AUSTRALIAN DENTAL COUNCIL

Dental Council
Te Kaunihera Tiaki Niho

Consultation paper - Proposed changes to the ADC/DC(NZ) Accreditation standards for dental practitioner programs

1. Introduction

1.1 The existing *Australian Dental Council (ADC) and Dental Council (New Zealand) (DC(NZ)) Accreditation standards for dental practitioner programs* ('the Standards') became effective from 1 January 2016.[1]

1.2 The Standards are used to evaluate education and training programs which lead to general or specialist registration in Australia or New Zealand, and endorsement of registration in Australia.

1.3 The Standards have been reviewed to ensure that they continue to be aligned with contemporary benchmarks and expectations, are easy-to-use and are appropriately focused on public safety.

1.4 The ADC and DC(NZ) are now consulting with stakeholders on proposed changes to the Standards. This consultation will be open from **18 February** to **20 April 2020**.

About this document

1.5 This document must be read in conjunction with the *Draft ADC/DC(NZ) Accreditation standards for dental practitioner programs – February 2020* (the draft Standards). The draft Standards include a detailed appendix outlining the changes proposed.

1.6 This document includes the following sections:

- Section one introduces the document and includes information about how to respond to the consultation.
- Section two provides information about the Standards.
- Section three explains the review process.
- Section four explains the main changes proposed to the existing Standards and provides brief rationales.

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[1] ADC/DC(NZ) Accreditation standards for dental practitioner programs available at. https://www.adc.org.au/sites/default/files/Media_Libraries/Accreditation/Accreditation%20Standards%20-%20From%201%20January%202016.pdf

1.7 There are two appendices:

- Appendix 1 is the ADC's assessment against the *Council of Australian Governments' (COAGs') Principles for Best Practice Regulation.*
- Appendix 2 sets out the members of the Accreditation Standards Review Working Party (the Working Party).

About the ADC and DC(NZ)

1.8 The ADC is an independent organisation appointed by the Dental Board of Australia (DBA) to conduct assessment and accreditation functions for the dental professions under the National Registration and Accreditation Scheme (NRAS).

1.9 The assessment and accreditation functions performed by the organisation under the Health Practitioner Regulation National Law (the National Law) include:

- developing accreditation standards for approval by the DBA;
- accrediting programs of study which lead to eligibility to apply for registration against those standards;
- assessment of overseas qualified dental practitioners who wish to practise in Australia; and
- providing advice to the DBA on accreditation and assessment matters.

1.10 The ADC is a not-for-profit company limited by guarantee under the Australian Securities and Investments Commission. It holds charity status under the Australian Charities and Not-for-profits Commission and is funded by a grant from the DBA and fee for service activities.[2]

1.11 The DC(NZ) is a regulatory authority established by the *Health Practitioners Competence Assurance Act* 2003. The DC(NZ)'s primary purpose is to protect the health and safety of the public by making sure that oral health practitioners are competent and fit to practise. The oral health practitioners regulated by the DC(NZ) are dentists, dental specialists, dental therapists, dental hygienists, oral health therapists, clinical dental technicians, dental technicians and orthodontic auxiliaries.

1.12 The DC(NZ) is responsible for:

- setting standards for entry to the register;
- registering oral health practitioners;
- setting standards of clinical and cultural competence, and ethical conduct to be met by all oral health practitioners;
- recertifying all practising oral health practitioners each year;
- reviewing and remediating the competence of oral health practitioners; and

[2] For more information about the ADC: www.adc.org.au/

- investigating the conduct or health of oral health practitioners where there are concerns about their performance, and taking appropriate action.[3]

Consultation questions

1.13 Responses to the consultation are welcome from anyone with an interest in the Standards. The below consultation questions are listed to assist stakeholders in responding to this consultation. These questions are not exhaustive and comments on any component of the draft Standards are welcome.

1.14 The consultation questions are as follows. Please provide detail in your responses wherever possible.

Q1. Do you consider that the draft Standards are at the threshold level required for public safety? (Yes, No, Partly, Do not know)

Q2. Do you consider that the draft Standards are applicable across all types of education providers delivering accredited programs? (Yes, No, Partly, Do not know)

Q3. Do you agree with the following specific proposals as incorporated in the draft Standards? (Yes, No, Partly, Do not know)

a. In New Zealand: A dedicated domain in the Standards on cultural competence for Māori and Pacific peoples, and its criteria (Domain **6a** in the draft Standards).

b. In Australia: A dedicated domain in the Standards on cultural safety for Aboriginal and Torres Strait Islander Peoples and its criteria (Domain **6b** in the draft Standards).

c. The introduction of a preamble explaining the purpose of the Standards and how they will be used.

d. An additional criterion requiring programs to ensure students understand the legal, ethical and professional responsibilities of a registered dental practitioner (criterion 1.8 in the draft standards).

e. Amended criteria to require the involvement of dental consumers in accredited program design, management and quality improvement (criterion 2.2 in the draft Standards).

f. For internal, external, professional and academic input into program design and development to be combined into one criterion (criterion 2.2 in the draft Standards).

