

Recertifying our oral health practitioners: Thinking about our future

Opening address at the Dental Council Symposium to commence a conversation with stakeholders and the sector on the recertification of oral health practitioners in New Zealand.

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Wellington

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Dental Council
Te Kaunihera Tiaki Niho

The regulatory framework

- Dental Council is established under the Health Practitioners Competence Assurance Act 2003 (the “Act”)
- The Act is framework legislation. It requires Council to fill in the gaps
- To protect the health and safety of the public, Council is tasked with ensuring oral health practitioners are competent and fit to practise
- Council does so by “...*providing for mechanisms to ensure that practitioners are competent and fit to practise...*”
- A primary mechanism is **recertification**

Council's developmental journey

- Council has been undertaking the journey mapped out in our strategic plan

- To understand where we are now and how we go forward, we share that journey briefly with you



What makes a
good regulator?

What makes a good regulator

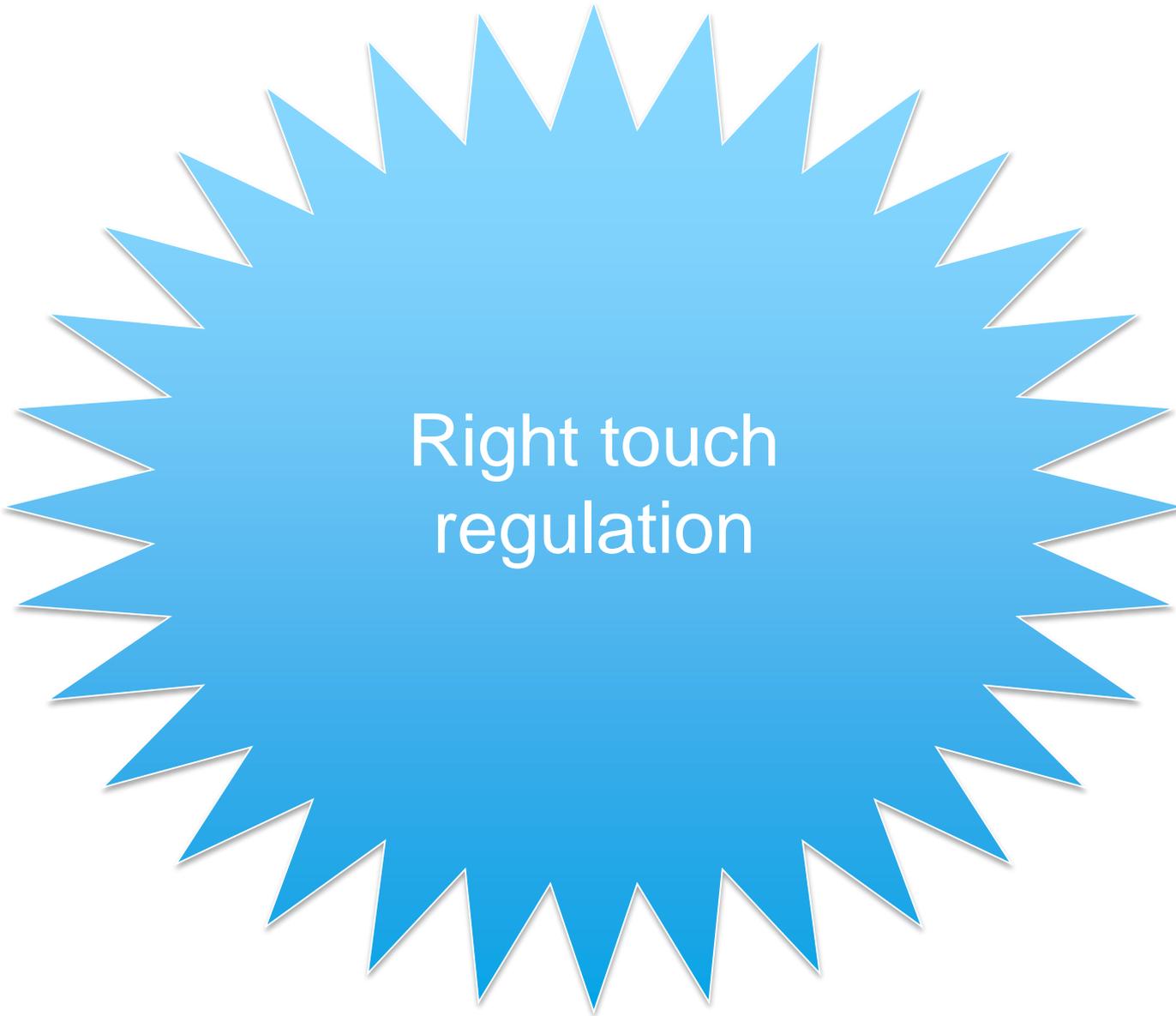
In a nutshell:

The delivery of effective
and cost-efficient
protection for the public.

But how?

By adopting the concept of '*Right Touch Regulation*'; and,

By focusing upon the philosophy of '*Risk Based Regulation*'.



Right touch regulation

Right touch regulation

- The first iteration of “right touch regulation” was developed in the UK in 1997 (*British Regulatory Task Force, 1997*)
- Widely considered to be the gold standard for judging the quality of regulation, both in the UK, and in other countries.
- Originally, five key “principles.”
- Sixth principle has been added recently.

The six principles

- Regulation should be proportionate to the risk posed.
- It must be consistent and implemented fairly.
- It should be targeted on the problem identified.
- It should be transparent, simple and user-friendly.
- Regulators must be accountable and able to justify their decisions.
- Regulation must be agile and able to adapt to change

Right touch regulation

To implement and apply the concept of '*Right Touch Regulation*' required Council to:

- Establish a framework of principles within which regulation is delivered (*e.g. set out in Council's Strategic Plan*)
- The first cornerstone was the establishment of the Standards Framework
- Next will be a Recertification Framework

Targeting – the 3rd principle

“Regulation should be focused on the problem and minimise side-effects.” (BRTF 1997)

- Avoid a scatter-gun approach; focus on those whose activities (or behaviours) give rise to the most serious risk.
- Adopt a clear and unambiguous goals based approach
- Allow those being regulated some flexibility to meet those goals (*minimise “one size fits all” approach to reduce side-effects*)



