitioners achieve learning objectives and outcomes associated with their professional development.

However, some respondents felt CPD could be repetitive and they struggled to find new or interesting topics. This was especially difficult for those who believed not much changed in dentistry during the four-year CPD cycle.

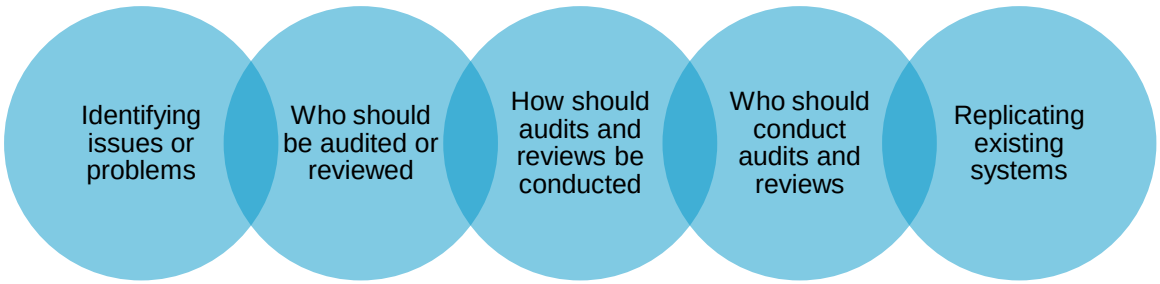
Other reflections about CPD for practitioners included:



Theme: audits and reviews

The discussion document identified six areas where we thought there were opportunities to make changes to our recertification framework. Area three focused on risk identification and included three questions in the survey about tools or mechanisms to identify and manage risk.

Respondents had a lot to say about risk identification tools and mechanisms—particularly audits and reviews. We have organised these comments into the following sub-themes:



Sub-theme: identifying issues or problems

Respondents were clear that a recertification framework should identify practitioners who are not competent and may currently be falling through the cracks.

Some respondents also wanted us to review existing data to identify any patterns/trends that could feed into decisions about who should be audited or reviewed and how frequently. Other respondents thought that:

- audits and reviews could be used to identify practitioners who have a "tick-the-box" mentality about recertification
- questionnaires and frequency of complaints and notifications could be used to identify risk factors
- Council could use feedback from peers, colleagues and patients as a way of identifying practitioners who may require additional support or assistance.

Sub-theme: who should be audited and reviewed

Some respondents believe the current number of practice audits undertaken is too low and felt more practitioners should be audited and/or reviewed. Other respondents felt everyone should be audited at least once within a set time period. Although there was no agreement about the time period, suggestions ranged between three and five year cycles.

On the question of who should be audited or reviewed, respondents thought that:

Sub-theme: how audits and reviews should be conducted

Respondents expressed a range of views about how audits and/or reviews should be conducted. This included:

- questioning whether reviews and audits should be mandatory and undertaken annually
- suggesting practitioners should have to undertake a systematic and periodic (rather than random) onsite audit or review which also included a practical compliance component.

Some respondents liked the written audit that is currently required for APC renewal. Other respondents thought the inclusion of a compliance checklist (perhaps as part of the written audit) would more strongly encourage practitioners to self-reflect on strengths and gaps in their knowledge and skills.

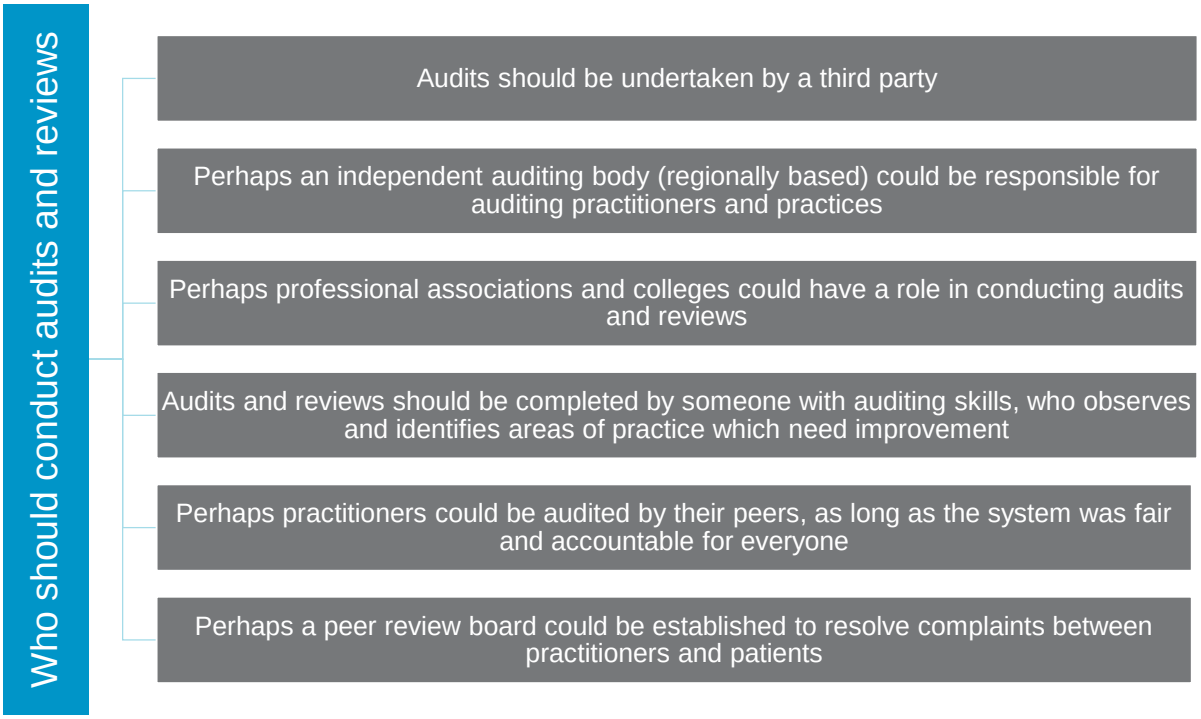
There was also a suggestion the audit process be a two-tier system, firstly designed to identify problems. And secondly, to undertake more intensive probing of the issues identified so appropriate recommendations could be made to address issues, arrange support and put a follow-up process in place to track a practitioner's progress.

Other comments included the need for audits and reviews to:

- be relevant to a practitioner's profession and practice environment
- be an assessment of a practitioner's skill—preferably done by observing a person in their practice/working environment
- include information comprised of patient feedback and peer reviews
- include clinical audits as a routine part of recertification.

Sub-theme: who should conduct audits and reviews

On the issue of who should conduct audits and reviews, respondents had the following comments:



Sub-theme: replicating existing systems

Some respondents also felt we already have good audit and review tools in use across different professions and in different practice environments. These respondents felt that if a practitioner was already subject to rigorous auditing/review processes within their own workplaces, the outcomes from these audits or reviews should be accepted in lieu of whatever audit and/or review mechanisms were put in place in our recertification framework.

