AUSTRALIAN DENTAL COUNCIL

Dental Council
Te Kaunihera Tiaki Niho

Report of the consultation on proposed changes to the ADC/DC(NZ) Accreditation standards for dental practitioner programs

May 2020

Document Version Control

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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 review process commenced in 2019 and has resulted in updates to the Standards, which were released for public consultation in February 2020.

1.5 The ADC and DC(NZ) consulted with stakeholders on proposed changes to the Standards between **18 February 2020** and **20 April 2020**. A small number of respondents requested extensions to the submission deadline, including stakeholders in Australia and New Zealand. Late submissions were accepted up until 15 May 2020.

1.6 This document summarises the responses received and outlines changes made to the draft Standards in response to this consultation process.

About this document

1.7 This document summarises the public consultation conducted by the ADC and DC(NZ) between 18 February 2020 and 20 April 2020, including late submissions received up until 15 May 2020. It also outlines the changes made to the draft Standards as a result of feedback received.

1.8 This document builds on the *Draft ADC/DC(NZ) Accreditation standards for dental practitioner programs – February 2020* (the draft Standards) and the associated consultation document released in February 2020. These documents are available from the ADC's website[2].

1.9 The consultation document explains the rationale for the more substantive changes proposed in the draft Standards released for public consultation. This document does not seek to reproduce these rationales, but rather explain the changes made in response to the public consultation process.

1.10 This document includes the following sections:

[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

[2] https://www.adc.org.au/Accreditation-Standards-Review

- Section **one** introduces the document and the role of the ADC and DCNZ.
- Section **two** provides a brief introduction to the current Standards.
- Section **three** explains the consultation process.
- Section **four** summarises the responses received.
- Section **five** explains the changes made following consideration of the consultation responses.

About the ADC and DC(NZ)

1.11 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).

1.12 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.

1.13 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.[3]

1.14 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.

1.15 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

[3] 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.[4]

2. About the current 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 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 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.

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

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 are not part of this consultation process**.

3. About the Standards review process

3.1 The Standards were last reviewed between 2013 and 2014. The current 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 This Standards review process has 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 included feedback on the focus areas outlined below. In total, 89 responses were received. The report detailing the outcomes of this initial stakeholder survey is available **here**.
- A 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 1.
- The updates to the Standards were developed with the working party and public consultation was undertaken between 18 February 2020 and 20 April 2020 on the updated draft Standards.

- The responses received from the consultation process were considered by the ADC/DC(NZ) Accreditation Committee at its meeting on 15 May 2020. Changes were made to the draft Standards based on the feedback provided during the consultation. The changes made based on the feedback provided are detailed in section 5 of this report.

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

3.5 At the commencement of this review, several 'focus areas' were identified in relation to external influences and/or feedback from stakeholders. Changes to the Standards have been made in each of these areas.

3.6 The focus areas identified and highlighted in the initial stakeholder survey were:

- Aboriginal, Torres Strait Islander and Māori Peoples' health outcomes;
- consumer involvement;
- inter-professional learning and practice; and
- assessment.[5]

3.7 The consultation processes specifically for the updated draft Standards are outlined in the next section.

Consultation on the draft Standards

3.8 Responses to the consultation were invited from anyone with an interest in the Standards.

3.9 Questions were included in the consultation document released and a rationale for changes made to the Standards was included. The consultation questions were replicated in an online survey tool (Survey Monkey) to assist stakeholders in formulating their responses.

3.10 The consultation questions were not exhaustive and comments on any component of the draft Standards were welcomed. The consultation questions are shown at Appendix 2.

3.11 Respondents were invited to email their responses to:

- For Australian stakeholders to: accreditation@adc.org.au
- For New Zealand stakeholders to: consultations@dcnz.org.nz

or respond using the online survey tool.

[5] 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

3.12 Respondents were asked to provide detail wherever possible to assist with revisions or amendments to the draft Standards.

3.13 Respondents were advised that the ADC and DC(NZ) would publish individual submissions received and a summary report.

3.14 The consultation period opened on 18 February 2020 and closed on 20 April 2020 at 5pm AEST.

Promotion of the consultation in Australia

3.15 The ADC used multiple channels and means by which to promote the release of the draft Standards for consultation, including:

- A dedicated page on the ADC's website (There were 474 page views between 18 February 2020 and 20 April 2020)
- Direct emails sent to 299 stakeholders inviting responses to the consultation (open rate of 69.9%). Stakeholders included all education providers offering dental practitioner programs, ADC examiners and assessors, state and territory health authorities and dental associations/organisations
- Letters sent directly to Ministers, government health departments, health and education regulators, other accrediting bodies (both nationally and internationally) and consumer health organisations
- Invitations sent to Aboriginal and Torres Strait Islander controlled community organisations and bodies
- Inclusion of the consultation in the Dental Board of Australia February 2020 Communiqué
- Articles in dental trade publications, such as *Australian Dentist* and *Bite Magazine* and dental association publications and newsletters
- LinkedIn posts, including videos explaining the importance of developing a culturally safe dental workforce and the key changes made in the draft Accreditation Standards
- Reminders of the consultation in ADC newsletters sent to stakeholders

Promotion of the consultation in New Zealand

3.16 The DC(NZ) issued the consultation document to all New Zealand registered oral health practitioners via email (4,981) and other key stakeholders (134 emails). These stakeholders included the two New Zealand educational institutions that offer accredited oral health programmes, Minister of Health and Associate Health Ministers, Ministry of Health and the district health boards, Health and Disability Commissioner, Accident Compensation

Corporation, other New Zealand health regulators, other international dental regulators/accreditation bodies with a relationship with DC(NZ)[6] etc.

3.17 For this consultation, other organisations with a potential interest were also targeted. This included the New Zealand Qualification Authority, Ministry of Education, and 14 Māori or Pacific departments or interest/research groups.

3.18 The consultation was available on the Council website for the duration of consultation.

3.19 Reminders to key professional associations, educational institutions and Ministerial agencies were issued.

3.20 New Zealand accreditation assessors were included in the ADC mailing list.

4. Summary of responses

4.1 This section explains more about the responses received to the consultation.

4.2 In total, 79 respondents commenced the consultation survey, with 61 advising they were responding as an individual and 18 responding on behalf of an organisation.

4.3 Of the 79 respondents who commenced the survey, only 40 respondents completed the first consultation question, comprising 29 individuals and 11 respondents representing organisations.

4.4 Another 28 respondents provided comments directly to the ADC or DC(NZ) via email. All 28 respondents who emailed did so on behalf of organisations.

4.5 The analysis included in the following section is based on the 68 respondents (40 responses to the survey with an answer to at least one consultation question and the 28 responses received via email).

4.6 The category of respondent and method of response is summarised in table 1.

Table 1. Category of respondent by response method

Category of respondent	Response by online survey	Response by email	Total
Individual	29	0	**29**
Organisation	11	28	**39**
Total	**40**	**28**	**68**

4.7 Feedback emailed directly to the ADC and DC(NZ) varied in its format. Some responses provided only direct feedback related to specific questions or areas of the draft Standards (eleven respondents, 16% of all respondents). Others answered all consultation questions (eight respondents, 11% of all

[6] Commission on Dental Accreditation of Canada, General Dental Council, Ireland Dental Council, Commission on Dental Accreditation

respondents) and some respondents made general statements regarding the draft Standards, either of overall support for the draft Standards (six respondents, 9% of all respondents), or advising that they had no comment or comments related to the Standards review process (three respondents, 4% of all respondents).

4.8 Where possible, the summarised data in the following section combines the responses received.

Interaction with the ADC and/or DC(NZ)

4.9 Respondents who indicated they were responding on behalf of themselves using the online survey tool were asked *'What is your interaction with the ADC and/or DC(NZ)? Check all that apply.'*

4.10 In total, 29 respondents answered this question. Respondents could tick multiple options from the list as shown in table 2.

Table 2. Individuals by respondent groups

Respondent group	Number	Per cent
Assessor of education programs	9	31%
Committee/Board member	5	17%
Community/Consumer representative	3	10%
Dental student	6	21%
Education provider	8	28%
Employer of dental graduates	3	10%
Examiner of overseas trained dental practitioners	7	24%
Member of a professional association/academy/society	11	38%
Representative of state/territory/DHB based or other health provider	0	0%
Other (please specify)	2	7%

Overall comments

4.11 Overall, there is broad support for the changes proposed to the Standards, as indicated in the responses summarised in Table 3.