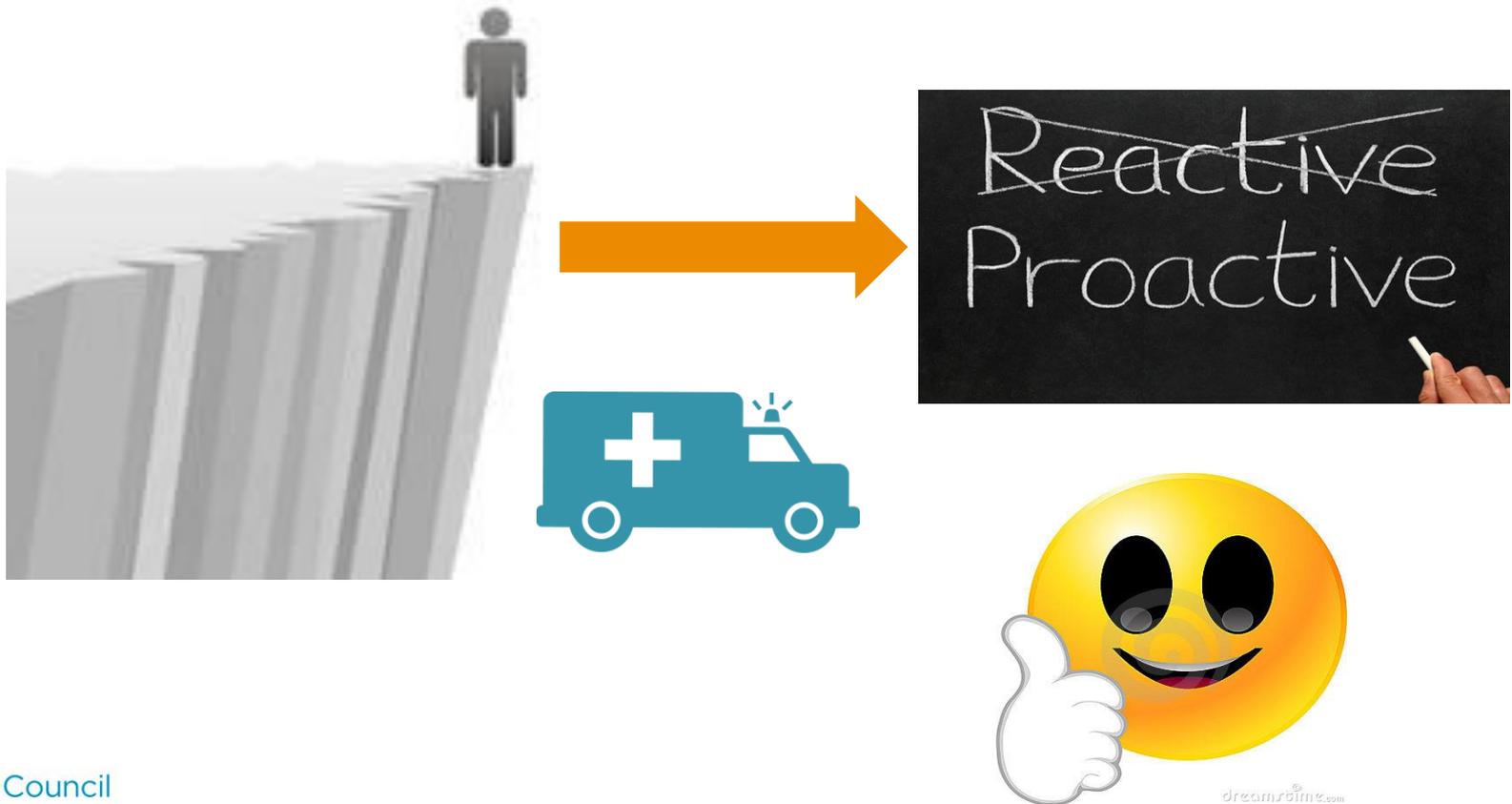
Risk based regulation

Risk based regulation

The philosophy of '*risk based regulation*' relies on Council's ability to identify risk in advance and address it before it becomes a problem – i.e. targeting

The targeted approach

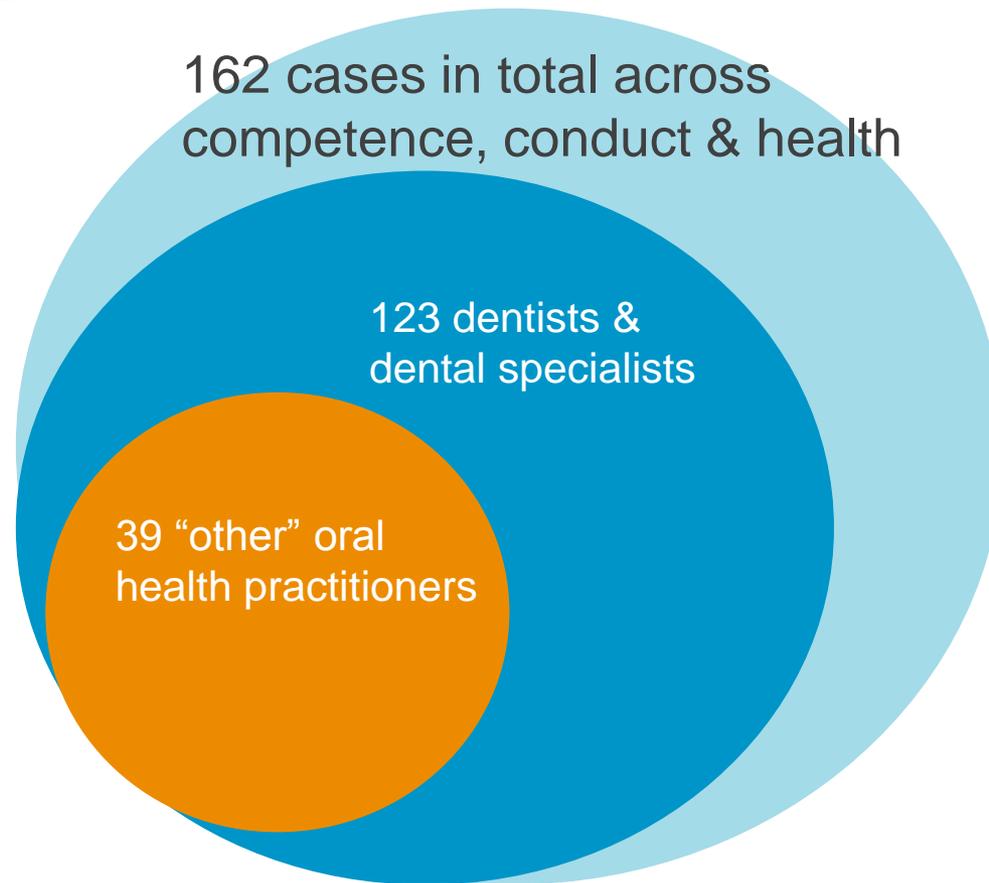
.....entails moving the ambulance from the bottom of the cliff and building a fence at the top of the cliff