[3] For more information about the DC(NZ): www.dcnz.org.nz

g. The revision of the criteria in Domain 2 – Academic governance and quality assurance to clarify that the focus of the Standards is at the program level.

h. A revised criterion regarding intra- and inter-professional education, replacing criterion 3.6 in the existing Standards.

i. Amendments to the domain on assessment, including changes to the Standard Statement and to the criteria underneath (Domain 5 in the draft Standards).

Q4. Are there any additional Standards that should be added? (Yes, No, Partly, Do not know)

Q5. Are there any Standards that should be deleted or reworded? (Yes, No, Partly, Do not know)

Q6. Do you have any other comments on the Standards?

How to respond to the consultation

1.15 To respond to the consultation, please use the following link: https://www.surveymonkey.com/r/Standards_review_ADC_DCNZ_2020

1.16 You can also email your response:
- For Australian stakeholders to: accreditation@adc.org.au
- For New Zealand stakeholders to: consultations@dcnz.org.nz

1.17 The deadline for completed responses to the survey is **20 April 2020** at **5pm AEST**.

1.18 Individual survey responses will be published, as will a summary of the responses received. Published submissions will include the names of the respondent and/or organisation making the submission.

1.19 The ADC and DC(NZ) will not place on our websites, or make available to the public, submissions containing offensive or defamatory comments or submissions outside the scope of the subject of this consultation. All personal contact details will be removed from submissions before publication.

2. About the Accreditation Standards

Structure of the current Accreditation Standards

2.1 The Standards, as currently worded, comprise five Domains:

1. Public safety
2. Academic governance and quality assurance
3. Program of study
4. The student experience
5. Assessment.

2.2 These are supported by a Standard Statement that articulates the key purpose of the Domain. Each Standard Statement is supported by multiple criteria.

2.3 The criteria are indicators that set out what is expected of an accredited program in order to meet each Standard Statement.

2.4 The criteria are **not** sub-standards assessed individually. When assessing a program, regard is given as to whether each criterion is addressed, but the ADC and DC(NZ) take an on-balance view of whether the evidence presented demonstrates that a particular Standard is met.

2.5 **The Standards are outcomes focused**. The Standards, deliberately, do not specify a number of clinical or teaching hours, or prescribe an educational approach, or define curricula. It is for the provider to show how the program meets the Standards and prepares dental graduates to practise safely and ethically.

2.6 New programs and established programs are assessed against the same Standards, although the assessment may be varied according to the circumstances of the provider.

Application of the Standards

2.7 The Standards must apply to programs that lead to all divisions of dental practitioner registration (dentist, dental specialist, dental hygienist, dental therapist, dental prosthetist/clinical dental technician, and oral health therapist), as well as programs that lead to endorsement in Australia. The Standards must also apply across all level of programs (e.g. Bachelor level, Master's level, Advanced Diploma and Fellowship), which are offered by a variety of different education provider types, such as universities, TAFEs and specialist colleges.

2.8 Each different type of education provider has different structures, different reporting relationships, and ways to provide students with the clinical experiences necessary to demonstrate they have achieved the professional competencies.

2.9 The focus of accreditation is on how a program can demonstrate it prepares students to be safe and competent practitioners. It is the responsibility of each

education provider to determine and to be able to demonstrate how the program seeking accreditation provides its graduates with the skills required for practice, as outlined in the relevant statement of professional competencies.

2.10 The professional competencies are referenced in the Standards and outline what is expected of a newly qualified practitioner within that division of registration. **The professional competencies are important reference documents used in the accreditation process, but they do not form part of this consultation process**.

3. About the review

3.1 The Standards were last reviewed between 2013 and 2014. The existing Standards represented a significant change. For the first time, a single set of Standards was published, replacing four previous sets of standards. The number of Standards was rationalised, with an outcomes-focused approach adopted.

3.2 Since their publication, the Standards have been well received by stakeholders and have been adopted in full or in part by other accreditation bodies in Australia and New Zealand.

3.3 At the commencement of this review, several 'focus areas' were identified in relation to external influences and/or feedback from stakeholders. Changes are proposed to the Standards in each of these areas. The focus areas were:

- Aboriginal, Torres Strait Islander and Māori Peoples health outcomes;
- consumer involvement;
- inter-professional learning and practice; and
- assessment.[4]

3.4 To inform the focus of the review, a wide range of stakeholders were engaged including education providers, professional associations, students and ADC and DC(NZ) assessors.