4.12 Of the six respondents (9%) that provided overall comments of support for the changes, comments included statements such as:

> *'the final document will be of great value to dental practitioners in dental schools, dental and oral health students, employers, and the public regarding expectations of new oral health and dental graduates.'*
>
> *'I note the purpose of the feedback is to help ensure the Standards remain contemporary and fit for purpose. The proposed changes to the*

accreditation standards are logically explained and appear to be an iterative set of changes from the existing standards. They are appropriate and can be supported.'

4.13 One respondent recommended that consideration be given to reference within the Standards to the Vocational Education and Training (VET) Quality Framework. The *ADC/DC(NZ) guidelines for accreditation of education and training programs for dental practitioners* (the Accreditation Guidelines) reference the role of other regulators within the higher education and VET sectors in Australia and New Zealand. This suggestion will be considered in the next review of the Accreditation Guidelines released to support the implementation of the revised Standards.

4.14 Comments made within the survey were not limited to the review of the Standards, but also related to the process of implementation of revised Standards (if approved), ongoing monitoring to ensure programs continue to meet the accreditation standards between site visits, and elements best captured in the Professional Competencies for newly qualified practitioners or how the ADC and DC(NZ) monitor programs.

4.15 These responses have been noted and will be considered as part of the implementation process, including in revisions to the Accreditation Guidelines. Section 5 of the report outlines how these comments will be considered and, where appropriate, acted upon by the ADC and DC(NZ).

4.16 A further detailed analysis of responses is arranged by consultation question in the following sections.

Responses to consultation questions

4.17 Table 3 provides a summary of the responses received to the consultation questions.

Table 3. Responses to the survey questions

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q1. Do you consider that the draft Standards are at the threshold level required for public safety?	40 (81%)	1 (2%)	5 (10%)	3 (6%)
Q2. Do you consider that the draft Standards are applicable across all types of education providers delivering accredited programs?	42 (87%)	2 (4%)	3 (6%)	1 (2%)

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated in the draft Standards?				
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).	30 (73%)	3 (7%)	3 (7%)	5 (12%)
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).	38 (86%)	3 (7%)	2 (5%)	1 (2%)
c. The introduction of a preamble explaining the purpose of the Standards and how they will be used.	39 (89%)	1 (2%)	4 (9%)	0 (0%)
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).	41 (91%)	2 (5%)	1 (2%)	1 (2%)
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).	30 (70%)	3 (7%)	10 (23%)	0 (0%)
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).	36 (82%)	5 (11%)	2 (5%)	1 (2%)
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.	39 (89%)	2 (5%)	2 (5%)	1 (2%)
h. A revised criterion regarding intra- and inter-professional education, replacing criterion 3.6 in the existing Standards.	35 (80%)	3 (7%)	4 (9%)	2 (5%)
i. Amendments to the domain on assessment, including changes to the Standard Statement and to the criteria underneath (Domain 5 in the draft Standards).	35 (80%)	3 (7%)	5 (11%)	1 (2%)
Q4. Are there any additional Standards that should be added?	8 (19%)	27 (64%)	2 (5%)	5 (12%)

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q5. Are there any Standards that should be deleted or reworded?	7 (17%)	23 (56%)	6 (15%)	5 (12%)

Note to table

- Percentages have been calculated based on actual responses to a question; data related to respondents who did not answer a specific question are not included.
- Responses that indicated overall support but did not answer the specific consultation questions are not included in the table.
- Percentages have been rounded.

4.18 The data included in Table 3 is replicated under each specific consultation question for ease of reference.

Q1: Do you consider that the draft Standards are at the threshold level required for public safety?

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q1. Do you consider that the draft Standards are at the threshold level required for public safety?	40 (81%)	1 (2%)	5 (10%)	3 (6%)

4.19 There is broad support that the draft Standards are overall at the level required for public safety. 81 per cent of respondents agreed with this statement. The one respondent that answered 'No' did not provide comment.

4.20 Examples of comments by those answering 'Yes' in response to this question included statements such as:

> *"Draft Standards meet requirements of public safety"*
>
> *"Building on an established and well supported Standards."*

4.21 Of those that responded 'Partly' one respondent indicated that the Standards should also focus on culturally and linguistically diverse groups, including migrants, while another indicated it was not the draft Standards, rather how they are implemented that is of concern.

4.22 One respondent indicated concern that there was insufficient detail in the Standards for providers or dental practitioners to understand how programs will be assessed against the criteria. This response is highlighted in the following quote:

> *'…although the Standards adequately outline the criteria against which the statements for each domain are assessed, they do not specify how dental practitioner programs will be assessed against these each of these criteria, nor the methods by which student professional competencies should be assessed.'*

4.23 This respondent also raised concerns over criterion 3.7 and 5.5 and what could be considered as "suitably qualified and experienced staff". These points will be addressed in later sections of this report as they relate to specific criteria.

4.24 A further respondent raised concerns that public harm may also occur due to environmental impacts arising from clinical operations and models of care. The respondent suggests that a criterion based on the Australian Healthcare and Hospitals Association's *Position statement - Climate Change and Health*[7] could be used to inform the inclusion of this criterion.

4.25 This area has not been raised previously as part of the ADC and DC(NZ) consultation processes. Healthcare service delivery's impact on climate change could be considered as part of the review of the Professional competencies for the newly qualified dental practitioners. This review is scheduled to commence later in 2020.

4.26 Comments were also provided relating to inter-professional practice as they relate to rural and remote health workforce and cultural safety. These comments are included under related questions.

Q2: Do you consider that the draft Standards are applicable across all types of education providers delivering accredited programs?

Consultation question	Number of responses			
	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?	42 (87%)	2 (4%)	3 (6%)	1 (2%)

4.27 Of the respondents, that directly answered this question, 87 per cent, agreed.

4.28 The two respondents answering 'No' did not provide any comment or explanation as to why they disagreed with this question.

4.29 Only one respondent that answered 'Partly' provided comment. The comment related to the process of maintaining accreditation throughout a period of accreditation and therefore did not relate to whether or not the

[7] https://ahha.asn.au/sites/default/files/docs/policy-issue/ahha_position_statement_-_climate_change_and_health_6.pdf

Standards could apply across all provider types. Ongoing monitoring of programs is already addressed in the Accreditation Guidelines and monitoring framework and is not directly related to the current consultation.

4.30 In response to this question, it was also suggested that an evidence guide aligned to education provider type may be of benefit to providers. The experience of the ADC and DC(NZ) have been mixed when providing examples of evidence to be submitted as part of the accreditation process. In some instances, providers have used the core evidence requirements included in the Accreditation Guidelines (refer page 27) as a checklist, with only this information provided as part of the self-assessment or accreditation submission. This lessens the benefit of the accreditation process to providers in self-assessing their ability to meet the Accreditation Standards and acting when issues are identified.

4.31 The result is requests for additional information or clarification from providers to gain a comprehensive understanding of the various aspects of program delivery. The different terminologies and ways of delivering accredited programs make such guides complicated and potentially confusing.

4.32 In response to this concern, the following is proposed. To support assessors in evaluating programs, *Prompts for assessors* have been developed. These prompts or guides are not exhaustive but could be made available publicly. The aim is to increase transparency and understanding of how a program's ability to meet the Standards is evaluated. This is aligned with the outcomes focused approach used by the ADC and DC(NZ). This may also assist in addressing comments mentioned in response to consultation question 1.

Q3a: 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).

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated in the draft Standards?				
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).	30 (73%)	3 (7%)	3 (7%)	5 (12%)

4.33 The majority of respondents (73%) support the inclusion of a dedicated domain regarding cultural competence for Māori and Pacific peoples.

4.34 The three respondents answering 'No' did not provide any comment or rationale for the answers provided.

4.35 Three comments were made relating to whether this domain should be expanded to include cultural competence and cultural safety for all groups

and recommending a more generalised statement. This was contrasted against responses such as:

> *"I agree that in New Zealand a dedicated standard on cultural competence for Māori and Pacific peoples is required."*
>
> *"This is a much needed addition to the Standards"*

4.36 Three respondents also proposed changes to the criteria within the domain.

4.37 One respondent recommended the inclusion of cultural safety within this domain and another recommended an additional criterion to be added.

4.38 Two Māori representative bodies considered that the standard and criteria needed to be reworked in partnership with Māori before they are finalised.

4.39 Consideration of these comments are reflected in Section 5 of this report.

Q3b: 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).

