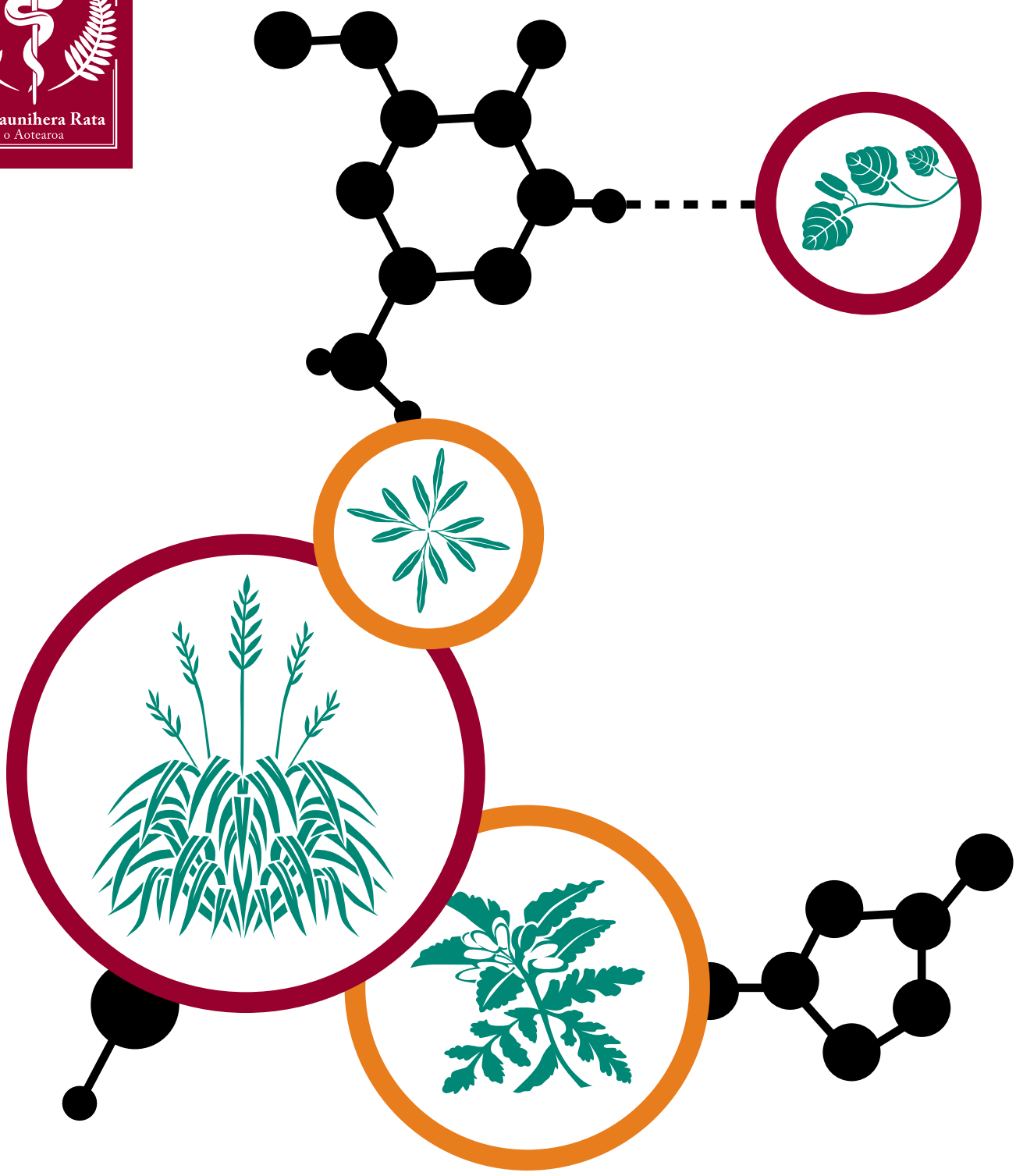
Medical Council of New Zealand
Te Kaunihera Rata o Aotearoa



MEDICAL COUNCIL OF NEW ZEALAND

ANNUAL REPORT

2016

TE KAUNIHERA RATA O AOTEAROA MEDICAL COUNCIL OF NEW ZEALAND

Protecting the public, promoting good medical practice
Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

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The Medical Council of New Zealand is pleased to submit this report for the year ended 30 June 2016 to the Minister of Health. The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003 (HPCAA) and includes a report on activities of the Health Practitioners Disciplinary Tribunal for doctors only.