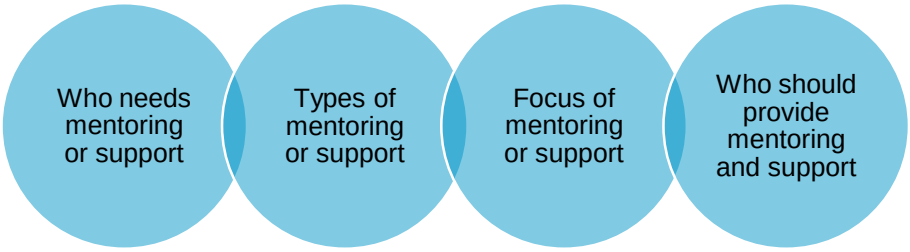
Some respondents pointed out that:

- a district health board (DHB) employee's standards of practice are documented and clinically reviewed annually
- DHB employees already have annual performance development reviews which help to identify CPD requirements
- New Zealand Dental Association (NZDA) and DHBs use peer audits (for DHBs these occur annually)
- all professional associations have internal mediation and conflict resolution processes that could help to identify potential issues
- existing patient complaints systems, especially through the Health and Disability Commissioner (HDC) and DHBs, are robust and could also help to identify practitioners who need additional support.

Theme: mentoring and support

Many respondents favoured a recertification framework which had a primary focus on support and assistance—as opposed to sanctions and punishment. Respondents felt that mentoring and support initiatives were a positive way to help practitioners and correct poor practice.

Comments about mentoring and support have been divided into the following categories:



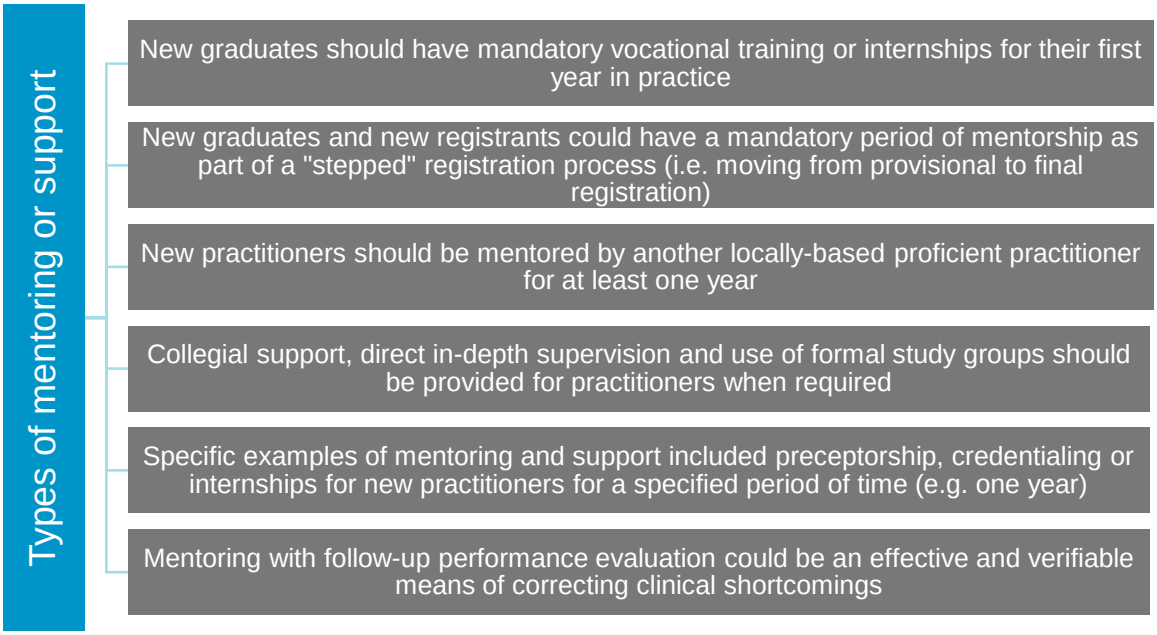
Sub-theme: who needs mentoring or support

Some respondents noted supervision, counselling and mentoring and guidance are important for all practitioners to some degree. Nevertheless, new graduates, new registrants (including those who enter via the NZDREX pathway), practitioners returning to work and practitioners with a pattern of poor care of their patients were frequently mentioned, by respondents, as requiring more mentoring or support than their peers and colleagues.

Respondents were unclear about the length of time the aforementioned groups should continue to receive mentoring or support. These respondents were also unclear about the point at which mentoring and support should be provided to practitioners. In the case of new graduates and new registrants, the general consensus was that additional support would be beneficial if provided at the beginning or in the early years of their practising careers.

Sub-theme: types of mentoring or support

On the issue of the types of mentoring or support practitioners may require, respondents had the following comments:



Sub-theme: focus of mentoring or support

Respondents reiterated that mentoring or support should be remedially focused. Mentoring, training and guidance should be provided for an appropriate period of time in those areas proving challenging for individual practitioners.

Respondents felt:

- that competence should be the focus of mentoring for new graduates
- a key focus for new registrants (especially overseas trained practitioners) should be orientating/negotiating their way through their new practising environment (i.e. gaining an understanding of the New Zealand healthcare system)
- new registrants needed mentoring and support that gave them time to adapt to new systems, manage/overcome cross-cultural misunderstandings and/or communication issues.

Sub-theme: who should provide mentoring and support

Respondents identified a range of people who could provide mentoring and support for new graduates, new registrants and other practitioners requiring additional support and guidance.

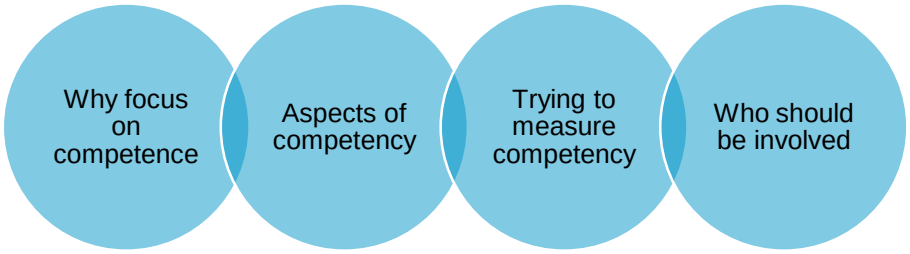
Respondents felt the following people and/or organisations were best placed to provide mentoring and support for practitioners:

- locally-based, experienced practitioners who could help build a new graduate's (and arguably new registrant's) confidence, build good skills sets and help their transition from an academic to workplace environment
- managers and employers (if relevant to profession and or type of practice environment) such as those from DHBs

- experienced peers and colleagues in corporate or group-based practices
- professional associations, colleges, tertiary institutions, sector-based or other practitioner-based groups.