Information as a predictor of risk

- Council - database of all competence, conduct and health referrals received since the introduction of the Act in 2004
- Analyse notifications resulting in a decision for Council to intervene
- Correlate those practitioners concerned with other 'events'
- Why?
 - to identify potential risk factors
 - to address issues at the earliest opportunity
 - to inform future policy development.

Analysis – basic demographics



No New Zealand-trained female dentists have been found to have deficiencies in their competence

Key findings

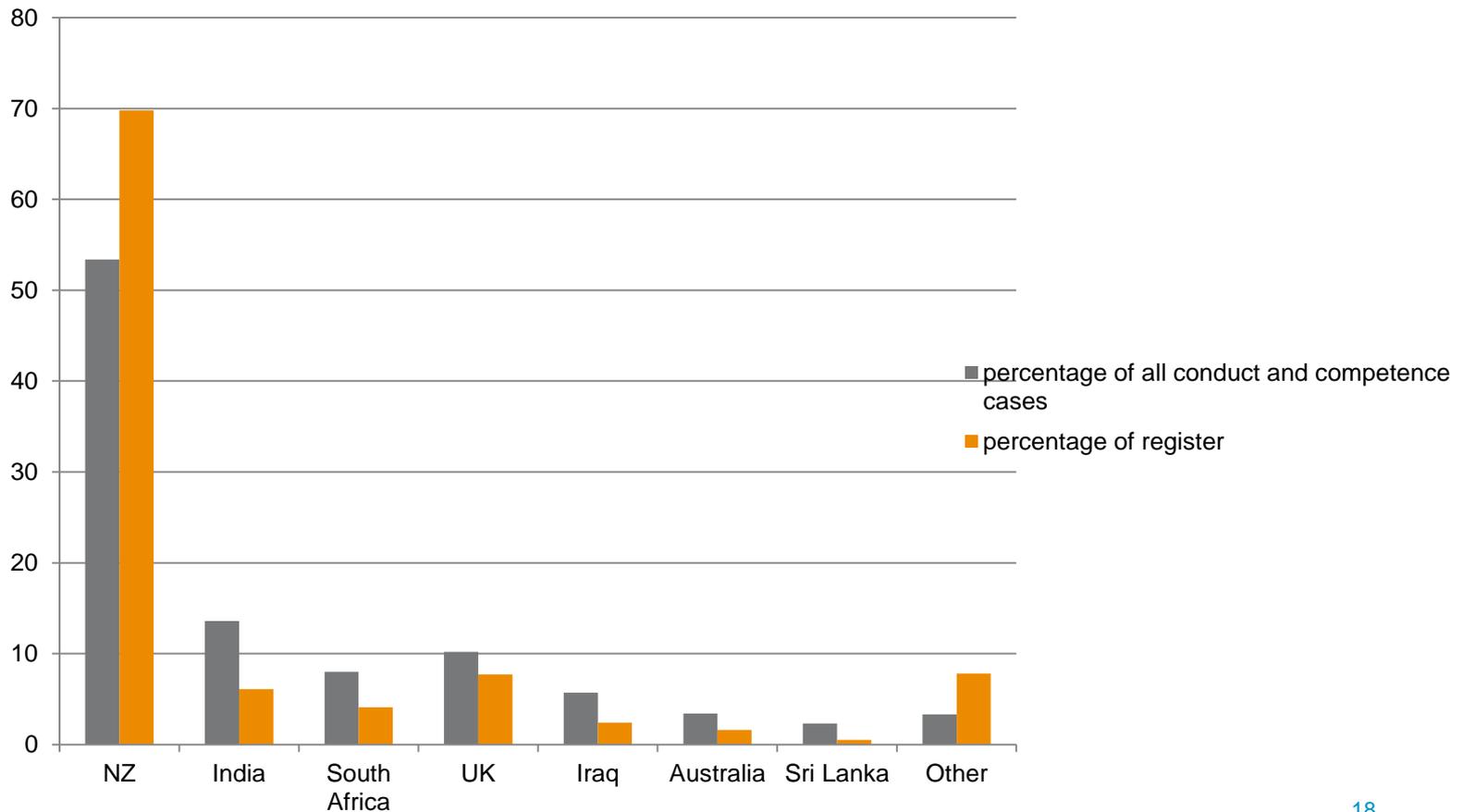
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Newly-registered overseas-trained practitioners, regardless of where they qualified, may need more support and oversight in their first years of practice in New Zealand