CONTACT DETAILS

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AUDITORS

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Wellington 6140

Office of the Auditor-General
Private Box 3928
Wellington 6140

FACTS AT A GLANCE

1 July 2015
to
30 June 2016

DOCTORS REGISTERED

(1 JULY 2015 TO 30 JUNE 2016)

– TRAINED IN NEW ZEALAND	427
– INTERNATIONAL MEDICAL GRADUATES	952
TOTAL PRACTISING DOCTORS AT 30 JUNE 2016	15,142
DOCTORS REGISTERED WITH VOCATIONAL SCOPES	11,107
CANDIDATES WHO SAT NZREX CLINICAL	81
CANDIDATES WHO PASSED NZREX CLINICAL	38
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CHAIRPERSON'S REPORT

COUNCIL MEMBER CHANGES

On 30 June 2015, the Hon Dr Jonathan Coleman, Minister of Health, appointed Drs Kathryn Baddock, Pamela Hale and Curtis Walker and reappointed Dr Jonathan Fox for 3-year terms commencing on 1 July 2015.

The appointments followed the Council's election in March 2015 and the doctors being the four highest-polling candidates.

The Hon Dr Jonathan Coleman, Minister of Health, reappointed the following Council members during the year:

- Mr Andrew Connolly for another 3-year term commencing on 3 December 2015.
- Dr T Lu'isa Fonua-Faeamani for another 3-year term commencing on 3 September 2015.
- Ms Susan Hughes QC as layperson member for another 3-year term commencing on 23 June 2016.
- Ms Laura Mueller as a layperson member for another 3-year term commencing on 3 December 2015.
- Ms Kim Ngārimu as a layperson member for another 3-year term commencing on 3 September 2015.
- Professor John Nacey for another 3-year term commencing on 23 June 2016.

CULTURAL COMPETENCE, PARTNERSHIP AND HEALTH EQUITY

Over the past year, cultural competence and genuine partnership with Māori were identified as important aspects of achieving excellence in medical practice and have become an ongoing focus for Council.

We have embedded cultural competence within our business plan and included two additional principles. They are intended to recognise Council's commitment to best practices when providing care to Māori patients and their whānau and to improving health equity for any disadvantaged group.

The two additional principles are:

- Council will promote the Treaty of Waitangi principles of partnership, participation and protection
- Council will work to improve cultural competence within the medical profession with the aim of improving health equity for disadvantaged groups within New Zealand.

Cultural competence is not discretionary. It is a standard that Council is required to establish and has done so. All doctors must meet the cultural competence standards.

Council expects that doctors will be culturally competent. Council will further encourage doctors and health organisations to establish and strengthen their partnerships with Māori organisations, with the aim of including Māori participation within their governance structures. The aim of these endeavours is to improve Māori health outcomes and reduce health inequity, through Council's role as the medical regulator responsible for professional standards and ensuring doctors' competence.

Health inequity is due to many factors, and only some aspects of inequity are likely to be under the direct influence of doctors. Where possible, doctors need to work to eliminate those aspects of inequity that are under their control. Council encourages doctors to examine relevant outcomes in their patients to identify any areas where a change in approach could improve those outcomes.

In the coming year, Council is committed to:

- working collaboratively with medical colleges to ensure that cultural competence is a necessary component of all college vocational training and CPD/recertification programmes
- working collaboratively with colleges to improve the number of Māori medical graduates entering and completing vocational training
- working collaboratively with colleges to recognise the additional demands Māori doctors may face due to their cultural identity and any wider community responsibilities they may have
- updating Council's statements and resources on cultural competence, which will include:
    - *Cultural competence* (August 2006)
    - *Best practices when providing care to Māori patients and their whānau* (August 2006)
    - *Best health outcomes for Māori: Practice implications* (October 2006)
- amending our accreditation standards for prevocational training to include cultural competence
- reviewing our supervision and assessment processes for international medical graduates to ensure doctors meet the required standards of cultural competence.