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated 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).	38 (86%)	3 (7%)	2 (5%)	1 (2%)

4.40 The response and comments provided indicate strong support for the inclusion of a dedicated domain related to cultural safety. A sample of comments received included:

> *"I am particularly pleased with the inclusion of the new Standard 6, acknowledging the responsibility of health professionals to have the knowledge and skills to deliver culturally safe health care and recognising the value Aboriginal and Torres Strait Islander health workers bring to the health system."*
>
> *"I agree that in Australia a dedicated standard on cultural competence for Aboriginal and Torres Strait Islander peoples is required. This is particularly important given the health inequity experienced by Aboriginal and Torres Strait Islander peoples. Cultural competence for other people and cultural groups is adequately addressed in Section 3. Program of study 3.9 Cultural competence is articulated clearly, integrated in the program and assessed,*

to ensure students are equipped to provide care to diverse groups and populations."

"This is a much needed addition to the standards"

"Important to have this incorporated as part of student education."

"This is very important that it's explicitly mentioned as often education institutes reduce/cut funding or teaching at expense of this fundamental component of curricula"

4.41 Of the two respondents who did not support a dedicated domain, no rationale or comments were provided.

4.42 Of the respondents who answered 'Partly' to this question, only one respondent provided clarification indicating that the domain should apply more broadly to reflect the need to be culturally safe to all cultural identities.

4.43 Multiple respondents proposed amendments to the criteria, each with a different approach or intent, but all supportive of the inclusion of the domain. One respondent indicated wording should be amended to reflect similar principles in Australia and New Zealand, where culturally appropriate. Only one respondent expressed this opinion, with the comments above indicating that, on balance, there is broad acceptance for the domain as worded.

4.44 Two respondents queried whether all criteria were achievable by all providers. Two respondents questioned the ability for all students to have the opportunity to provide clinical care for Aboriginal and Torres Strait Islander Peoples (criterion 6.4).

4.45 Another query was whether a shortage of academics and educators of Aboriginal and Torres Strait Islander background would impact on programs and their ability to address criterion 6.5.

4.46 It was suggested that further clarification is required about what "*Staff with specialist knowledge, expertise and cultural capabilities*" means". This can be addressed in the guidance provided with the implementation of the revised Standards, including *Prompts for assessors*.

4.47 Opportunities to strengthen the implementation of the domain have been provided by some respondents, including that the principle that '*the presence, or absence, of cultural safety must be defined by the Aboriginal and Torres Strait Islander peoples receiving the care'*. This aspect could form part of patient feedback.

4.48 Two respondents have proposed additional or amendments to criteria. These responses are considered in Section 5 of this report.

Q3c: The introduction of a preamble explaining the purpose of the Standards and how they will be used.

Consultation question		Number of responses			
		Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated in the draft Standards?					
c.	The introduction of a preamble explaining the purpose of the Standards and how they will be used.	39 (89%)	1 (2%)	4 (9%)	0 (0%)

4.49 There was strong support for the inclusion of the preamble, with 89% of respondents agreeing to the introduction of the preamble.

4.50 Comments were largely positive in relation to the introduction of the preamble. Comments received included:

> *"Introduction explaining the purpose of the Standards and how it is used, relevant and confirming task to be undertaken."*
>
> *"This background information is useful to put the Standards in context."*

4.51 Five respondents answered either 'No' or 'Partly', with only one response providing comment on the preamble as worded. The comment indicated that there should be an explicit statement referring to the recent policy direction given by health ministers to the Australian Health Practitioner Regulation Agency (AHPRA) and National Boards, that public protection is paramount in the administration of the National Registration and Accreditation Scheme[8], as it relates to Australia.

Q3d: 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).

Consultation question		Number of responses			
		Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated in the draft Standards?					
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).	41 (91%)	2 (5%)	1 (2%)	1 (2%)

[8] COAG Health Council, Communique 11 September 2018, *Purpose of the National Registration and Accreditation Scheme*. https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20110918_1.pdf

4.52 Overall, 91% of respondents supported inclusion of this criterion. Several supportive comments include:

> *"I think this is a very important inclusion."*
>
> *"It is critical to ensure public safety that dental graduates are able to understand the legal, ethical and professional responsibilities of a registered dental practitioner and to practise in accordance with these responsibilities."*
>
> *"Yes agree, and important for public safety."*

4.53 No comments or rationale was provided from those who disagreed with the inclusion of the criterion within the Standards.

4.54 The one respondent identified as 'Partly' supporting the criterion agreed with the criterion's intent but suggested that the wording "ensures" be changed.

4.55 Several amendments are proposed to the criterion as worded and are addressed in Section 5 of this report. The comments are aimed at either strengthening the requirement or clarifying how the Standard is evaluated.

Q3e: Amended criteria to require the involvement of dental consumers in accredited program design, management and quality improvement (criterion 2.2 in the draft Standards).

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated 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).	30 (70%)	3 (7%)	10 (23%)	0 (0%)

4.56 Although supported by the majority of respondents (70%), there is a significant minority of respondents who 'Partly' support the criterion as worded (23%) and three respondents not supporting the statement.

4.57 Those that responded 'No', indicated concern as to whether dental consumers or patients were suitably skilled to assist in program design and development. Comments included:

> *"…I don't believe that consumers have an adequate understanding of patient safety and how this needs to be reflected in training of health professionals"*

"Not sure that dental consumers appreciate the intricacies of dental treatment"

4.58 Those supporting the change provided rationales for the inclusion of consumer input, including:

"Dental consumers are in a unique position to provide feedback on the quality and appropriateness of the dental services they receive. In better understanding the wants, needs and experiences of this important stakeholder group, dental programs will be able to design, deliver and quality assure curricula that will meet current societal expectations and demands. Inclusion of consumer feedback is also consistent with expectations of other accreditation bodies and contemporary moves by universities to co-create programs and program curricula more generally."

"I think it is essential to involve consumers in the education of health professionals, and in the provision of healthcare services. The providers may require some guidance to help them meet this standard when it is first introduced; this could be included in the guidelines accompanying the standard."

"While this might be challenging for dental schools to manage in practical terms the intention is sound and supported by ADOHTA. It is important that practitioners and curricula preparing them for practice reflect, understand and incorporate the needs of consumers of dental services and respect their expertise in their own health. The new wording offers flexibility in the application of the principles which is important to school's ability to address the intention and meet the standard."

4.59 Of those who supported the inclusion of dental consumers, several strongly supported the inclusion. Comments included that the revised criterion addresses the recommendations of the Accreditation Systems Review as endorsed by Australian Health Ministers.

4.60 Several respondents queried the difference between dental patients and dental consumers, questioning the need for both to be included within the criterion, or requested further clarification on the difference.

4.61 Another theme identified by a small number of respondents included introducing a requirement for patients to be involved in student assessment, as well as for guidance to providers as to how they may provide evidence of addressing this criterion.

4.62 Respondents highlighted that not all dental specialties require direct patient contact, which may create challenges to incorporating patient feedback. The outcomes focused nature of the Standards allow flexibility in how the Standards are implemented relevant to the outcomes expected.

Q3f: 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).

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated 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).	36 (82%)	5 (11%)	2 (5%)	1 (2%)

4.63 The majority of respondents supported the criterion (82%). Two respondents partly supported the amendment, but no comments or rationale were provided.

4.64 Five respondents (11%) opposed the change, with three making comment including:

> *"I think that having separate standards is clearer despite the overlap. I fear that combining the standards is likely to result in reduced input from external parties"*
>
> *"This has now become removed from "Academic governance" as governance is now shared among all."*

4.65 The other respondent questioned the ability of education providers to bring together feedback with very different processes and disparate groups.

4.66 Those supporting the revised criterion identified the benefits to providers, including reduction of duplication in the accreditation process.

4.67 One respondent advised that by combining the criterion, it implies equal weighting to each stakeholder group, acknowledging the importance of each group.

4.68 One respondent identified that there is opportunity to also require inter-professional input into program design and delivery. This has been considered and is addressed in Section 5 of this report.

Q3g: 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.

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated in the draft Standards?				
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.	39 (89%)	2 (5%)	2 (5%)	1 (2%)

4.69 There was strong support for the revision of the criteria within domain 2, with 89% of respondents indicating they support the amendments.

4.70 Of the four respondents who indicated they did not support, or partly supported the revisions, only one provided any comment or justification.

4.71 This respondent opined that there is need for oversight or accreditation from statutory authorities to ensure public and patient safety. There was no further rationale or information supporting this assertion.