3.5 The review included the following steps:

- Benchmarking the existing Standards against other relevant standards nationally and internationally.
- Meeting with stakeholders to seek feedback on the Standards.
- A stakeholder survey to seek feedback on the existing Standards, including how they are working and how they might be improved. This

[4] ADC/DC(NZ) (2019). Review of the ADC/DC(NZ) Accreditation standards – stakeholder feedback survey. https://www.adc.org.au/sites/default/files/Media_Libraries/Accreditation_Standards_Review/Stakeholder_feedback_survey_covering_paper_FINAL.pdf

included feedback on the focus areas outlined above. In total, 89 responses were received.

- The Working Party was convened to provide expert advice about possible changes to the Standards. The results of the benchmarking, stakeholder survey, and stakeholder engagement informed the work plan of the Working Party and the changes proposed to the Standards. A list of the Working Party members is provided in Appendix 2.

3.6 The ADC and DC(NZ) are consulting with a broad range of stakeholder groups on the proposed changes to the Standards. The responses received will help to refine the proposed changes and ensure the Standards remain fit for purpose.

3.7 Following the closure of the consultation period, changes to the Standards will be refined, taking into consideration the responses received. The revised Standards will then be considered by the ADC and DC(NZ). In accordance with the National Law in Australia, once the Standards are endorsed by the ADC, they must then be submitted to the DBA for approval. In New Zealand, the DC(NZ) is responsible for approving the Standards.

3.8 If the DBA and DC(NZ) approve the revised Standards, they will then be published. If approved according to the above timeline, the revised Standards are anticipated for release in mid-2020, coming into force from 1 January 2021. The ADC and the DC(NZ) will keep stakeholders updated of the implementation timelines.

4. Proposed changes to the Standards

4.1 The results of the initial stakeholder survey and early consultation indicate that the Standards are working well and that substantial changes to content or structure are unlikely to be necessary. Many of the changes proposed are minor in nature and aim to ensure clarity and ease of use of the Standards.

4.2 This section provides information about the more significant changes proposed.

Cultural safety and cultural competence

4.3 The existing Standards have a criterion which states:

‘Cultural competence is integrated within the program and clearly articulated as required disciplinary learning outcomes: this includes Aboriginal, Torres Strait Islander and Māori cultures. (3.10)’

4.4 In the stakeholder survey views were sought on the proposal for a dedicated domain on cultural safety / cultural competence. A dedicated domain and associated criteria increases the expectations on education providers to have regard for cultural safety / cultural competence as is it relates to Aboriginal and Torres Strait Islander Peoples in Australia and Māori in New Zealand. The

proposed changes focus ADC and DC(NZ) assessors on ensuring graduates of accredited programs are prepared to help address the disparities in health outcomes as detailed later in this section.

4.5 To recognise the unique connection to place, histories and cultures of Aboriginal and Torres Strait Islander Peoples in Australia and Māori within New Zealand, and the respective legal and regulatory environments of each jurisdiction, specific Standards for Australia and New Zealand are proposed.

4.6 A dedicated domain of the Standards is proposed for programs seeking accreditation in Australia, focused on cultural safety for Aboriginal and Torres Strait Islander Peoples. In New Zealand, a dedicated domain of the Standards focused on cultural competence for Māori and Pacific peoples is proposed.

4.7 The criteria under each domain have been developed to be as consistent with each other as possible, whilst recognising jurisdictional differences relating to context and language.

4.8 The broader context of cultural competence is proposed to be retained in an updated criterion 3.10 (now 3.9 in the draft Standards). The proposed criterion states:

'Cultural competence is articulated clearly, integrated in the program and assessed, to ensure students are equipped to provide care to diverse groups and populations.'

4.9 The 2016 Australian census reported that nearly half (49 per cent) of Australians were born overseas (first generation Australian) or one or both parents were born overseas (second generation Australian)[5]. The 2016 census also reported that 21 per cent of Australians spoke a language other than English at home and that there were over 300 separately identified languages spoken. Given this diversity, it is important that dental practitioners are prepared to communicate effectively within the communities they serve, including those for which English is a second language.

4.10 Based on the 2018 New Zealand census data, around 28 per cent of the population usually resident in New Zealand were born outside of New Zealand.[6] The 2015 DC(NZ) workforce analysis indicated about 23 per cent of the registered oral health practitioners in New Zealand obtained their primary qualification overseas. Thirty per cent of new registrants in New Zealand during the 2018/19 period were qualified overseas. Given the broad diversity within both the New Zealand population and dental team members, cultural competence is becoming increasingly important to ensure effective and culturally safe treatment and practice environments.

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[5] Australian Bureau of Statistics, ' Media Release - Census reveals a fast changing, culturally diverse nation', 27 June 2019, Available at https://www.abs.gov.au/

[6] https://www.stats.govt.nz/assets/Uploads/2018-Census-totals-by-topic/Download-data/2018-census-totals-by-topic-national-highlights.xlsx

4.11 The following provides a brief overview of the context and proposal in each jurisdiction as it relates to cultural safety / cultural competence related to Aboriginal and Torres Strait Islander Peoples in Australian and Māori and Pacific Peoples in New Zealand.