RECERTIFICATION

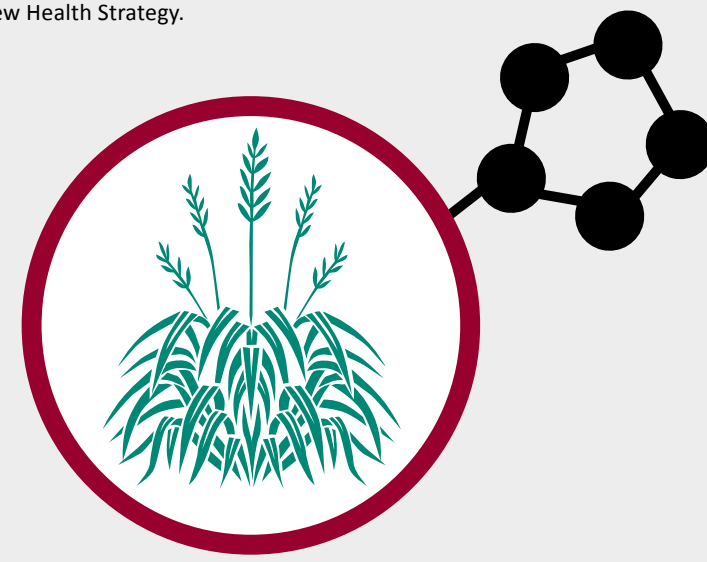
Much work has continued in this very important area. Council has reviewed the continuing professional development (CPD) and recertification requirement for doctors. We have enhanced our principles-based approach, emphasising the importance of evidence-based recertification, led by the profession. It is very important the profession views the annual practising certificate as more than a tax receipt. It should be viewed as tangible recognition of competence. The definition of 'competence' is a judgement made on a combination of learning, performance and professional behaviour.

These factors mean competence is best assessed in a collegial fashion, influenced by knowledge of performance in the workplace. Relevant data plays an important role in doctors being able to reflect on the year they have had and to plan their learning and scope of practice for the year ahead. Council very much sees a collaborative leadership approach with the colleges as vital to successful recertification. Where relevant, employers will also play an important role. The content of a well functioning CPD/recertification programme is best left to the colleges, as they are the subject-matter experts.

COMMUNITY-BASED ATTACHMENTS FOR INTERNS

In 2014, Council made a major decision to require all interns by the end of postgraduate year 2 to undertake a 3-month community-based attachment (CBA). This is being introduced in a step-wise fashion over the next few years. The background to this is a need to expose our graduates to the way medicine is delivered outside of the hospital environment. This is to give greater understanding of the interface between community care and secondary care and to stimulate new graduates to think of ways in which the system could change to provide greater benefits for patients. CBAs have now been established in every District Health Board, and in 2017, we anticipate approximately 30 percent of interns will have had a CBA by the time they complete postgraduate year 2. By 2020, this figure will have risen to 100 percent.

The CBA is not restricted to general practice. Indeed, many of the CBAs are in hospice care, mental health services and integrated care, and Council sees considerable opportunities to expand into urgent care and other settings. Council is working very closely with many stakeholders over this important strategy. Council sees the CBA programme as perhaps the most tangible step taken so far towards implementation of the new Health Strategy.



BULLYING, DISCRIMINATION AND SEXUAL HARASSMENT

Considerable publicity has surrounded the release of the Royal Australasian College of Surgeons Expert Advisory Group report into bullying, discrimination and sexual harassment in the practice of surgery. It is vital, however, to be clear that poor professional behaviour can exist in all branches of medicine. It is not limited to one particular speciality or location.

I attended two major meetings of the Taskforce Group as well as several teleconference discussions on this subject, and there is sector-wide cooperation to address the issues as they arise as well as change the attitudes and drivers of such behaviour. There is clear evidence that such behaviours are a risk to patient care as well as to the good standing of the profession.