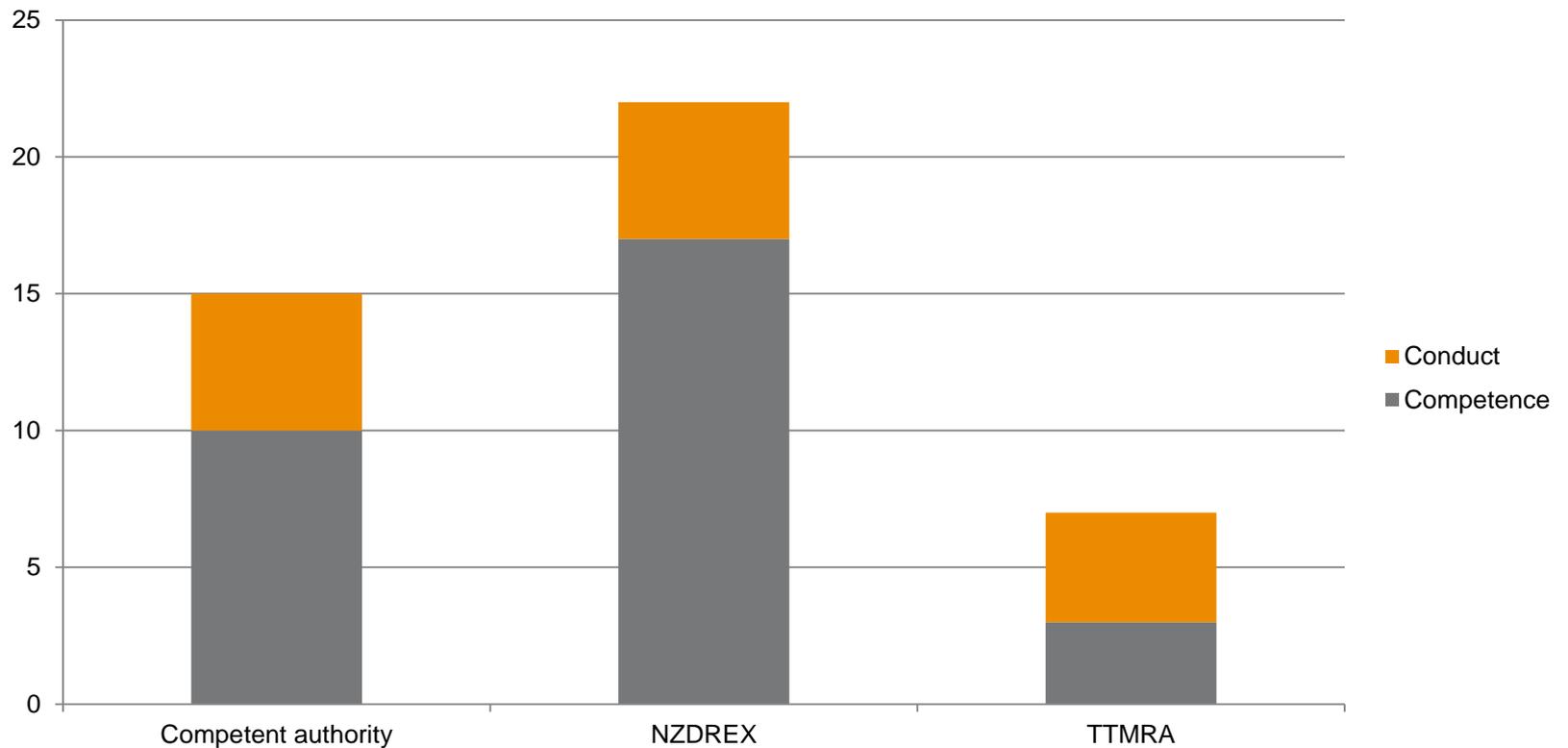
Key finding 1 – supporting data

% of dentists with conduct and competence issues compared with % of total dentists on the register, by country of qualification