Australia

4.12 The Closing the Gap strategy in Australia was first developed in 2008 and is a Commonwealth Government initiative that aims to close the gap in health and other outcomes between Aboriginal and Torres Strait Islander Peoples and non-Indigenous Australians. Whilst recent reports indicate there has been some progress, most targets remain unachieved. As an example, life expectancy for Aboriginal and Torres Strait Islander Peoples is approximately eight years less than for non-Indigenous Australians. This gap remains larger in remote and very remote areas.[7]

4.13 Several mechanisms have been identified to help address these disparities in health outcomes, which remain a focus of health services and government agencies.

4.14 Australian governments (state, territory and federal) have recently consulted on changes to the National Law through the COAG Health Council. The amendments consulted on include:

- an additional guiding principle of the National Registration and Accreditation Scheme (NRAS) to foster cultural safety of Aboriginal and Torres Strait Islander Peoples; and
- an additional objective to address health disparities between Aboriginal and Torres Strait Islander Peoples and non-Indigenous Australians.

4.15 The rationale for these proposed reforms to the National Law includes:

- addressing the lack of progress in addressing gaps in health disparities,
- improving the under-representation of Aboriginal and Torres Strait Islander Peoples in the health workforce, and
- embedding culturally-safe practices in the health services provided by non-Indigenous health practitioners thereby increasing the likelihood of culturally safe clinical care.[8]

4.16 The consultation document to the National Law changes makes clear that such amendments (accepted in principle by the COAG Health Council at its 31

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[7] Australian Government (2019). Closing the Gap. Report 2019. https://ctgreport.niaa.gov.au/sites/default/files/ctg-report-20193872.pdf?a=1

[8] COAG Health Council (2018). Regulation of Australia's health professions: keeping the National Law up to date and fit for purpose. A consultation paper. http://www.coaghealthcouncil.gov.au/Portals/0/Regulation%20of%20Australias%20health%20professions_Keeping%20the%20National%20Law%20up%20to%20date%20and%20fit%20for%20purpose%20FINAL.pdf

October-1 November 2019 meeting[9]) will ensure that cultural safety is embedded in registration and accreditation standards for each health profession to help address health disparities. The changes to the Standards as proposed are aligned to these objectives.

4.17 There is also an under-representation of students identifying as Aboriginal and Torres Strait Islander in dental practitioner programs as reported in the Health Professions Accreditation Collaborative Forum (HPACF) project - *The role of accreditation in improving Aboriginal and Torres Strait Islander health outcomes project*[10]. Given that one of the ways identified to reduce the disparities in health outcomes is to increase Aboriginal and Torres Strait Islander participation in the health workforce, it is important that the Standards make clear that program providers must offer a culturally safe learning environment for students to improve retention and completion. This will help give effect to the strategy to reduce the gap.

4.18 The terminology adopted in the proposed Standards has been given specific consideration. The terminology as proposed for the assessment of Australian programs is consistent with the Australian Health Practitioner Regulation Agency's (AHPRA's) Aboriginal and Torres Strait Islander Health Strategy Group Statement of Intent and the shared definition of cultural safety.

4.19 As advised in the Aboriginal and Torres Strait Islander Health Strategy Group December 2019 Communique:

'By using terminology that can be applied across the NRAS Scheme, it is envisaged that similar approaches to accreditation standards could be adopted by other accrediting bodies.'[11]

New Zealand

4.20 In New Zealand, poor outcomes for Māori have been a perennial concern for successive governments and for generations of whānau (family), hapū (kinship group) and iwi (extended kinship group) who experience(d) these outcomes. One defining characteristic of New Zealand's history is its continued failure to lift Māori outcomes across a wide range of areas - including health and wellbeing.

4.21 The signing of Te Tiriti o Waitangi – The Treaty of Waitangi in 1840 led to a series of events that fundamentally changed the landscape for Māori. From the nineteenth century onwards, it resulted in Māori having to adapt to a new set of values, beliefs, language and customs.

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[9] COAG Health Council (2019). Communique - 31 October – 1 November 2019. https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique_Final_31%20Oct%201%20Nov%20meeting_Issued%20011119.pdf

[10] HPACF (2019). The role of accreditation in improving Aboriginal and Torres Strait Islander health outcomes. https://www.adc.org.au/Publications-and-forms/Corporate-Publications

[11] AHPRA (2019). A consistent baseline definition of cultural safety for the National Scheme. https://www.ahpra.gov.au/documents/default.aspx?record=WD19%2f29396&dbid=AP&chksum=mzhNlwXd6g%2fBK3rOTWGzTg%3d%3d

4.22 Today, there is a strong interest in New Zealand to successfully embrace biculturalism. At the same time, the country is experiencing increased multicultural diversity that brings new experiences, perspectives, cultural values and expectations. For New Zealand, both are critical for a shared future. Just as critical, both will require a significant increase in social acceptance and tolerance of difference and diversity.