4.72 A similar theme was identified in comments from those supporting the amendments, indicating the need to consider the relevance of the broader academic governance arrangements for the education provider and how these impact at the program level. These issues can be addressed during implementation, with the revisions made to the criterion enabling these factors to be considered, but ensuring they are not the focus of the accreditation assessment.

4.73 Comments made in support of the changes, identified overlap in the criteria as previously worded noting that the revised wording provides clarity of intent.

4.74 One respondent recommended a revision of the Domain, to ensure a focus at the program level as well as proposed amendments focused on criterion 2.1. Each of these are addressed in Section 5 of this report.

Q3h: A revised criterion regarding intra- and inter-professional education, replacing criterion 3.6 in the existing Standards.

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated in the draft Standards?				
h. A revised criterion regarding intra- and inter-professional education, replacing criterion 3.6 in the existing Standards.	35 (80%)	3 (7%)	4 (9%)	2 (5%)

4.75 This area of the consultation generated several detailed responses, with varied views regarding the wording of the criterion. Overall, 80% of

respondents were supportive of the criterion, but several amendments were proposed to the wording.

4.76 Those that supported the proposed wording included statements such as:

> *"Very important for the dental team approach to dentistry."*
>
> *"Given the criticality of interprofessional practice in contemporary health delivery an increased focus on interprofessional education is appropriate."*
>
> *"A multi-discipline approach will hopefully re-connect the mouth to the rest of the body"*

4.77 The one respondent that did not support the revision identified that the revised wording did not place the emphasis on communication needed to avoid oral health "being a silo".

4.78 Of the four respondents who partly supported the revised wording, two proposed that the wording be revised. One suggested a focus on patient outcomes and the other recommended revision to more closely reflect the definition of interprofessional education created by the World Health Organisation (WHO) and incorporating collaborative practice.

4.79 Respondents who supported the revised criterion, also proposed amendments to the wording, highlighting the need to ensure that both inter- and intra- professional collaboration is addressed.

4.80 These various comments and amendments are detailed in Section 5 of the report, along with the action taken to address the feedback received.

4.81 One respondent highlighted the importance of inter-professional practise within rural and remote practice. Although supportive of the criterion, the context in which many rural and remote health workers operate was highlighted as an essential element of preparing a health workforce ready to meet the challenges of delivering care in a variety of settings.

4.82 The need to prepare a dental workforce ready to provide care in a rural and remote context may be better addressed in the professional competencies, rather than within the Standards. The professional competencies aim to articulate what is required of a newly qualified dental practitioner, which includes the ability to work across settings, including those in rural and remote locations where referral opportunities may be severely limited.

Q3i: Amendments to the domain on assessment, including changes to the Standard Statement and to the criteria underneath (Domain 5 in the draft Standards).

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q3. Do you agree with the following specific proposals as incorporated in the draft 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).	35 (80%)	3 (7%)	5 (11%)	1 (2%)

4.83 There was broad agreement to the revisions, with few comments included regarding the proposed revised domain.

4.84 Three respondents answered 'No' to this question, but only one made comments, indicating that the revised Standard Statement was not beneficial. This respondent also suggested revisions to criterion 5.4, which are addressed in Section 5 of this report.

4.85 Five respondents partly supported the amendments, but only two provided their rationale. One indicated that one criterion should be amended. This is addressed in Section 5 of this report. The other proposed that programs accredited as Nationally Recognised programs by the Australian Skills Quality Authority should be exempt from the requirement to map learning outcomes to the professional competencies. The learning outcomes are designated by the training package and providers are not able to add additional learning outcomes under the VET Framework in Australia.

4.86 It is the experience of the ADC that programs delivered under the same training package by different providers, vary in how they map the delivered units of competency to the professional competencies. The mapping provides accreditation assessors with the information needed to determine whether assessment practices demonstrate competence expected of a safe beginner practitioner.

4.87 Other comments received during consultation were largely supportive of the amendments, highlighting the reduction in duplication and improved clarity of the criteria.

Q4: Are there any additional Standards that should be added?

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q4. Are there any additional Standards that should be added?	8 (19%)	27 (64%)	2 (5%)	5 (12%)

4.88 Of the respondents who answered 'Yes' to this question, the majority focused on amendments to existing criteria. These proposed amendments are considered in Section 5 of this report against the appropriate criterion.

4.89 Two other comments were received, one regarding the requirements for teaching staff to be registered and the other suggesting that students should be able to undertake clinical work within their home country.

4.90 The Standards do not prohibit overseas experience for students, with many providers incorporating overseas experiential learning as part of programs.

4.91 The requirements for registration are addressed in criterion 1.4 and as such, no amendment is proposed based on this feedback.

4.92 One respondent indicated that an additional Standard should be considered 'Understanding of evidence- based research to guide practice'. No other comments were received relating to research literacy. Criterion 3.5 requires graduates to be competent in research literacy for the level and type of the program. This is also an area addressed in the Professional competencies of the newly qualified dental practitioner, under domain 3 – Critical thinking. No changes are proposed to the Standards based on this feedback.

4.93 Other respondents noted that specific provision for the care of vulnerable populations (e.g. patients with special needs, linguistically diverse or low socioeconomic groups) and who experience significant barriers to access of care, are notably absent from all Standards. Actions to address this area of need are included in section 5 of this report.

Q5: Are there any Standards that should be deleted or reworded?

Consultation question	Number of responses			
	Yes	No	Partly	Do not know
Q5. Are there any Standards that should be deleted or reworded?	7 (17%)	23 (56%)	6 (15%)	5 (12%)

4.94 Seven respondents answered yes to this question, providing comments related to specific criteria. These have been incorporated into the following section of the report and addressed as appropriate.

4.95 Any responses to question 6 that are directly related to the consultation process have also been considered in the following section.

5. Changes made following consideration of the consultation responses

5.1 This section details the changes made to the Standards following the consultation process. The changes that were proposed by respondents were identified, as is the action taken after consideration of proposed amendments and comments received. If an amendment is proposed, it is clearly stated whether the proposed change has been accepted or not. Comments related to specific Standards or criteria are also identified, as is the action taken to consider the feedback provided.

Preamble

5.2 Public protection is paramount in the administration of the National Registration and Accreditation Scheme under which the Accreditation Standards are developed and approved in Australia.

5.3 In New Zealand, DC(NZ)'s primary purpose is to protect the health and safety of the public by ensuring that oral health practitioners are competent and fit to practise. This responsibility is mandated in the Health Practitioners Competence Assurance Act 2003.

5.4 During the consultation process, an opportunity was identified to strengthen the preamble and ensure that this focus on public protection is clear. This suggested amendment has been incorporated into a revised preamble, specific to each jurisdiction.

5.5 It is evident from the responses received that there was ambiguity created by including the cultural competence domain and cultural safety domain within the same document released for public consultation.

5.6 The ADC is required to submit the Standards for approval to the DBA in accordance with the National Law, however there may be ambiguity in a Standard recommended for approval to the National Board that incorporates a domain that is not applicable to Australian programs.

5.7 To simplify the Standards and make explicit their application, it is proposed to have two versions of the Standards, one version applicable for programs seeking accreditation in New Zealand, and the other for programs seeking accreditation in Australia.

5.8 The Standards remain joint Standards as identified by the title, except for domain 6 and criterion 3.9. This is in recognition of the jurisdictional differences between Australia and New Zealand. All other Standards and criteria are identical. This has provided an opportunity to simplify the preamble and make it specific to each jurisdictional context.

5.9 A further addition is included in the preamble for each jurisdiction to recognise that the Cultural safety/Cultural competence domains have been developed in consultation with Aboriginal and Torres Strait Islander health leaders and Māori and Pacific health leaders as appropriate.

Revised preamble - Australia

The *ADC/DC(NZ) Accreditation Standards for Dental Practitioner Programs* (the Standards) are endorsed by the ADC and approved by the Dental Board of Australia (DBA) - pursuant to the *Health Practitioner Regulation National Law Act* 2009 (National Law).

Public protection is paramount in the administration of the National Registration and Accreditation Scheme, under which the Accreditation Standards are developed and approved in Australia in accordance with the National Law.

The Standards help to ensure that only suitably trained and qualified dental practitioners can register to practise in Australia. The Standards apply to all dental education programs that are approved programs that enable graduates to apply for registration as dental practitioners in Australia. The Standards also apply to programs that enable graduates to apply for endorsement of registration for conscious sedation.