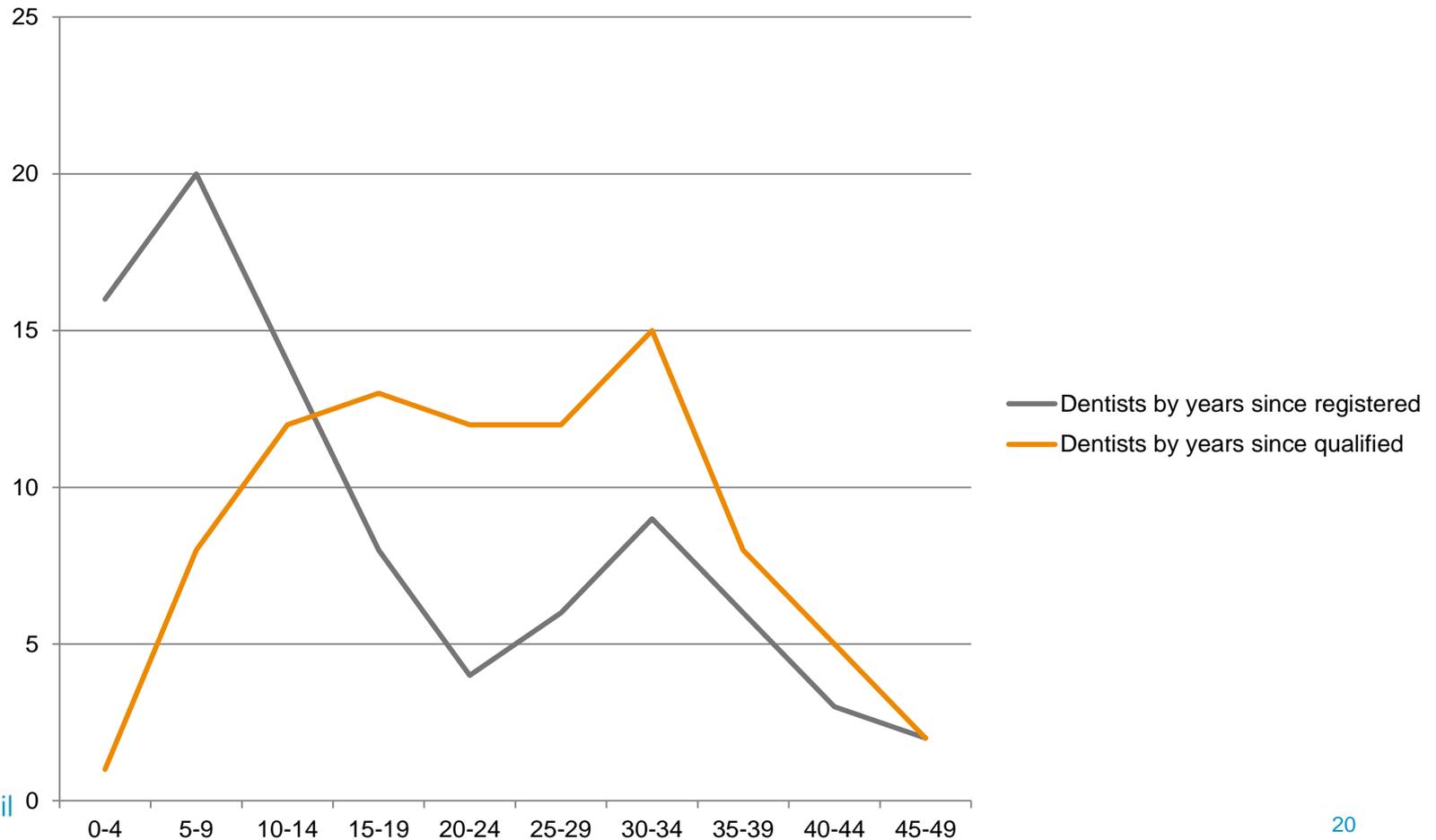
Key finding 1 – supporting data

Overseas trained dentists with conduct and competence issues by registration pathway