4.23 Although Māori share a common language and customs, Māori people are not a homogenous group. Perspectives, experiences and attitudes vary between individuals, families and their wider communities. The same can be said of Māori views of health and wellbeing, which are informed by life experiences, the impact of disparity and inequitable access to resources and the opportunities that form the foundation of good health and wellbeing. For Māori, one size, one perspective, one approach, one answer, does not fit all.

4.24 Traditional Western models of thinking have not delivered on their promises of wellbeing for Māori. It can even be argued that the failure to improve Māori outcomes is largely due to a persistent failure of successive governments to consider sufficiently issues and the implications of change from a Māori worldview. The challenge for New Zealand is to understand what drives these outcomes, how they contribute (un)consciously to these outcomes and how health and therefore tertiary educational providers and institutions, and other sectors can support Māori to aspire to and realise their own good health and wellbeing.

4.25 In New Zealand, the place of Māori as the Indigenous people is given effect through the Treaty of Waitangi and the resultant special relationship between Māori and the Crown as Treaty partners. Alongside this relationship, is the recognition of the continually growing diversity of peoples and groups within New Zealand society.

4.26 The New Zealand Ministry of Health's Pacific Health Action Plan acknowledges that on a population basis, Pacific communities experience poor health outcomes in New Zealand. Pacific health status remains unequal with non-Pacific across almost all chronic and infectious diseases.[12] The Ministry of Health's 2009 oral health survey reported both Māori and Pacific children and adolescents aged 2–17 years had poorer oral health care access. Additionally, worse oral health outcomes were experienced by Māori and Pacific children and adolescents, and children and adolescents living in areas of higher socioeconomic deprivation.[13]

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[12] https://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018

[13] https://www.health.govt.nz/publication/our-oral-health-key-findings-2009-new-zealand-oral-health-survey

4.27 Including Pacific Peoples into the cultural competence standard for New Zealand dental programs acknowledges oral health practitioners' role to improve oral health outcomes for pacific communities in New Zealand.

4.28 The term 'cultural competence' is used in the *Health Practitioners Competence Assurance Act* 2003, regulating health practitioners in New Zealand. Cultural safety is not specifically defined.[14]

4.29 In the New Zealand context, considerable debate and thinking about cultural responsiveness to Māori health and wellbeing has taken place over an extensive period of time. Both the debate and the testing of different ideas, models and regulatory approaches has led to the development of two broad schools of thought about health and wellbeing through a cultural lens:

- *cultural safety* - usually viewed from the patient, and their family's, perspective. Key questions are asked about whether the patient, and their family's, experience of the treatment received was delivered in a way that acknowledge and encompassed their cultural considerations.
- *cultural competence* - usually viewed from the practitioner's perspective. Key questions are asked about how the practitioner's values, beliefs, attitudes and experiences influence and impact the practitioner's interaction with and treatment of a patient, and their family, with different values, beliefs, attitudes and experiences from their own.

4.30 This means that both models, cultural safety and cultural competence, have relevance and validity in the way that biculturalism and multiculturalism is acknowledged and being addressed in New Zealand.

4.31 For health regulators, it is a question of choosing the focus which best suits each regulator's approach to health and wellbeing outcomes for Māori and other groups and it is conceivable that the right focus could be a new or hybrid approach to cultural safety and cultural competence.

4.32 The DC(NZ) definition of cultural competence specifically recognises cultural diversity and acknowledges that culture includes gender, spiritual beliefs, sexual orientation, lifestyle, beliefs, age, social status and perceived economic worth. [15]

Consumer / patient involvement

4.33 The existing Standards include the following criterion:

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[14] Section 118 of the Act sets out the functions of the regulatory authorities under the Act including i) 'to set standards of…cultural competence (including competencies that will enable effective and respectful interaction with Māori).'

[15] Dental Council (New Zealand) (2008). Cultural competence practice standard. https://www.dcnz.org.nz/assets/Uploads/Practice-standards/Statement-on-cultural-competence.pdf

'There is relevant external input to the design and management of the program, including from representatives of the dental professions. (2.3)'

4.34 The criterion specifically refers to the involvement of the dental professions but does not include the consumer – those that use the services of dental practitioners.

4.35 The final report of the Accreditation Systems Review (ASR)[16] published in 2018 recommends the following:

'Accreditation standards should include a consistent requirement that education providers demonstrate the involvement of consumers in the design of education and training programs, as well as demonstrate that the curricula promote patient-centred health care.'

4.36 Benchmarking of the existing Standards to other national and international comparators highlighted that there is variation in how other accrediting bodies require patients or consumers to be involved in program design and delivery. Overall, where consumers, or equivalent, are mentioned in standards, the requirement is for involvement in quality assurance and/or quality improvement of programs. This includes requirements to gather consumer feedback to monitor, evaluate and improve programs, and consumers providing input into the development and review of curricula.