The Standards comprise six domains:

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

Each Domain includes a standard statement that articulates the key purpose of the Domain. Each standard statement is supported by multiple criteria, which set out what is expected of an ADC accredited program in order to meet each standard statement. The criteria are not sub-standards that will be individually assessed. When assessing a program, the ADC will have regard for whether each criterion is met, but will take an on-balance view of whether the evidence presented by a program provider clearly demonstrates that a particular Standard is met.

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

For queries related to these Standards contact the ADC via accreditation@adc.org.au.

Revised preamble – New Zealand

The *ADC/DC(NZ) Accreditation Standards for Dental Practitioner Programs* (the Standards) are approved by the DC(NZ) pursuant to the *Health Practitioners Competence Assurance Act* 2003 (the Act).

DC(NZ)'s primary purpose is to protect the health and safety of the public by ensuring that oral health practitioners are competent and fit to practise. This responsibility is mandated to Council under the Health Practitioners Competence Assurance Act 2003.

The Standards help to ensure that only suitably trained and qualified oral health practitioners can register to practise in New Zealand. The Standards apply to all

dental education programs that are prescribed programs that enable graduates to apply for registration as oral health practitioners in New Zealand.

The Standards comprise six domains:

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

Each Domain includes a standard statement that articulates the key purpose of the Domain. Each standard statement is supported by multiple criteria, which set out what is expected of a DC(NZ) accredited program in order to meet each standard statement. The criteria are not sub-standards that will be individually assessed. When assessing a program, the DC(NZ) will have regard for whether each criterion is met, but will take an on-balance view of whether the evidence presented by a program provider clearly demonstrates that a particular Standard is met.

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

For queries related to these Standards contact the DC(NZ) via inquiries@dcnz.org.nz.

5.10 The following section outlines by Standard and criteria how the feedback provided has been actioned. Commentary is provided under each Standard to provide context for approaches taken and proposals made.

Standard 1

Domain: Public safety

Standard statement: Public safety is assured.

Draft criteria	Comments/responses	Actions
1.1 Protection of the public and the care of patients are prominent amongst the guiding principles for the program, clinical ~~training~~ **education** and learning outcomes.	**Comment:** This criterion uses' clinical training, whereas 1.4 refers to 'clinical education' Recommended to use consistent terminology.	**Action:** Accepted – 'clinical training' replaced with 'clinical education'.
1.2 Student impairment screening and management processes are effective.	**Proposed amendment:** Mechanisms to monitor student fitness to practise.	**Action:** Not accepted – The focus of the criterion is consistent with obligations imposed on education providers under the National Law. Focus is appropriately on patient safety; conduct issues are managed under criterion 1.9: high levels of ethical and professional conduct. The *Prompts for assessors* will also provide guidance as to how this criterion may be addressed.
1.3 Students achieve the relevant competencies before providing patient care as part of the program.		
1.4 Students are supervised by suitably qualified and registered dental and/or health practitioners during clinical education.		
1.5 Health services and dental practices providing clinical placements have robust health and safety, patient safety and quality and care policies and	**Proposed amendment:** Suggest inclusion of 'academic institutions', as 'health services and dental practices' does not	**Action:** Not accepted – Clarification will be provided in the *Prompts for assessors* all settings in which students

	processes and meet all relevant regulations and standards.	necessarily include a university clinic.	provide clinical care must met the criterion.
1.6	Patients consent to care by students.	**Proposed amendment:** Amend to require informed consent.	**Action:** Not accepted – informed consent can only be provided when the patient is aware of all facets of care, including cost, risks and benefits, which goes beyond the intent of the criterion. The purpose is to advise the patient that a student or trainee may be involved in their care. Informed consent is necessary when treatment planning is discussed with the patient.
1.7	~~In Australia, a~~**A**ll students are registered with the relevant regulatory authority/ies.	**Proposed amendment:** Proposed rewording for clarity '...appropriately registered...', as many students will be ineligible for general registration	**Action:** Not accepted – this criterion relates to student registration with the National Board, mandated under the National Law applicable in Australia. As this criterion is not applicable in New Zealand, it is proposed that this be moved as the last criterion in the domain (to become 1.9). With two versions of the Standards now proposed for Australia and New Zealand, the New Zealand version could not include this criterion and the balance of the criterion numbering will correlate between jurisdictions.
1.8	~~Ensure that s~~**S**tudents understand the legal, ethical and professional responsibilities of a registered dental practitioner.	**Proposed amendment:** To ensure students understand the legal, ethical and professional responsibilities of a registered dental practitioner *prior to delivering dental care to patients*.	**Action:** Not accepted – The amendment duplicates the information gathered to address criterion 1.3.
		Proposed amendments:	**Action:**

	Removal of the words 'Ensure that' – difficult to measure	Accepted - The Standard has been revised and the words 'Ensure that' removed.
	Proposed amendment: This criterion be expanded to specifically refer to interprofessional training with Aboriginal and Torres Strait Islander Health Practitioners and Workers.	**Action:** Not accepted – The revision would be duplicative of criterion 3.6.
	Proposed amendment: **The program provider** ensures that students understand the legal, ethical and professional responsibilities of a registered dental practitioner**.**	**Action:** Not accepted - The revised criterion addresses the wording issue identified. The program provider is responsible for meeting all of the Standards.
	Proposed amendment: To include reference to student dental practitioners within the criterion.	**Action:** Not accepted - Jurisdictional differences between Australia and New Zealand set different requirements of students, including registration in Australia.
1.9 The program provider holds students and staff to high levels of ethical and professional conduct.		

Commentary

5.11 Additions proposed to this standard also included 'Providing culturally appropriate care to migrant groups (can help reduce this disparity).' This is already addressed in criterion 3.9 and has not been incorporated within this domain.

5.12 A suggested amendment was to incorporate a statement regarding an education provider's obligation to comply with the requirements under the National Law. This proposed amendment was not accepted as it replicates elements of evidence provided under criteria 1.4, 1.5 and 1.9. There are also jurisdictional differences on the regulation of program providers compared with health practitioners.

5.13 One respondent proposed that protection of the public should also consider the impact that health service delivery has on climate change, and proposed that this issue be incorporated within the domain. No change has

been made to the Standards based on this feedback, however there is opportunity to consider the environmental impact of health care within the review of the Professional competencies of the newly qualified dental practitioner to be undertaking later in 2020.

5.14 The current Professional competencies for all divisions of registration include the following description within the Professionalism domain:

'8. to understand the principles of efficient, effective and equitable utilisation of resources, and recognise local and national needs in health care and service delivery across Australia's geographical areas.'

5.15 There is opportunity to take into consideration the environmental impacts of healthcare service delivery, including in identifying opportunities to reduce waste and to move towards more energy efficient materials and products within the professional competencies framework.

5.16 Another area raised as a concern related to the preparedness of graduates to work in rural and remote communities. The opportunities for students within accredited programs to gain experience in these settings is greatly varied, as some programs are delivered within rural settings, while others offer students opportunities to undertake rural placements.

5.17 The professional competencies set the expectation that programs prepare students to work across geographical locations, which includes rural and remote communities. This is an area that can be further expanded with the review of the professional competencies. As such, no change has been made to the Standards based on this feedback.

Standard 2

Domain: Academic governance and quality assurance

Proposed amendment to the Domain: Academic governance and quality assurance of the program.

Action: Not accepted. The domain provides a heading for ease of navigation. Programs are assessed against the Standard Statement. Other domain headings do not follow this format.

Standard statement: Academic governance and quality assurance processes are effective.

Draft criteria	Comments/responses	Actions
2.1 ~~The program can demonstrate a~~ **A**cademic governance arrangements are in place **for the program** and include systematic monitoring, review and improvement.	**Proposed amendment:** To reword to 'Governance arrangements of a program are appropriate…'	**Action:** Accepted with amendment - Revised criterion to 'Academic governance arrangements are in place for the program and include systematic monitoring, review and improvement.'
2.2 Students, ~~patients,~~ dental consumers **(including patients)**, ~~and~~ internal and external academic, and professional peers contribute to the program's design, management and quality improvement.	**Comment:** It is unclear what the difference is between patients and dental consumer.	**Action:** Accepted with amendment – the criterion has been reworded to identify that patients are a subset of dental consumers.
	Proposed amendment: To also require consumers to be integrated into assessment processes.	**Action:** Not accepted - Although supportive of the approach of incorporating consumers into the assessment processes where it is considered appropriate, the ability of some providers to address this as a minimum requirement may be limited by the Standards for Registered Training Organisations (RTOs) 2015 with which RTOs must comply. This obligation was also not consulted on and may have substantial impact on programs.