Key finding 1 – supporting data

Dentists with conduct and competence issues by range of years since registered in New Zealand and range of years since primary qualification



Key findings

2

Dentists in solo practice are over-represented in competence issues



This is particularly the case where they are professionally isolated

Key findings

3

Failure to renew an APC in a timely manner may indicate a risk of a dentist having competence or other underlying issues



Data supports the position that poor compliance may indicate an increased risk of other issues

Next steps

- More robust data analytics to better identify risk factors to more **proactively prevent risk of harm to patients**
- Opportunities for greater collaboration and sharing of information within the health sector in New Zealand
- Similar opportunities across international dental regulators for comparisons and sharing of lessons learnt...most significantly with Australia
- Working with the Dental Board of Australia to share some of the analysis results gathered this far, across jurisdictions
- Our challenge – small regulator; small practitioner numbers and limited resources.





What is recertification

- Dictionaries define the transitive verb “recertify” as being “*to attest as certain; to confirm.*”
- When we annually recertify a practitioner, it is our confirmation or affirmation to the public that the practitioner is competent to practice.
- It is signified by the issue of an annual practising certificate.
- The Act prohibits us from issuing a practising certificate to a practitioner unless we are satisfied the practitioner meets the required standard of competence.
- The question is, how do determine whether or not a practitioner meets the required standard of competence?

Recertification – our journey

- We commenced work on recertification in late 2014
- We engaged a specialist policy consulting company to facilitate that process
- The consultants worked with both Council and secretariat staff
- The process involved a return to first principles, followed by:
 - Problem definition
 - An examination of the scale and importance of the problem
 - The establishment of policy objectives
 - Design principles and policy options

The current policy design is flawed

We concluded quite quickly that the current intervention logic doesn't stack up.

This appears largely due to a series of flawed (not supported by evidence) assumptions, including:

1. That participation in CPD alone ensures ongoing competence
2. That hours of CPD is a valid proxy for value/outcomes
3. That regulation of CPD is the most effective means of regulatory intervention, for the purpose of protecting patient safety
4. That self-declaration is an appropriate form of assurance across the board, when lack of self-awareness is a risk factor
5. That practitioners (or patients via the HDC) will identify risky practitioners or practitioners will self-identify themselves.

The current policy has become skewed

- An almost singular focus on CPD hours
- “Are you enjoying the conference”
- “It’s OK, but I am really here because I need the hours”
- Dr Ian St George

“Why do so many of us have a sneaking feeling we are barking up the wrong tree with these recertification activities, participating for the sake of appearances rather than really for the sake of self improvement”