4.37 Accreditation bodies are increasingly expected to demonstrate how they have engaged with consumers as the end recipients of care provided by registered health professionals. In Australia, the discussion paper of the ASR concluded:

'[Consumers]…as end-users of the system, have a right and responsibility to participate in the development and execution of the accreditation standards and processes to ensure the future health workforce is flexible and responsive in meeting the evolving needs of the community.'[17]

4.38 In Australia and New Zealand, the existing Standards could be argued to be out of step with other accreditation bodies whose standards are more explicit in different ways, about the need to involve consumers, particularly in providing input into the design, management and quality improvement of the program.

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[16]Woods, M. (Date 2017; published 2018). Strengthening Australia's health workforce: strengthening the education foundation. Independent review of accreditation systems within the National Registration and Accreditation Scheme for health professions. https://www.coaghealthcouncil.gov.au/Portals/0/ASReview%20FINAL%20Report.pdf

[17] Woods, M. (2017). Independent review of accreditation systems within the National Registration and Accreditation Scheme for health professions. Discussion paper. https://www.coaghealthcouncil.gov.au/Portals/0/Accreditation%20Systems%20Review/Accreditations%20Review%20Discussion%20Paper%2027%20Feb%202017_1.pdf

4.39 Whilst the ASR in Australia focuses on consumer involvement in the design of programs, there are some examples of standards, particularly internationally, which encourage, or mandate, involvement across the breadth of program design and delivery. For example, the General Dental Council (UK) requires that assessment processes utilise feedback from patients and/or customers as part of how students are evaluated.

4.40 Given the outcomes focus of the Standards, it remains important that innovation and development in dental curricula is supported, without prescription or limitation. The revised Standards aim to foster broad input into dental program design, management and quality improvement, including from patients and dental consumers, as well as from the profession and educational experts.

4.41 The revised criterion 2.2 states:

'Students, patients, dental consumers, internal and external academic, and professional peers contribute to the program's design, management and quality improvement.'

Inter-professional learning and practice

4.42 The existing Standards have a criterion which states:

'Principles of inter-professional learning and practice are embedded in the curriculum. (3.6)'

4.43 The experience of the ADC and DC(NZ) in implementing the Standards has been that there are differences in how providers and assessors interpret the existing criterion. Some accreditation submissions have focused on working with other members of the dental team, while others provide examples of the dental team working with other health practitioners. The ways in which this area is addressed varies from provider to provider, however this remains a focus of accreditation assessments. A primary analysis of accreditation outcomes of site visits undertaken from 2016 to 2019 reveals that the ADC has made14 quality improvement recommendations related to intra and inter professional practice.

4.44 For New Zealand programs, two conditions have been placed on dental specialist programs regarding inter-professional, and one quality improvement recommendation made to an undergraduate program; all during 2018 accreditation reviews.

4.45 Today's dental practitioner works in increasingly complex clinical environments, with care being provided by multiple health practitioners. It is crucial that new graduates are prepared to work within the broader healthcare system to provide the best care possible.

4.46 Inter-professional education, learning and practice was a key theme of the ASR in Australia. The ASR final report made several key points including:

- Drawing on the published evidence and the work of organisations such as the World Health Organisation (WHO) and the Centre for the Advancement of Interprofessional Education (CAIPE), the report notes the contribution of inter-professional practice to positive health outcomes.

- Inter-professional education must be purposeful' and 'extend beyond the classroom where different professions learn common subjects, to pursue opportunities for shared communication, understanding roles and functions of other health professions, and collaborative and innovative team-based practice models with patients at the centre of care.' (pg.84)

4.47 In New Zealand, one of the amendments to the *Health Practitioners Competence Assurance Act* (HPCAA) 2003 that came into effect on 1 April 2019 is the responsibility of health regulatory authorities to:

'promote and facilitate inter-disciplinary collaboration and co-operation in the delivery of health services'[18]

4.48 As a regulator, the DC(NZ) now has a responsibility to fulfil this function through the Standards it sets for entry to the Register and for registered oral health practitioners. One of the cornerstones of facilitating inter-professional care is embedding it into the education and clinical experiences of students.

4.49 In the HPCAA Bill's third reading the Minister of Health, Hon. Dr David Clark, emphasised the importance of interdisciplinary collaboration and cooperation to support the one-team approach of the New Zealand Health Strategy. The one-team approach recognises the:

"…need to reduce the fragmentation of services and care in our health system, and foster greater trust and collaboration. Getting rid of fragmentation will provide us with opportunities to improve the quality of services, improve timeliness of access and reduce duplication of resources."

4.50 Much has been written about this area, including how terms should be defined and the outcomes that can and should be achieved.