	Proposed amendment: Removal of the first 'and' from the criterion.	**Action:** Accepted – The first 'and' in the sentence deleted to improve clarity.
	Comment: There should also be a requirement that unit co-ordinators provide evidence that they have acted on consumer feedback.	**Action:** Noted – This will be included within the revised *Prompts for assessors* to help guide providers and assessors.
	Proposed amendment: Inter-professional input into program design should be encouraged.	**Action:** No amendment required - The wording of the criterion enables providers to seek inter-professional input. External academic input is not limited only to the dental professions, but may also be demonstrated by the inclusion of other health professions or educational expertise in curriculum design. This may already occur in programs that have inter-professional learning in place.
	Proposed amendment: Professional associations should be included in the criteria.	**Action:** Not accepted – The term professional peers can include, but is not limited to, professional associations. Additionally, not all dental specialties have specialist associations with which to engage.
2.3 Mechanisms exist for responding within the curriculum to contemporary developments in clinical practice and health professional education.	**Comment:** Is the expectation that a graduate will be competent to practice largely independently?	**Action:** No change required. In Australia, the DBA *Scope of Practice Registration Standard (Revised)*[9] and associated guidelines to be implemented in mid-2020

[9] Dental Board of Australia. *Scope of Practice Registration Standard (Revised) – Mid 2020. Accessed from* https://www.dentalboard.gov.au/Registration-Standards.aspx

	removes the requirement for dental hygienists, dental therapists and oral health therapists to work in a structured professional relationship. Each practitioner is responsible for the care they provide and must only perform treatment for which they are competent. Similarly, in New Zealand, a graduate from an accredited program is eligible to register and start practising in NZ; all practitioners are responsible for the care they provide – with some practitioner groups practising under defined supervision levels for some activities.

Commentary

5.18 Comments were provided regarding implementation of the standard and the requirement to demonstrate consumer feedback has been acted upon. Evidence is provided as part of the accreditation process that feedback from employers, students and external academic input is actioned in program review and improvement. The ADC and DC(NZ) expect that similar evidence will be used to demonstrate compliance with the Standards.

5.19 The revised criterion 2.1 allows for a focus, at the program level, on the effectiveness of broader academic governance arrangements, highlighted by respondents' comments that connection to the overall governance arrangements for the provider remain important. The criterion and Standard statement as worded, provide the ADC and DC(NZ) flexibility to address any broader issues of governance that may impact on the program and its ability to deliver on its expected outcomes in instances where these issues are identified.

5.20 A further comment received related to ensuring an emphasis on student engagement in curriculum and assessment design and review, and for the provision of evidence that this outcome is achieved. In addition to criterion 2.2, this is also addressed in criterion 4.6 which requires students to have representation on program committees and/or decision-making bodies.

Standard 3

Domain: Program of study

Standard statement: Program design, delivery and resourcing enable students to achieve the required professional competencies.

Draft criteria		Comments/responses	Actions
3.1	A coherent educational philosophy informs the program's design and delivery.		
3.2	Program learning outcomes address all the required professional competencies.	**Comment:** The word "addresses" in 3.2 commonly means "deals with or discusses" and is not the same as "attain" as many practitioners might expect of graduates. Are there core competencies in clinical practice that should be attained (as opposed to just addressed)?	**Action:** No change required - Providers demonstrate that students have attained the required competencies, including clinical competencies, to a level required to be a competent practitioner. Programs demonstrate this by compliance with the assessment standard.
3.3	The quality, quantity and variety of clinical education is sufficient to produce a graduate competent to practice across a range of settings.	**Comment:** Could include e-learning and changes to pedagogy	**Action:** No change required - The criterion as worded already allows flexibility to providers.
3.4	Learning and teaching methods are intentionally designed and used to enable students to achieve the required learning outcomes.	**Comment:** Could include e-learning and changes to pedagogy	**Action:** No change required - The criterion as worded already allows flexibility to providers.
3.5	Graduates are competent in research literacy for the level and type of the program.		
3.6	Students work with and learn from and about relevant dental and	**Comment:**	**Action:** Noted – Addressed in the revised criterion. The *Prompts*

health professions **to foster interprofessional collaborative practice**.	The importance of team-based treatment should be highlighted.	*for assessors* provide further guidance regarding interpreting this criterion.
	Proposed amendment: Proposed to separately address intra- and inter-professional education to improve the inclusion and application of both within curriculum.	**Action:** Not accepted - Criterion as stated makes expectation clear that both should be included in the program. The revised criterion also requires this understanding to be put into practice.
	Proposed amendment: Students learn about, from and with other dental and health professionals, and engage in interprofessional collaborative practice.	**Action:** Accepted with amendment – The words 'engage with', have been revised to 'to foster interprofessional collaborative practice'.
	Comment: The new standard does not place the emphasis on communication which was vital to this standard and preventing the issue of oral health being a silo.	**Action:** Noted - Communication is only one aspect of Inter-Professional Learning. The professional competencies can be strengthened during the review.
	Comment: This needs to be more clearly articulated against provision of patient care (outcome focus).	**Action:** Noted – revised criterion is expressed as outcome.
	Proposed amendment: Criteria on inter-professional practice should reflect learning outcomes relevant to a rural and remote health workforce, characterised by flexible, overlapping and interchangeable roles.	**Action:** Not accepted – This area will be addressed in the revision of the Professional competencies.
	Proposed amendment: This criterion should be reworded to better articulate desired outcomes in terms of patient care.	**Action:** Accepted with amendment – The revised criterion is expressed as an outcome.

3.7	Teaching staff are suitably qualified and experienced to deliver their educational responsibilities.	**Proposed amendment:** Teaching staff are suitably qualified, experienced and participate in continuing professional development to deliver their educational responsibilities	**Action:** Not accepted – The requirements for practitioners to participate in professional development are integral to the maintenance of registration as practitioners in both jurisdictions. The introduction may duplicate requirements already imposed.
		Comment: Neither the draft Standards, nor the Guidelines, define what is meant by "suitably qualified and experienced staff" for the purposes of teaching and assessing students.	**Action:** Noted - The ADC and DC(NZ) have developed *Prompts for assessors* to assist in the accreditation process. These prompts assist in assessment of the criterion. Factors considered include, but are not limited to, educational context (higher education versus vocational), level of autonomy in curriculum development and implementation, clinical responsibilities, legislative and regulatory requirements, and experience to deliver content. The Prompts will be made available to assist in understanding how compliance with the Standards are evaluated.
3.8	Learning environments and clinical facilities and equipment are accessible, well-maintained, fit for purpose and support the achievement of learning outcomes.	**Proposed amendment:** Criterion could be extended to include business continuity planning.	**Action:** Not accepted – Providers already include details of capital expense and equipment renewal within accreditation documentation submitted as well as highlighting risks and mitigating strategies to programs meeting the Standards.

Australian Criterion: 3.9 Cultural ~~competence~~ **safety** is articulated clearly, integrated in the program and assessed, ~~to ensure students are~~ **with graduates** equipped to provide care to diverse groups and populations. **New Zealand Criterion:** 3.9 Cultural competence is articulated clearly, integrated in the program and assessed, ~~to ensure students are~~ **with graduates** equipped to provide care to diverse groups and populations.	**Proposed amendment:** To include culturally and linguistically diverse groups and migrants.	**Action:** Not accepted – These groups are already covered by 'diverse groups and populations'. Specific focus on care for linguistically diverse and migrant groups may be considered in the review of the Professional competencies and in the guidance provided to programs and providers, such as in the *Prompts for assessors*.
	Proposed amendment: Should be reworded to describe cultural safety (not competence). This would align the criteria within the Standard to Australian National Law.	**Action:** Accepted in the Australian context - Terminology changed with a criterion created specific to programs seeking accreditation in Australia. No change as a result of this amendment to the wording as applies in New Zealand.
	Comment: The use of 'ensure' is difficult to quantify. Suggested to amend to "graduates are equipped to provide...	**Action:** Accepted for both Australian and New Zealand criteria - Wording changed.
	Comment: The Guidelines should specify precisely what is meant in criterion 3.9 by the term "diverse groups and populations". In addition to the linguistically diverse overseas-born Australians who are mentioned in the consultation document, that specification should include reference to refugees and asylum seekers, and gender diverse members of the community.	**Action:** Noted - To be included in *Prompts for assessors*.
3.10 The dental program has the resources to sustain	**Propose amendment:**	**Action:**

	the quality of education that is required to facilitate the achievement of the professional competencies.	The dental program has the resources to ensure the quality of education required to achieve the professional competencies	Not accepted – The inclusion of the wording 'to sustain' is an important factor and signifies that ongoing support for the program is required across the period of accreditation.
3.11	Access to clinical facilities is assured, via formal agreements as required, to sustain the quality of clinical training necessary to achieve the relevant professional competencies.	**Proposed amendment:** Suggest adding 'cultural' between 'professional' and 'competencies.	**Action:** Not accepted - The Professional competencies are broader and encompass the knowledge and skills required to provider dental care.
		Comment: It is not clear how the new criterion 3.11 is not covered by 3.8.	**Action:** Not accepted – The focus is on the access to facilities and how the program can sustain access. This is particularly important in instances where the provision of clinical experience is dependent on an external entity.