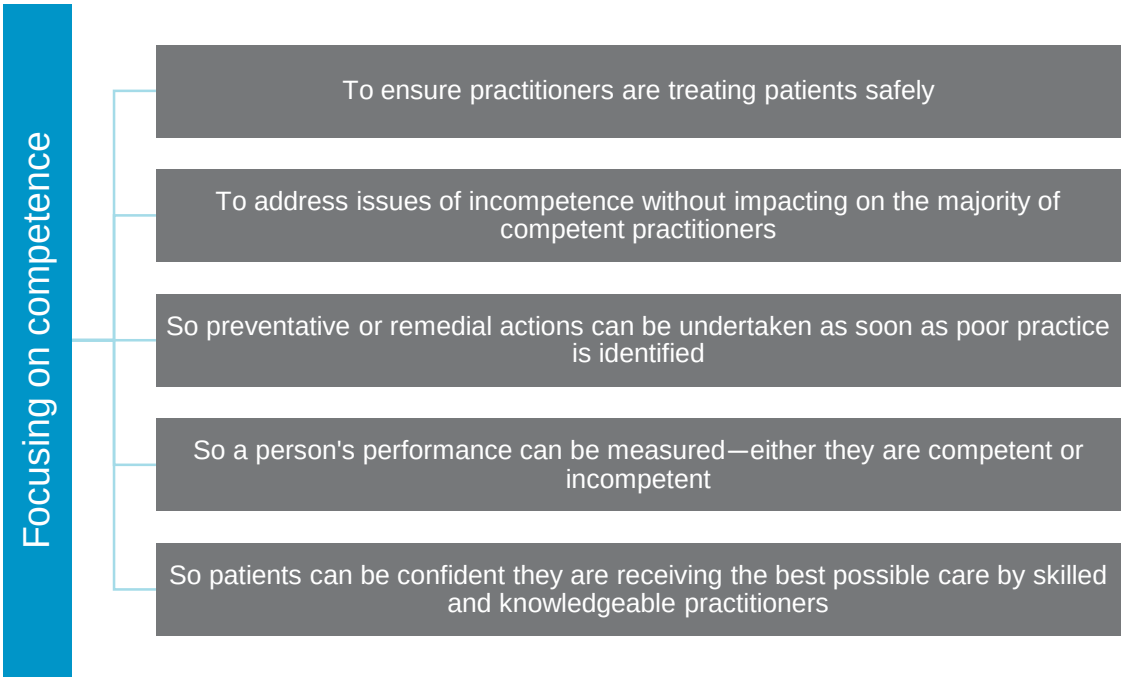
Theme: competency

Respondents had a range of comments and questions regarding competency. These comments have been divided into four sub-themes:



Sub-theme: why focus on competence

Respondents had the following comments on why competence should be a focus in a recertification framework:



Sub-theme: aspects of competency

Some respondents felt competence covered a wide range of subjects concerned with a practitioner's knowledge and skills. They saw competence as having multiple components that were influenced in part by a practitioner's profession and level of experience.

Some respondents asked whether clinical outcomes (i.e. working a minimum number of clinical hours) should be a focus of competence. Other respondents questioned whether recertification should include a measure about maintained or improved competency in a specific scope of practice.

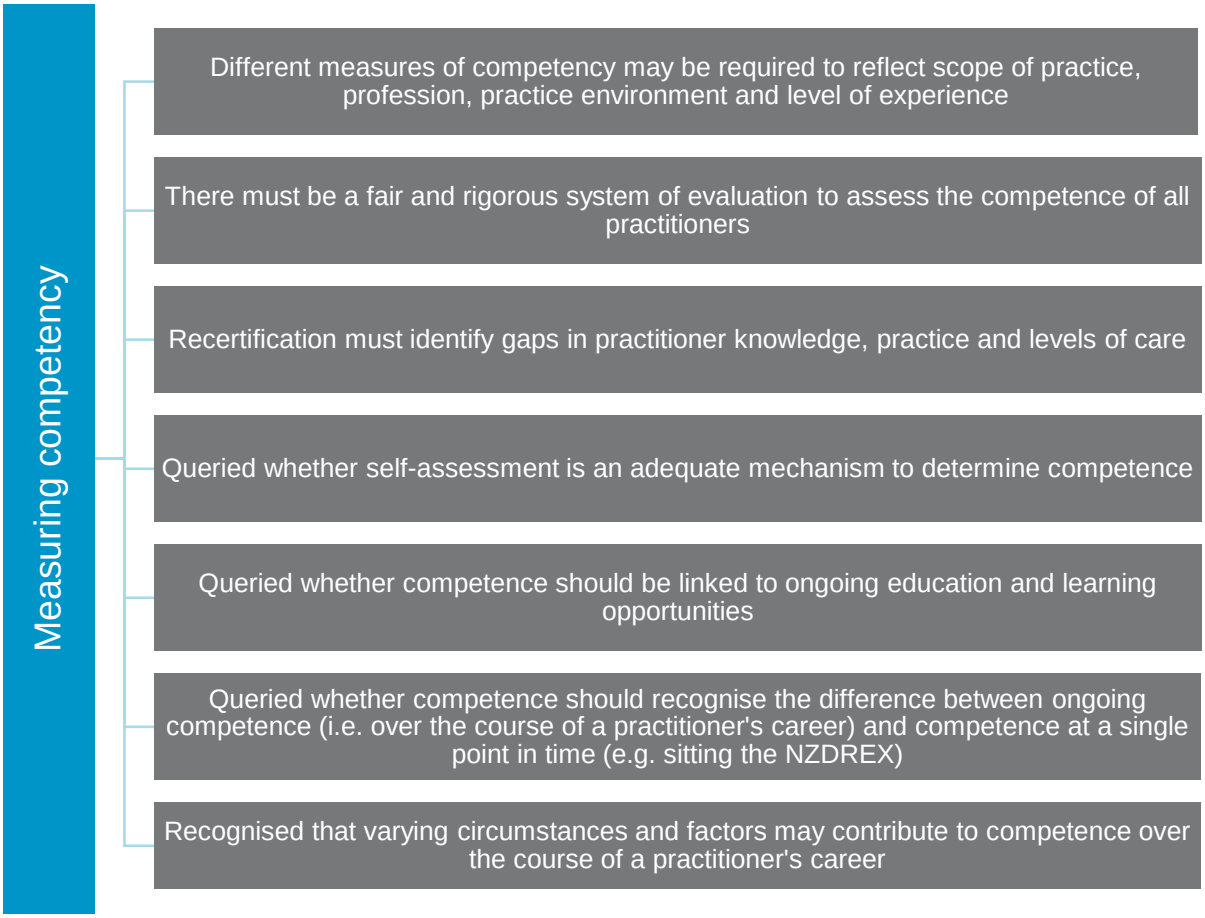
Respondents also:

- suggested an assessment of competence could include case presentations to peers—with critical feedback and discussion being necessary components of the presentation
- wondered whether public surveys should be used to ascertain how safe patients felt in terms of practitioner competence
- queried the relevance of multiple complaints and repeated incidents of non-compliance as an indicator or measure of competence
- suggested performance modules—such as those used by the Nursing Council—could be used as part of a recertification framework.