4.51 The most commonly quoted definition of inter-professional education is that used by the WHO:

> **Interprofessional education** occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.

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[18] Health Practitioners Competence Assurance Act 2003 section 118(ja). http://legislation.govt.nz/act/public/2019/0011latest/LMS12004.html

Collaborative practice in health-care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings.[19]

4.52 Collaborative practice is the outcome of inter-professional education, with the WHO noting there is 'sufficient evidence to indicate that effective interprofessional education enables effective collaborative practice'. (Pg.7)

4.53 The proposed criterion (3.6) takes the broadly used WHO definition and adapts it for the dental context. The criterion as proposed states:

'Students work with and learn from and about relevant dental and health professions.'

The criterion recognises the outcomes of various reviews and advice from the WHO as to the importance of inter-professional education. The aim is for students to do more than just learn about other dental and health professions, but to work with various health professions to provide collaborative and innovative team-based practice models with patients at the centre of care.

Assessment

4.54 There are currently six criteria included under the Domain 5 - Assessment:

- There is a clear relationship between learning outcomes and assessment strategies. (5.1)
- Scope of assessment covers all learning outcomes relevant to attributes and competencies. (5.2)
- Multiple assessment tools, modes and sampling are used including direct observation in the clinical setting. (5.3)
- Program management and co-ordination, including moderation procedures ensure consistent and appropriate assessment and feedback to students. (5.4)
- Suitably qualified and experienced staff, including external experts for final year, assess students. (5.5)
- All learning outcomes are mapped to the required attributes and competencies, and assessed. (5.6)

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[19] World Health Organization (2010). Framework for action on interprofessional education and collaborative practice. https://www.who.int/hrh/resources/framework_action/en/

4.55 In Australia, the purpose of accreditation within the NRAS is to ensure that those graduating from an accredited program are safe and competent practitioners, ready to enter the workforce.

4.56 In New Zealand, the purpose of the *Health Practitioners Competence Assurance Act* 2003[20] is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.

4.57 The way that an education provider collects evidence to demonstrate that a student has achieved this expected standard is by the assessments used throughout the program. The proposed standard statement has been revised to reflect this expectation.

4.58 To inform the review, the accreditation standards of other accrediting bodies were considered to ensure the Standards remain contemporary. There is variation in how explicit or specific other accreditation bodies' standards are regarding assessment, but there are several common elements that can be identified.

4.59 These common elements include:

- a need for a link between the outcomes expected and the assessments used to evaluate whether the expected outcomes have been achieved;
- a range or variety of assessments are to be used;
- feedback must be provided to enable students to learn and improve;
- those assessing students must be qualified and/or experienced to do so;
- moderation procedures must be in place to ensure consistency of assessment and feedback; and
- students must be advised in advance of the assessment requirements and what is required to progress in the program.

4.60 The revisions to the Standard ensure all of the above elements are evaluated as part of the accreditation process. The revisions take into account the broader purpose of considering assessment as part of the accreditation process.

4.61 In the proposed Standards, we have revised the criteria and reduced the number of statements from six to five. This has been achieved by combining elements of criteria 5.2 and 5.6.

4.62 Based on the experience of the ADC and DC(NZ), when responding to the Standards as currently worded, education providers often combine their responses to some of the criteria. This is most commonly seen between criterion 5.1, 5.2 and 5.6, although this varies between providers.

4.63 Criterion 5.6 requires assessments to be mapped to the required professional attributes and competencies, whereas criterion 5.1 and 5.2 address the scope of

[20] Parliamentary Counsel Office. New Zealand Legislation. *Health Practitioners Competence Assurance Act 2003*. http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html

assessment and how assessments relate to the learning outcomes and professional competencies. The inter-related nature of the criterion is most notably observed in the mapping provided of assessments to the stated learning outcomes, which is used in the self-assessment against all three criteria by providers.

4.64 Criteria 5.3 and 5.4 have also been reworded to enable a broader application.

4.65 The proposed revisions to criterion 5.4 takes into consideration that the majority of other accreditation standards reviewed include moderation, as well as other aspects considered imperative to assessment (e.g. standard setting, examiner training and calibration, assessment development, marking techniques). These mechanisms should be in place to ensure assessments are fair and valid. The broadening of the criteria allows for all of these factors to be considered when assessing a program for accreditation.