Commentary

5.21 A respondent raised queries of the absence of information regarding radiation safety within the Standards document. The safe use of ionisation radiation within the dental context is addressed within the Professional competencies of the newly qualified dental practitioner. Additionally, criterion 1.5 requires that dental clinics providing placement must meet all relevant regulations. This includes regulation related to the safe use of radiation sources. No changes to the Standards have been made based on this feedback.

Standard 4

Domain: The student experience

Standard statement: Students are provided with equitable and timely access to information and support.

Draft criteria		Comments/responses	Actions
4.1	Course information is clear and accessible.		
4.2	Admission and progression requirements and processes are fair and transparent.		
4.3	Students have access to effective grievance and appeals processes.		
4.4	The program provider identifies and provides support to meet the academic learning needs of students.		
4.5	Students are informed of and have access to personal support services provided by qualified personnel.	**Comment:** Could specifically refer to emotional health and wellbeing.	**Action:** No change required - Providers already include details of the services provided to students and trainees to support emotional health and wellbeing. The *Prompts for assessors* highlights this.
4.6	Students are represented within the deliberative and decision making processes for the program.		
4.7	Equity and diversity principles are observed and promoted in the student experience.		

Commentary

5.22 Few comments were received in relation to this domain. The one comment received was focussed on what would be considered in assessing against a specific criterion. This is addressed in the *Prompts for assessors*.

Standard 5

Domain: Assessment

Standard statement: Assessment is fair, valid and reliable to ensure graduates are competent to practise.

Draft criteria		Comments/responses	Actions
5.1	There is a clear relationship between learning outcomes and assessment strategies.		
5.2	**All required professional competencies are mapped to** ~~L~~learning outcomes ~~are mapped to the required professional competencies~~ and are assessed.	**Proposed amendment:** Include the word "all" and is slightly re-worded – i.e. "All learning outcomes are mapped to, and assessed against, the required professional competencies".	**Action:** Accepted with amendment – The statement has been revised to emphasise that all professional competencies must be mapped to learning outcomes and that these must be assessed. Providers may include learning outcomes that are outside the required professional competencies, however the professional competencies are the threshold required for practice.
5.3	Multiple assessment methods are used including direct observation in the clinical setting.		
5.4	~~A range of~~ Mechanisms facilitate ~~ensure~~ a consistent approach to appropriate assessment **and timely** ~~assessment and~~ feedback to students.	**Proposed amendment:** A range of mechanisms ensure a consistent approach to appropriate and timely feedback and assessment to student	**Action:** Accepted with amendment - The revised criterion incorporates the feedback provided.
		Comment: It is unclear what this means? What are mechanisms? Why does a "range ensure a consistent" as opposed to a single process?	**Action:** Accepted - The revised statement removes any ambiguity on the range of mechanisms.

5.5	Suitably qualified and experienced staff, including external experts for final year, assess students.	**Comment:** They (The Standards) also fail to specify the selection criteria (e.g. qualifications, clinical and research experience in relevant subject areas, educational experience and recency of practice) used to choose the "external experts" who help assess the competencies of final year students (draft Standard 5.5).	**Action:** Noted - the *Prompts for assessors* will be made available to provider further guidance to providers. The skills required vary considerably dependent on the skills assessed, program type and level (e.g. master's versus advanced diploma), the knowledge and skills being evaluated (e.g. research thesis compared to an Objective Structured Clinical Examination for a final year dental specialist demonstrating integrated knowledge of clinical care options for medically compromised patients within a domiciliary setting.)

Commentary

5.23 The changes made have been widely supported. Only one respondent queried whether the amendment to the standard statement added anything to the domain, which was contrasted by comments supporting the change.

5.24 Comments related to the specific criterion were aimed at clarifying the requirements of the statement, the majority of which have been acted on.

Standard 6a

Domain: Cultural competence (Applicable to programs seeking accreditation in New Zealand)

Standard statement: The program ensures students are able to provide culturally competent engagement and appropriate care for Māori and Pacific peoples.

Draft criteria		Comments/responses	Action
6.1	The program demonstrates its commitment to honouring the Treaty of Waitangi as the foundation document of New Zealand.		
6.2	The program upholds both the Articles and Principles of the Treaty through its educational philosophy and delivery.		
6.3	The program, staff and students understand the Māori perspective of health and wellbeing, their beliefs and cultural practices as it pertains to oral health in particular.		
6.4	Cultural understanding of Māori and Pacific peoples are integrated throughout the program, clearly articulated in required learning outcomes (including competencies that will enable effective and respectful interaction with Māori).		
6.5	Clinical experiences provide students with experience of providing culturally competent		

	care for Māori and Pacific peoples, and clinical application of cultural competence is appropriately assessed.	
6.6	There is a partnership in the design and management of the program from Māori and Pacific peoples.	
6.7	The program provider promotes and supports the recruitment, admission, participation, retention and completion of the program by Māori and Pacific peoples.	
6.8	The program provider ensures students are provided with access to appropriate resources, and to staff and the community with specialist knowledge, expertise and cultural capabilities, to facilitate learning about Māori health.	
6.9	The program recognises the important role of Māori Te Reo, Ngā Mokai o Ngā Whetu (Māori Dental Students' Association) and Te Aō Marama (The New Zealand Maori Dental Association) in achieving cultural competence to oral health practitioners.	
6.10	Staff and students work and learn in a culturally appropriate environment.	

6.11	The program demonstrates its commitment to honouring the Treaty of Waitangi as the foundation document of New Zealand.

Commentary

5.25 No specific amendments have been proposed to the criteria as drafted. Rather respondents that made comment on the Standards either suggested a revised focus to the overall domain or additional criteria.

5.26 Two Māori representative groups supported the intent to include new cultural competence domains and described it as "admirable" and "*a milestone and are very excited and hopeful on the positive impacts this will have across all Dental Practitioner Programmes*". However, they wanted to "*discuss the framing of the accreditation standards overall and the content of the cultural competence domain for Aotearoa. For this reason, we think the criteria need to be reworked in partnership with Māori before they are finalised.*"

5.27 One of these submitters described their concerns as:

- The framing around Māori health, te Tiriti o Waitangi and equity in the consultation document that accompanies the draft accreditation standard is confusing.
- The cultural competence domain for New Zealand is out of step with the most recent literature on cultural safety and health professionals.
- We recommend rewriting the cultural competence domain of the accreditation standards.
- DCNZ must look across its areas of responsibility to address the significant inequities in oral health.

5.28 As part of its strategic plan the DC(NZ) is scheduled to start the review its cultural competence framework soon. The DC(NZ) deferred the start of its review until the Medical Council New Zealand (MCNZ) review of its cultural competence has been completed, to leverage from some of their findings. Particularly, since the Ministry of Health and other Māori health professional organisations supported the MCNZ approach and framework reached.

5.29 The DC(NZ) review will include Māori representation from both the respondent organisations.

5.30 As part of this review, the framing of Māori oral health within the broader health context will be considered, as well as the scope of our framework in relation to cultural competence and cultural safety. As part of this review, all other related regulatory components will be revisited to fit within the new

framework. This includes the accreditation standards' cultural competence domain for NZ programs, professional competencies, practice standards and recertification etc.

5.31 The proposal is to not defer the overall acceptance of the joint accreditation standards, and to accept the proposed cultural competence domain for NZ programs (subject to minor changes if considered appropriate), and to revisit the NZ cultural competence domain as part of the overall DC(NZ) cultural competence framework review.