Sub-theme: trying to measure competency

Respondents felt it was important for a recertification framework to include a clear definition of competence. They also felt it was important to distinguish competence from compliance.

Respondents also had the following comments about measuring competency:



Sub-theme: who should be involved

Some respondents felt we (and in some cases employers):

- needed to better support practitioners to maintain their competency and skills

- must use the full range of regulatory tools available to maintain assurance of competence in practitioners—especially when undertaking a review and/or assessment of a practitioner's competence

- needed to ensure the use of any risk-profiling tools did not result in pre-judgment about competence—especially if a practitioner trained overseas.

Some respondents believed tertiary institutions must also ensure all graduates are competent and safe to practice at the point of graduation. Other respondents thought the standard of the NZDREX needed to be improved to assure practitioner competence.

Comments broader than the review

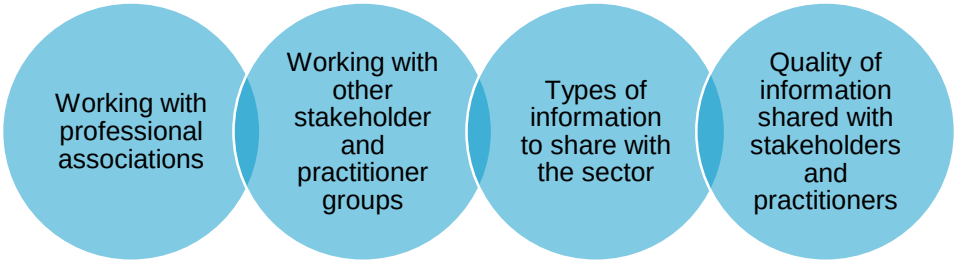
We received a group of comments, which, while relevant to recertification, also have broader application than this review. These comments have been organised under two themes:

- our relationships and engagement with practitioners and stakeholders
- awareness of existing models and approaches

Theme: relationships and engagement

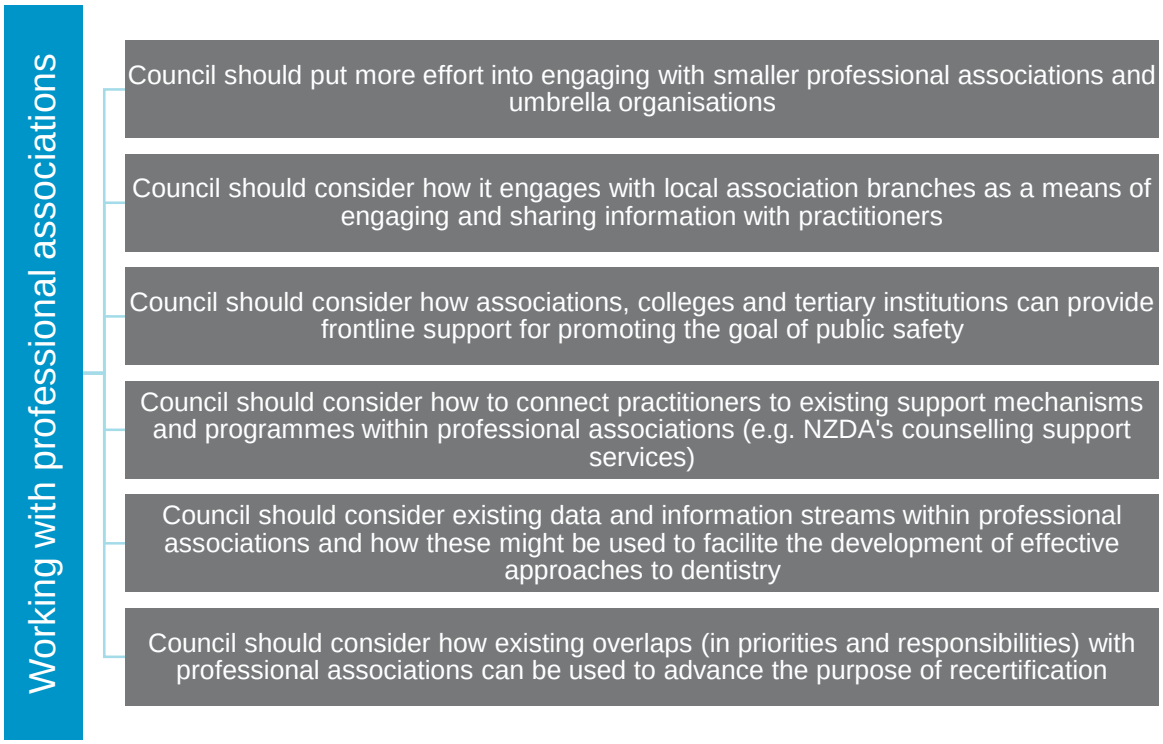
Respondents had wide-ranging opinions about our relationships and engagement with practitioners and stakeholders. They felt we needed to work on continually building and reinforcing these relationships and identify opportunities to collaborate wherever possible.

Respondents' comments about relationships and engagement have been organised under the following sub-themes:



Sub-theme: working with professional associations

On the issue of working with professional associations, respondents had the following comments:



Sub-theme: working with other stakeholder and professional groups

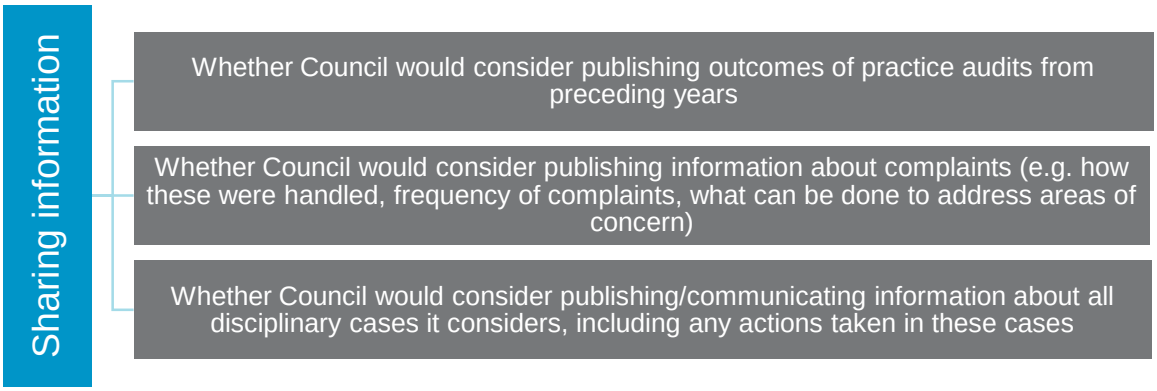
Some respondents felt we needed to invest more time and effort into the work we do with our stakeholders and professional groups.