Appendix 1: Assessment against COAG principles for Best Practice Regulation

In Australia, accreditation authorities must make an assessment of proposed new or amended standards against the Council of Australian Government's (COAG's) Principles for Best Practice Regulation and make this available during the consultation process. This is outlined below.[21]

COAG principle	Assessment
a. whether the proposal is the best option for achieving the proposal's stated purpose and protection of the public	Based on the evidence gathered through initial consultation with a variety of stakeholders, overall the Standards are working well. The amendments proposed consider the recommendations from wide ranging reviews conducted with board stakeholder input, such as the Woods review[22]. The inclusion of a dedicated domain related to cultural safety aims to ensure the dental workforce is providing culturally safe care for Aboriginal and Torres Strait Islander Peoples. This is consistent with the existing aims and objectives of the National Law, as well as changes consulted on by the COAG Health Council in 2018[23]. Other amendments, such as clarification of the assessment Standard, involvement of dental consumers and requirements regarding

[21] Australian Health Practitioner Regulation Agency (2014). Procedures for the development of accreditation standards. https://www.ahpra.gov.au/Publications/Procedures.aspx

[22]Woods, M. (Date 2017; published 2018). Strengthening Australia's health workforce: strengthening the education foundation. Independent review of accreditation systems within the National Registration and Accreditation Scheme for health professions. https://www.coaghealthcouncil.gov.au/Portals/0/ASReview%20FINAL%20Report.pdf

[23] COAG Health Council (2018). Regulation of Australia's health professions: keeping the National Law up to date and fit for purpose. A consultation paper. http://www.coaghealthcouncil.gov.au/Portals/0/Regulation%20of%20Australias%20health%20professions_Keeping%20the%20National%20Law%20up%20to%20date%20and%20fit%20for%20purpose%20FINAL.pdf

	interprofessional practice have been developed to better prepare graduates for practice.
b. whether the proposal results in an unnecessary restriction of competition among health practitioners	The proposed Standards would not impose any unnecessary restrictions on competition among health practitioners. The Standards require education providers to design programs that produce graduates who are component to practise safely.
c. whether the proposal results in an unnecessary restriction of consumer choice	The proposed Standards would not impact on consumer choice. There are no workforce implications of the proposed changes. The proposed Standards will not impact student intake, increase the time taken to train the health workforce or impose additional barriers to graduates entering the workforce. The focus in the proposed Standards on consumer involvement and cultural safety will be beneficial to consumers by ensuring dental education and training takes into account the views and experiences of consumers and that programs produce practitioners who can work in a culturally safe way with Aboriginal and Torres Strait Islander Peoples.
d. whether the overall costs of the proposal to members of the public and/or registrants and/or governments are reasonable in relation to the benefits achieved	Implementation of the Standards would not result in additional costs to members of the public, dental practitioners or governments. There may be some financial impact on some education providers in order to meet the proposed Standards. This includes, for example, involving dental consumers in programs and an increased focus on cultural safety. However, it is anticipated that over the longer term, a better prepared, culturally safe workforce is expected to improve health outcomes, particularly, for Aboriginal and Torres Strait Islander Peoples, with an overall net benefit to the broader health system.

e. whether the proposal's requirements are easily stated using 'plain language' to reduce uncertainty, enable the public to understand the requirements, and enable understanding and compliance by registrants;	The changes to the Standards have been made using clear, simple language to ensure understanding by stakeholders including education providers, dental practitioners and the public. Consumer groups have been invited to respond as part of the consultations undertaken. Community members have participated as members of the Working Party to assist with ensuring plain language is used and to reduce uncertainty. Each stage of the consultation process has been widely circulated to health service providers, government agencies (state, territory and federal), dental practitioners (through professional associations) and consumer organisations, such as the Health Consumers Forum, have been invited to respond to and inform the consultation process. During the initial consultation phase, two respondents identified as consumer of community representatives.
f. whether the Board has procedures in place to ensure that the proposed standards remain relevant and effective over time.	The Standards are formally reviewed at least once every five years. Continuous review occurs and if necessary, a proposal for early review will be developed for consideration of the Dental Board of Australia.

Appendix 2: Members of the Accreditation Standards Review Working Party

Name	Affiliation or Role
Ms Jan Connolly (Chair)	ADC/DC(NZ) Accreditation Committee
Associate Professor Werner Bischoff	ADC/DC(NZ) Accreditation Committee
Ms Suzanne Bornman	Standards and Accreditation Manager, DC(NZ)
Dr John Bridgman	DC(NZ) Assessor
Professor John Broughton	Associate Dean (Māori), Faculty of Dentistry, University of Otago
Professor Ivan Darby	ADC and DC(NZ) Assessor
Mr Mark Ford (From 21 October 2019)	Director, Accreditation and Quality Assurance, ADC
Mr Michael Guthrie (To 18 October 2019)	Director, Accreditation and Quality Assurance, ADC
Ms Phoebe Haywood	Senior Project Officer, Queensland College of Teachers
Ms Narelle Mills	Chief Executive Officer, ADC
Professor Alison Rich	Acting Dean, Faculty of Dentistry, and Head of Department of Diagnostic and Surgical Sciences, University of Otago
Ms Marie Warner	Chief Executive Officer, DC(NZ)
Professor Roianne West	Director, First Peoples Health Unit, Griffith University

Note: The content of this consultation document is the responsibility of the ADC and the DC(NZ)