5.32 No re-accreditation reviews are scheduled until 2022. In the interim, both NZ educational programs have already strong Māori and Pacific health components embedded within their education.

5.33 One respondent stated that it "strongly supports a dedicated domain in the Standards on cultural competence for Māori and Pacific peoples, and its criteria for New Zealand programmes". It further expressed its commitment to cultural competence in its programmes, and ongoing consultation and engagement with other Māori and Pacific units within the University and Māori health providers in New Zealand.

5.34 One respondent proposed the additional criterion: "The program is able to demonstrate appropriate community and expert engagement to teach cultural competence." This has not been accepted. The criteria 6.5, 6.6 and 6.8 all contribute toward the required expertise and community participation/experience and would be duplicated in the proposed additional criterion.

5.35 One respondent proposed an additional criterion to include 'strengths based learning' in the domain to more accurately describe the relationship required between program provider, staff and student to facilitate learning about Māori and Pacific peoples' health. This has not been accepted. The Standards do not prescribe any approach or learning pedagogy.

5.36 A small number of respondents suggested to expand the cultural competence to include migrant and refugee groups who are now making up significant proportions of New Zealand and Australian populations and tend to have high oral health needs. Criterion 3.9 covers cultural competence for diverse groups and populations. The focus of the new domain 6 is specific to the Māori and Pacific peoples.

5.37 Another respondent proposed that a more general standard reflecting the need to be culturally safe to all cultural identities is developed. This has not been accepted as the proposal duplicates the intent of criterion 3.9. A generalised standard is unlikely to lead to the changes required in health service delivery to address the inequities in health outcomes observed for Māori and Pacific peoples.

Standard 6b

Domain: Cultural safety (Applicable to programs seeking accreditation in Australia)

Standard statement: The program ensures students are able to provide culturally safe care for Aboriginal and Torres Strait Islander Peoples.

Draft criteria		Comments/responses	Action
6.1	There is external input into the design and management of the program from Aboriginal and Torres Strait Islander Peoples.		
6.2	The program provider promotes and supports the recruitment, admission, participation, retention and completion of the program by Aboriginal and Torres Strait Islander Peoples.	**Comment:** This could be strengthened by public reporting of Aboriginal and Torres Strait Islander student numbers in programs, by programs.	**Action:** Noted - The ADC will be guided by *the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025*, as to how we can increase participation within the NRAS, noting the initiative to develop and implement strategies to monitor and improve data on Aboriginal and Torres Strait Islander participation in the National Scheme.
6.3	Cultural safety is integrated throughout the program and clearly articulated in required learning outcomes.		
6.4	Clinical experiences provide students with experience of providing culturally safe care for Aboriginal and Torres Strait Islander Peoples.	**Comment:** Providers must promote culturally safe access to services at teaching clinics for Aboriginal and Torres Strait Islander people.	**Action:** No change required – An outcome of the implementation of the criterion as worded will be that providers and those organisations supporting student clinical placements will need to increase services to Aboriginal and Torres Strait Islander Peoples to enable

			students to have experience of the provision of care.
		Comment: A requirement for students to work with people of Aboriginal or Torres Strait Islander background can be very difficult to meet. This is highly desirable, but not possible.	**Action:** Noted – The inclusion of this criterion is specifically designed to require programs to demonstrate students are able to provide culturally safe care.
6.5	The program provider ensures students are provided with access to appropriate resources, and to staff with specialist knowledge, expertise and cultural capabilities, to facilitate learning about Aboriginal and Torres Strait Islander health.	**Comment:** The criterion may also need to be reframed to be clearer about what 'staff with specialist knowledge, expertise and cultural capabilities' means.	**Action:** Noted - The Prompts for assessors will be made available to provider further guidance to providers.
6.6	Staff and students work and learn in a culturally safe environment.		

Commentary

5.38 An additional criterion was proposed 'the program is able to demonstrate appropriate community and expert engagement to teach cultural competence'. This amendment has not been accepted. Evidence that may be presented to address criteria 6.1 and 6.5 would duplicate evidence demonstrating the proposed criterion is addressed.

5.39 The inclusion of 'Strengths based learning' in the Standard was proposed. This has not been accepted. The Standards do not prescribe any approach or learning pedagogy.

5.40 A small number of respondents proposed that a more general standard reflecting the need to be culturally safe to all cultural identities is developed. This has not been accepted as the proposal duplicates criterion 3.9. A generalised standard is unlikely to lead to the changes required in health service delivery to address the inequities in health outcomes observed for Aboriginal and Torres Strait Islander Peoples.

5.41 Respondents raised concerns that other vulnerable populations (e.g. patients with special needs) that experience significant barriers to accessing care are not addressed specifically within the Standards. The ADC proposes to consider these vulnerable populations during the review of the Professional competencies of the newly qualified practitioner. Additionally, guidance will be provided in the *Prompts for assessors* encouraging this is to be considered under criterion 3.9.

5.42 One respondent advised that to meet a threshold outcome for culturally safe and appropriate program delivery, program providers must take steps to actively encourage participation of Aboriginal and Torres Strait Islander students in education and training, as well as to promote culturally safe access to services at teaching clinics for Aboriginal and Torres Strait Islander people. The implication of the introduction of criterion 6.4, requiring students to have clinical experience with providing culturally safe care is expected to necessitate the promotion of clinical services, which will only be successful if care is provided in a culturally safe manner. As a result, no amendment has been made based on this feedback.

5.43 It was also recommended that the principle 'the presence, or absence, of cultural safety must be defined by the Aboriginal and Torres Strait Islander peoples receiving the care' be incorporated within the domain 6b – Cultural safety and within its assessment. This principle will be incorporated within the *Prompts for assessors*, and as part of the development of a common curriculum to support dental practitioner programs to train practitioners to provider culturally safe care for Aboriginal and Torres Strait Islander Peoples.

5.44 One respondent supported a consistent approach across the regulated health professions to the accreditation standards. A document template highlighting how the Accreditation Committees supporting National Boards within the NRAS had incorporated cultural safety throughout the five-domain accreditation model, initially developed by the ADC and DC(NZ) was also provided. This approach was considered by the ADC and DC(NZ) but has not been accepted given the positive response to the domain as worded.

5.45 One respondent recommended the domain be worded to reflect similar principles in Australia as in New Zealand – where culturally appropriate. Revised criteria were proposed. This revision has not been accepted. There is broad support for the domain and criteria as incorporated within the draft Standards. The revised criteria have been included within the summary above.

Appendix 1: 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)

Appendix 2: Consultation questions

The consultation questions were as follows. Respondents were asked to provide comments wherever possible.

Name
Organisation (if applicable)
Contact details

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).

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?

Appendix 3: Consultation respondents

Organisations

Aboriginal and Torres Strait Islander Health Strategy Group
ACT Health Directorate
Ahpra Community Reference Group
Australian and New Zealand Association of Oral & Maxillofacial Surgeons
Australian Dental and Oral Health Therapists' Association
Australian Dental Association Inc
Australian Dental Prosthetists Association Ltd
Australian Skills Quality Authority
Australian Society of Medical Imaging and Radiation Therapy
Australian Society of Periodontology
Canterbury District Health Board
Charles Sturt University
Dental Council of New South Wales
Dental Hygienists Association off Australia
Department of Health
Department of Health (Tasmania)
Department of Health and Human Services
Department of Health, Northern Territory Government
Griffith University School of Dentistry
Indigenous Dentists' Association Australia
Māori Oral Health Quality Improvement Group
mcdm
Minister for Health, Queensland Government
Ministry of Health
National Health Practitioner Ombudsman and Privacy Commissioner
New Zealand Dental & Oral Health Therapists Association
New Zealand Institute of Dental Technologists
Not provided 1
Occupational Therapy Council of Australia Ltd
Oral Medicine Academy of Australasia
Parliamentary Secretary for Health, NSW Government
Public Health Association of Australia
RMIT University
Royal Australasian College of Dental Surgeons
Royal College of Pathologists of Australasia
Tertiary Education and Quality Standards Agency
The New Zealand Māori Dental Association
The University of Newcastle
University of Otago Faculty of Dentistry

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Achala Gaihre
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Kevin Rafferty
Martin Tyas
Mathew Lim
Melanie Hayes
Not provided 1
Not provided 2
Not provided 3
Paul Geyer
Peter Manuson
Prakruti
Prakruti
Rakesh
Richard Logan
Rod Marshall
Sherene Alexander
Sofie Bui
Tim Benson
Tony Skapetis