Some respondents thought:

- work needed to be done to overcome the perception of an “us and them” mentality between Council and the oral health sector
- improvements in relationships with professional associations may also yield more collaborative approaches to shared areas of interest
- we should utilise existing networks and groups—other than those provided through professional associations—as a means of providing additional support for practitioners
- we needed to capitalise on mentor/peer/study groups throughout the regions so practitioners have another mechanism they can use if/when they require additional support
- we needed to focus on data-sharing with key agencies (i.e. HDC, the Accident Compensation Corporation (ACC and the Ministry of Health (MOH)) to better inform our decision-making, policy development and implementation processes.

Sub-theme: types of information shared with the sector

Respondents had views on three issues relating to types of information shared with the sector. These were:



Sub-theme: quality of information shared with practitioners and stakeholders

Respondents felt communications with the sector—especially practitioners—needed to occur regularly. They also wanted these communications to be clear and concise.

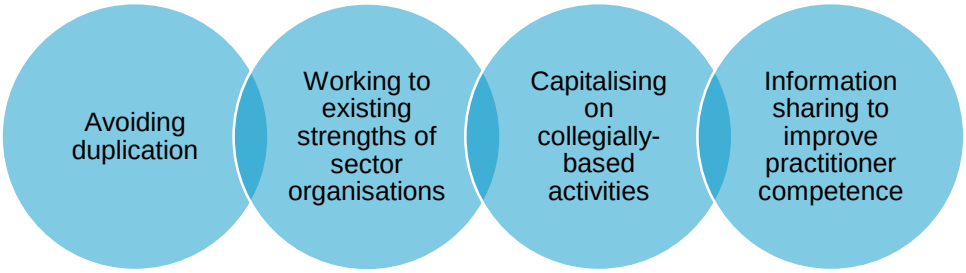
Some respondents felt information on our website needed to be better targeted to practitioners. For some respondents this meant giving greater consideration to scope of practice and profession.

Some respondents also felt information relating to practice standards was confusing. These respondents asked whether information about practice standards could be clarified and housed in one section of our website—to improve accessibility for practitioners.

Theme: existing models and approaches

We received a variety of comments about models and approaches already operating in the oral health sector. Many of these comments are directly relevant to recertification and have been incorporated, wherever possible, into other areas of this summary report. However, we felt it was also worth grouping these comments under a separate theme because of their relevancy beyond the recertification review.

As with previous sections of this summary report, respondents' comments have been organised under sub-themes. These are:



Sub-theme: avoiding duplication

Respondents were keen that duplication of existing models and approaches be avoided wherever possible. Respondents shared the following comments about existing models and approaches with us:

Sub-theme: working to existing strengths of sector organisations

In addition to identifying a range of programmes and systems already in use across the oral health sector, respondents saw merit in using and/or building on existing mechanisms. Respondents encouraged us to give consideration to the following suggestions:

- consider how services provided by professional associations could be used to develop individual remedial programmes for practitioners

- consider the efficacy of using clinical educators or mentors to undertake audits (as a third party) where this system already exists within an individual's practice environment
- consider the possibility of third parties undertaking systematic audits (including random audits) on Council's behalf, especially if a decision is made to increase the number of practice audits undertaken every APC renewal cycle
- consider how data, already collected by professional associations, could be used to inform the development and ongoing monitoring of the effectiveness of a recertification framework
- consider using existing support/mentoring programmes and structures within professional associations and some practice environments (e.g. corporate practices)
- encourage professional associations and other organisations/groups to expand access to support/mentoring programmes they already have.

Sub-theme: capitalising on collegially-based activities

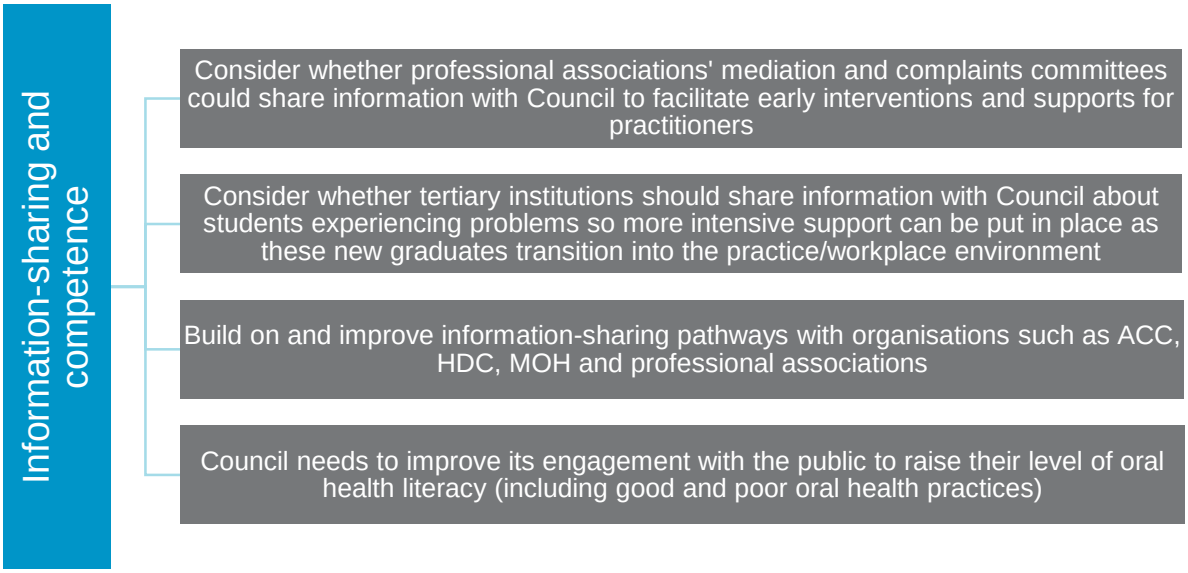
Some respondents spoke positively about existing groups and activities based on collegial relationships between peers and colleagues.

Some respondents wanted a framework encouraging practitioners to engage in peer reviews as part of their reflection on whether they were meeting recertification requirements.

Other respondents encouraged the establishment of formal and/or informal peer groups and peer support structures. These respondents felt new graduates, newly registered overseas trained practitioners and practitioners working in isolated communities or sole practices could benefit from access to and use of these mechanisms.

Sub-theme: information-sharing to improve practitioner competence

On the issue of information-sharing to improve practitioner competence, respondents offered the following comments and suggestions:



Reflecting on your comments

When we undertook this first phase of consultation, our aim was to gather practitioner and stakeholders' experiences, observations and opinions about recertification. This included how you felt about the current recertification framework as well as your views on how this framework could be improved.

Practitioners and stakeholders who made a submission and/or participated in the forums and webinars expressed a range of perspectives about their experiences, concerns and suggestions of recertification.