The Good Doctor, Paterson R p141

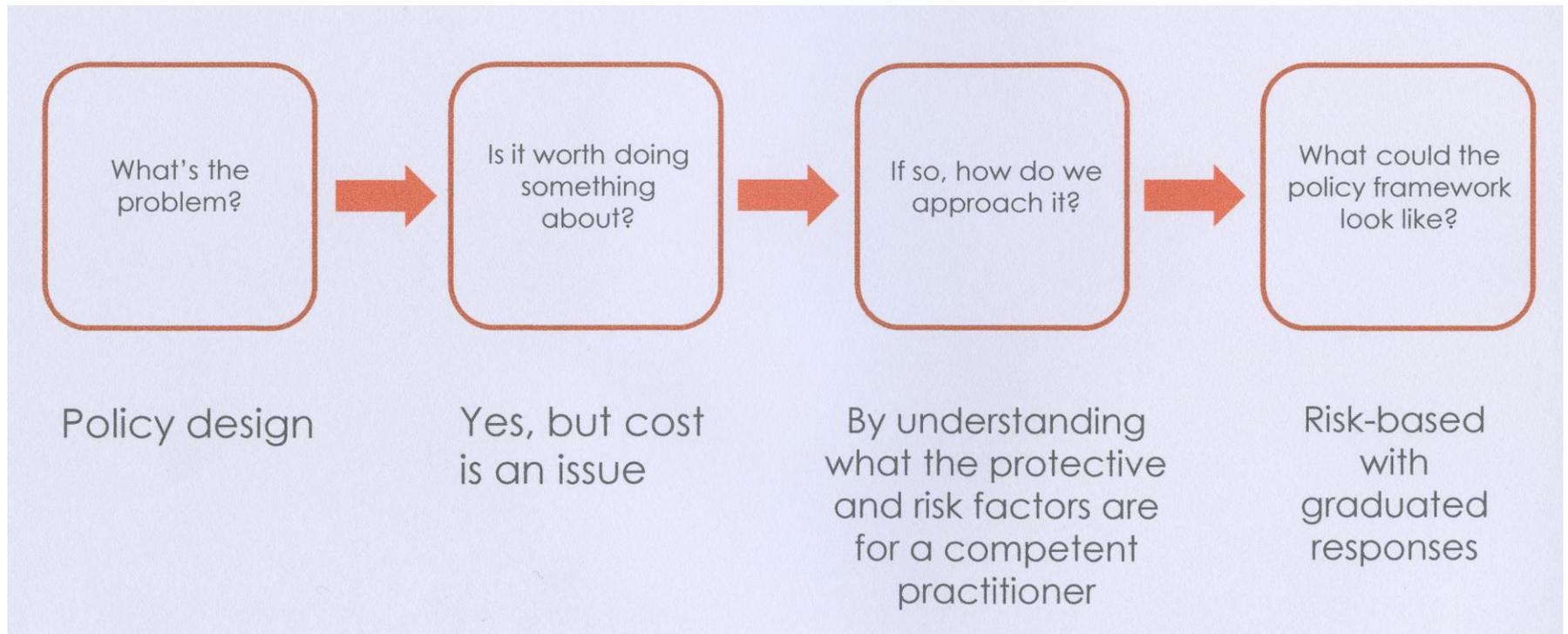
Recertification – first principles

We concluded:

- There is an information asymmetry between practitioners and patients as to the competence (or safety) of a practitioner when being treated.
- Patients are frequently unable to ‘act in their best interest’, and are therefore vulnerable to the risks created by deficiencies in the performance of practitioners (of which competence is a contributing factor).
- At the same time, practitioners are not always in the best position to identify and correct their own issues, or self-limit their own practise. They can unwittingly cause harm to patients.
- The OH professions pose particular issues, since many work alone or in small practices, without the benefit of peer contact or benchmarking.

Recertification – our journey

Our preliminary conclusions were:



Recertification – potential areas for change

The potential areas for change are primarily concerned with how we can assure the public that a practitioner meets the required standard of competence



Recertification – potential areas for change

In addition to what is envisaged by the Act, that is ensuring practitioners meet the required standard of competence, adopting a *right touch, risk based* approach to regulation means finding new or alternative ways to:

- Differentiate between and more fairly treat those practitioners who consistently comply with our recertification requirements
- Support the diverse learning and skill requirements of practitioners
- Emphasis the importance of practitioner engagement in ongoing education and learning opportunities that support and enhance their competence
- Intervene as early as possible for practitioners at risk of non-compliance

Recertification – your challenge

You have received our discussion document. It identifies:

- the critical issues we think are affecting the effectiveness of our recertification framework
- potential changes that may address these issues and deliver more effective and efficient outcomes for the public and practitioners

We want to talk to you about:

- your experiences of recertification
- whether or not you agree with the issues and options we have identified
- whether there are other issues we have not considered
- whether there are better solutions than those we have identified

Recertification – your challenge

Issues

- are the issues and challenges we identified the same ones that you identified?
- do you have different or additional issues and challenges - if so, what are they?

Changes

- are the changes we have identified the same as those you identified?
- do you have different or additional changes that we have not thought of - if so, what are they?

Anything else?

- is there anything else that we have not considered that you think we need to know?
- If so, please share your ideas and information with us.

Thank you