The quantitative responses to questions (e.g. see for example the responses to questions about CPD in Appendix one) indicate the majority of practitioners who participated in the survey are happy with the status quo. Despite this positive affirmation, the qualitative comments for these same questions suggests many respondents had issues or questions about our current approach. Or at the very least, had aspirations for how the current system might be improved.

Our intent in the first phase of consultation was to test and challenge our own thinking and assumptions about recertification with the people most affected by our framework—our practitioners. Having received all of the feedback, we must now consider how best to incorporate your views and opinions into our thinking, as we enter the next phase of work on this review.

There is a balancing act that must be achieved. One that requires us to give due consideration to the comments you have provided—not an easy task when some responses to questions were almost evenly split, or where respondents suggested differing (and sometimes opposite) perspectives on the same issue.

Your comments and opinions must also be considered alongside the findings from the literature review we completed to inform this review. We will be considering advice and information we have gathered from discussions with other responsible authorities and regulators (in New Zealand and overseas) about recertification. We will also look at the data currently available to us to determine the best way forward for everyone.

We want a recertification framework which is:

- effective (i.e. it protects the health and safety of the public)
- fair to all our practitioners
- robust and evidence-based.

It is clear from the comments you have provided that you want these same things too.

Appendix one – responses to the survey questions

Overview of responses to the online survey questions

Appendix one contains the quantitative information taken directly from the online survey questions. Because we used SurveyMonkey to run our survey, we were able to use the analytics function of that platform to complete basic quantitative computations.

The SurveyMonkey analytics are based on the online survey responses only. However, it should be noted that due to a technical fault one respondent had to submit their answers to the survey in a free-form written submission. The results of this respondent's submission are also included (predominantly in footnotes) within this appendix.

Format of the online survey

There were 19 questions in the survey. Questions one to three asked for general information about the person, group or organisation making a submission. Questions four to 19 sought specific feedback on different aspects of recertification.

It should also be noted that:

- questions 14 and 19 were open-ended questions, which means the qualitative responses to these questions is captured in the main body of this summary report
- questions 5 and 17 asked respondents to rank a list of responses according to statements provided in these questions
- question 9 asked respondents to select from a range of responses provided and/or to add tools and mechanisms not included in the list provided
- the SurveyMonkey analytics for questions 5, 9 and 17 do not include the responses from the person who submitted the free-form written submission.

Demographic information of respondents who completed the survey

Question 1: This submission was completed by …

We received 246 online submissions.[7] In addition to these submissions, we also received:

Written submissions responding directly to online survey questions	1
Free-form written submissions[8]	9

[7] The total includes completed and partially completed submissions.

[8] We received two written submissions from one organisation. The difference between the two submissions was that one submission responded directly to some of the online survey questions and the second was a free-form submission. We have considered the information in both submissions, but for the purposes of analysis, have counted both responses as one submission.

Question 2: Are you making this submission survey by …

Of the 246 who answered question 2:

As a registered practitioner	93.44% (228)
As a member of the public	2.05% (5)
On behalf of a group	1.64% (4)
On behalf of a company or organisation	2.87% (7)
Skipped	(2)

The breakdown of free-form written responses received by Council were:

As a registered practitioner	20% (2)
On behalf of a group	10% (1)
On behalf of a company or organisation	70% (7)

Question 3: Please tell us which part of the sector your submission survey represents?

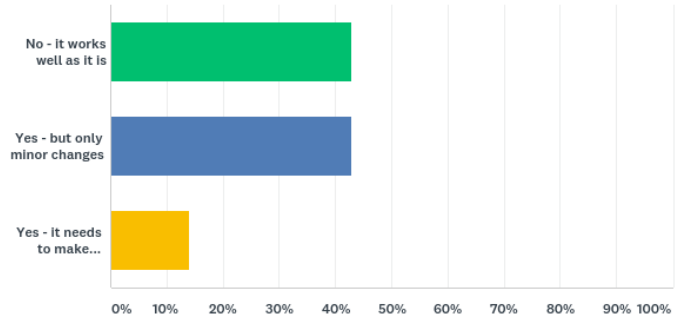
The breakdown of online (246) and free-form written (10) submissions received were:[9]

As a registered dentist or dental specialist	65.63% (168)
As a registered dental hygienist	9.77% (25)
As a registered dental therapist	14.06% (36)
As a registered clinical dental technician	7.03% (18)
As a registered dental technician	5.08% (13)
As a registered orthodontic auxiliary	1.17% (3)
As a professional association	3.52% (9)
As a company/organisation	1.56% (4)
As a consumer group	1.56% (4)
As an education provider	1.95% (5)
As a responsible authority	2.34% (6)

[9] It should be noted that the percentages and actuals do not add up to the total number of submissions because some online respondents identified themselves as belonging to more than one profession or group when completing their submission.

Introductory survey question

Question 4: Do you think the Dental Council needs to make changes to its current recertification framework?



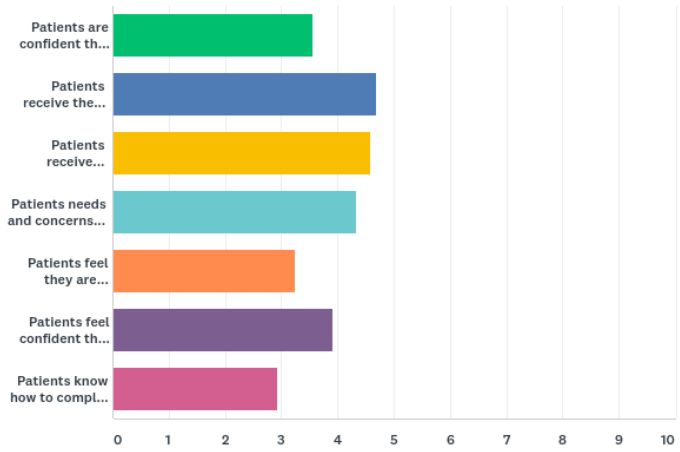
Of the 214 people who answered question 4:

No – it works well as it is	42.99% (92)
Yes – but only minor changes	42.99% (92)
Yes – it needs to make substantive changes[10]	14.02% (30)
Skipped the question	(32)

[10] The person who submitted a free-form written submission answered, "*Yes – it needs to make substantive changes"* to question 4.

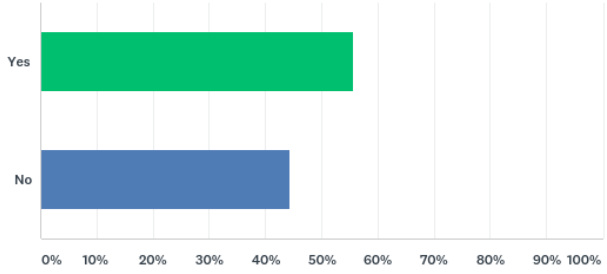
Area for change one: public assurance

Question 5: Each of the seven statements below are equally important components of good oral health care. We want to identify where there are gaps and weaknesses in the way our oral health practitioners serve the public. Please rank the components from 1 to 7, with 1 being the component you think needs the most improvement and 7 being the component you think needs the least improvement:



It should be noted that the graph above presents the responses as *weighted average answers* of the 165 people who completed question 5.[11] Eighty one respondents skipped question 5.

Question 6: Do you think the Dental Council needs to equip patients and the public to recognise poor practise?



Of the 174 people who answered question 6:

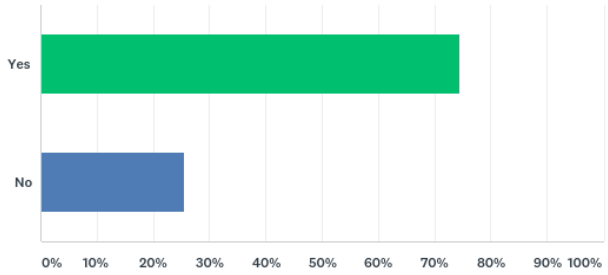
Yes[12]	55.75% (97)
No	44.25% (77)
Skipped the question	(72)

[11] The person who submitted a free-form written submission ranked their responses to question 5 as follows - *patients are confident their practitioner will not harm them (5); patients receive the appropriate treatment for their oral health concern or issue (1); patients receive appropriate information about their treatment and care (2); patients needs and concerns are discussed and addressed with their practitioner (4); patients are treated with dignity and respect at all times (7); patients feel confident their practitioner has the knowledge and skills to treat them (6); and patients know how to complain about treatment they have received from their practitioner (3)*.

[12] The person who submitted a free-form written submission answered, *"yes"* to question 6.

Area for change two: public assurance

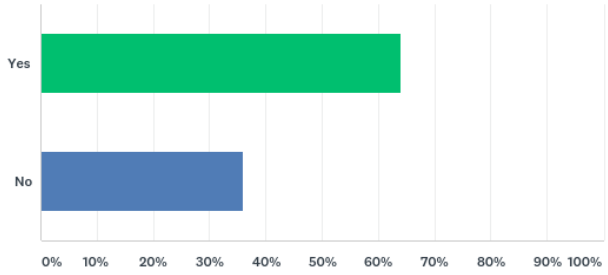
Question 7: Do you feel you have adequate information about the Dental Council's approach to regulation?



Of the 160 people who answered question 7:

Yes[13]	74.38% (119)
No	25.62% (41)
Skipped the question	(86)

Question 8: 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?



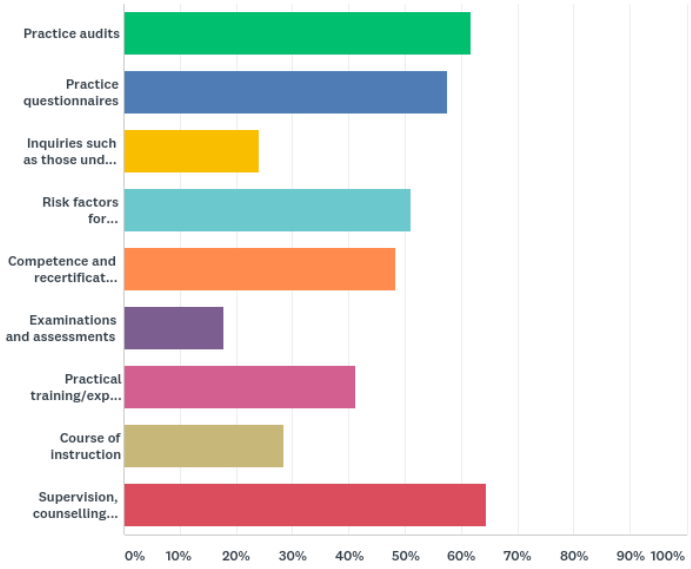
Of the 153 people who answered question 8:

Yes[14]	64.05% (98)
No	35.95% (55)
Skipped the question	(93)

[13] The person who submitted a free-form written submission answered, *"yes"* to question 7.
[14] The person who submitted a free-form written submission answered, *"yes"* to question 8.

Area for change three: risk identification

Question 9: Which (if any) of these tools and mechanisms do you think the Dental Council should be using to identify and manage risk?

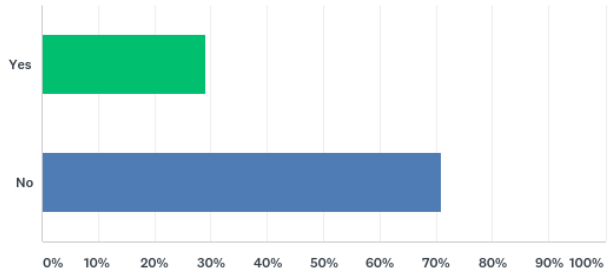


The 141 people who answered question 9 identified the following tools and mechanisms:[15]

Practice audits	61.70% (87)
Practice questionnaires	57.45% (81)
Inquiries such as those under section 36 of the HPCA Act 2003	24.11% (34)
Risk factors for practitioners	51.06% (72)
Competence and recertification programmes	48.23% (68)
Examinations and assessments	17.73% (25)
Practical training/experience for a period of time	41.13% (58)
Course of instruction	28.37% (40)
Supervision, counselling and/or mentoring	64.54% (91)
Skipped the question	(105)

[15] The person who submitted a free-form written submission selected *practice audits, risk factors for practitioners, practical training/experience for a period of time and supervision, counselling and/or mentoring* from the available responses to question 9.

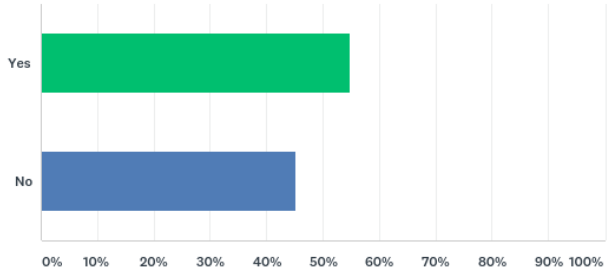
Question 10: Are you aware of any other tools or mechanisms the Dental Council should be using to identify and manage risk?



Of the 144 people who answered question 10:

Yes	29.17% (42)
No[16]	70.83% (102)
Skipped the question	(102)

Question 11: Do you think any of these risk tools or mechanisms are more effective than others?



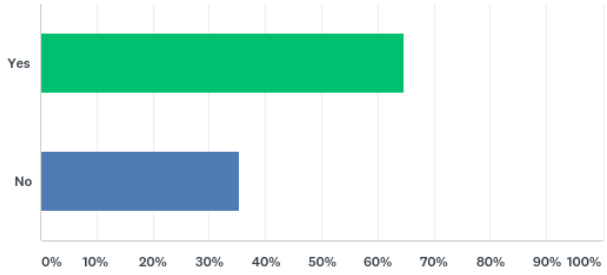
Of the 135 people who answered question 11:

Yes[17]	54.81% (74)
No	45.19% (61)
Skipped the question	(111)

16 The person who submitted a free-form written submission answered, *"no"* to question 10.
17 The person who submitted a free-form written submission answered, *"yes"* to question 11.

Area for change four: early intervention

Question 12: Do you think the Dental Council should explore the use of risk analysis and risk-profiling to identify poor practise sooner?



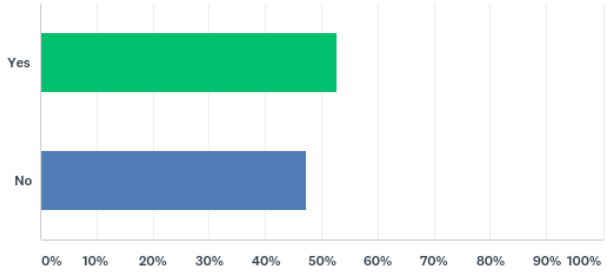
Of the 144 people who answered question 12:

Yes[18]	64.58% (93)
No	35.42% (51)
Skipped the question	(102)

[18] The person who submitted a free-form written submission answered, *"yes"* to question 12.

Area for change five: compliance

Question 13: Do you think the Dental Council should explore the use of incentives to encourage practitioner compliance?



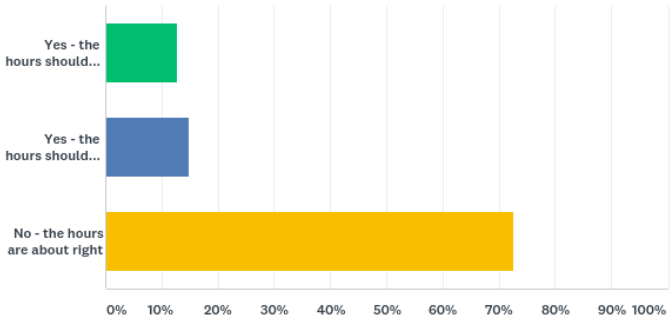
Of the 144 people who answered question 13:

Yes	52.78% (76)
No[19]	47.22% (68)
Skipped the question	(102)

[19] The person who submitted a free-form written submission answered, *"no"* to question 13.

Area for change six: ongoing education and learning opportunities

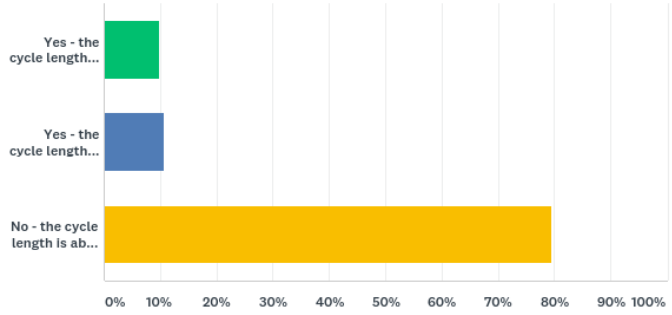
Question 15: Do you think the Dental Council should change its current amount of prescribed hours and peer activities?



Of the 142 people who answered question 15:

Yes – the hours should be increased	12.68% (18)
Yes – the hours should be decreased	14.79% (21)
No – the hours are about right[20]	72.54% (103)
Skipped the question	(104)

Question 16: Do you think the Dental Council should change the current length of its education and learning opportunities (CPD) cycle?

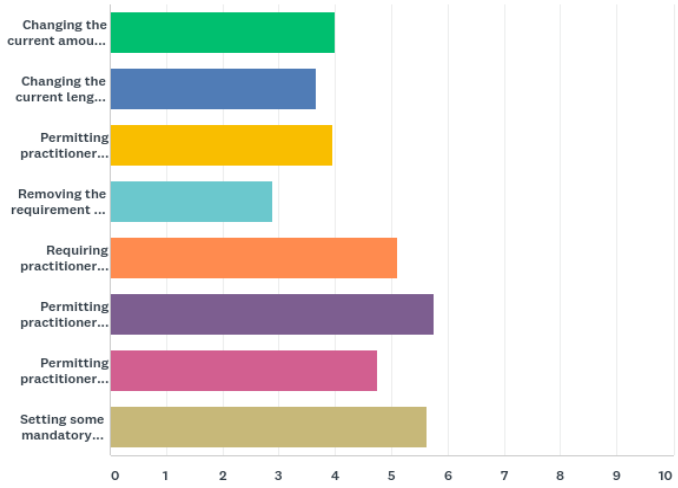


Of the 141 people who answered question 16:

Yes – the cycle length should be increased	9.93% (14)
Yes – the cycle length should be decreased	10.64% (15)
No – the cycle length is about right[21]	79.43% (112)
Skipped the question	105

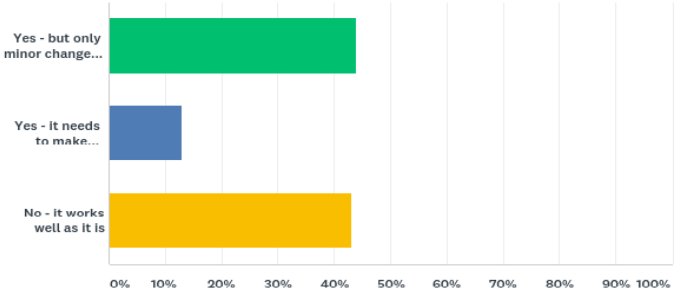
[20] The person who submitted a free-form written submission answered, *"no – the hours are about right"* to question 15.
[21] The person who submitted a free-form written submission answered, *"no – the cycle length is about right"* to question 16.

Question 17: Please rank the following statements (with 1 being most important and 8 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?



135 people answered and 113 people skipped question 17. As with question 5 the SurveyMonkey graph above presents the responses as *weighted average answers*.[22]

Question 18: Do you think the Dental Council needs to make any other changes or improvements to the ongoing education and learning process?



Of the 139 people who answered question 18:

Yes – but only minor changes or improvements	43.88% (61)
Yes – it needs to make substantive changes or improvements[23]	12.95% (18)
No - - it works well as it is	43.17% (60)
Skipped the question	(107)

[22] The person who submitted a free-form written submission ranked their responses to question 17 as follows – *changing the current amount of prescribed hours and peer activities (8); changing the current length of education and learning opportunities (CPD) cycle (7); permitting practitioners to set their own hours of education and learning opportunities (5); removing the requirement to have verifiable education and learning activities (6); requiring practitioners to maintain an accurate record of their education and learning activities (3); permitting practitioners to choose some of their education and learning opportunities from prescribed categories (2); permitting practitioners to choose all of the education and learning opportunities from prescribed categories (4); and setting some mandatory education and learning opportunities based on the Dental Council's Practice Standards (1)*.

[23] The person who submitted a free-form written submission answered, *"yes – it needs to make substantive changes or improvements"* to question 18.