Most of the solutions to bullying lie with cultural change in the workplace. Council should only need to be involved in the most serious of cases, but a consistent message of 'it's not OK' from all areas of the sector, including Council, is critical. The benefits of a good workplace culture cannot be overestimated, as some of the causes of poor interactions are founded in less than ideal workplace structures and functions.

MEDICO-LEGAL ISSUES

This year has seen several legal challenges to Council decisions, which have been the subject of intense media interest.

The most prominent and challenging one for Council involved a general practitioner who twice appealed Council's decision to suspend him following his arrest and charging on allegations of sexual misconduct.

Unfortunately, under current legislation, Council is unable to immediately suspend a doctor in these circumstances without first notifying the doctor of our 'proposal' to suspend. The end result is that the doctor can challenge the proposal and then engage in a court process that can take many months to resolve while the doctor continues to practise. Council has significant concerns that, when we believe we have exhausted patient safety measures, short of suspension, the ability to protect public health and safety is restricted due to the processes required under the HPCAA. This is not to say we favour a system where the doctor loses their rights of appeal – that is a very important safeguard – but we do favour the ability to act immediately and decisively when, in Council's opinion, the only safe solution is suspension.

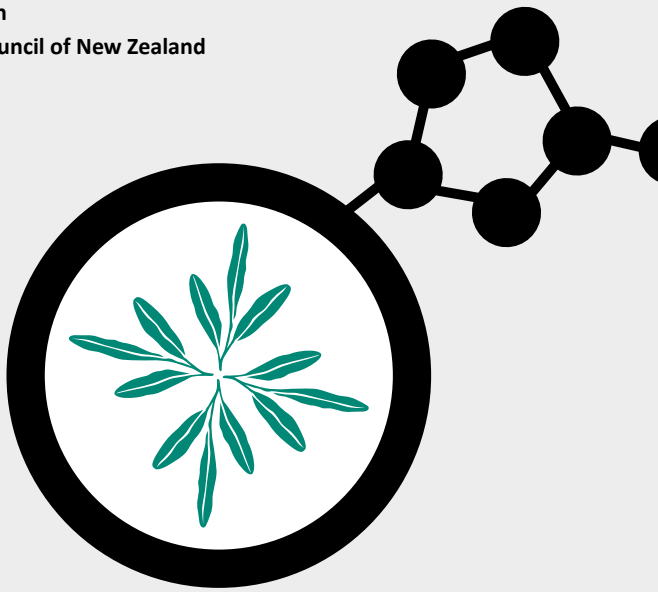
Very simply, to enhance patient safety, a law change is needed so that we are allowed to suspend immediately in very worrying situations.

Over the past 8 years, Council has filed three formal submissions to the Ministry of Health calling for a law change. Although we have not been successful to date, we will continue to advocate actively for a law change going forward.

THANKS

I extend my thanks to members and staff of the Council for their support over the past year and meeting the challenges and demands that we have faced. I also extend a sincere thanks to all our stakeholders who have contributed greatly to our work and our decision making. It is a privilege to chair the Medical Council.

Mr Andrew Connolly
Chairperson
Medical Council of New Zealand



AUDIT COMMITTEE REPORT

The Audit Committee is a standing committee of the Council

TERMS OF REFERENCE

The terms of reference for the Audit Committee as approved by Council are to:

- oversee the risk management programme
- review the risk profile (including legal compliance, financial, statutory reporting and fraud risks)
- monitor the internal control systems and assessment
- oversee the annual external audit by the Office of the Auditor-General
- oversee any internal audit
- ensure the integrity of external financial reporting
- ensure appropriate financial management policies and practices are in place
- ensure that Council and management are provided with financial information that is relevant and of high quality
- conduct special investigations as required by Council.

FEES REVIEW

During 2015, Council undertook a review of the fees that it charges for the services it provides using activity-based costing methodology. Council consulted with the profession and other stakeholders, and as a result of the feedback received, many of the fees that had previously been charged have been changed to reflect the actual cost involved in delivering the service. While some fees increased as a result of the review, other have decreased. The Audit Committee is satisfied that the new fees are fair and remove the cross-subsidisation that existed in the previous fee structure.

The fee changes introduced in September 2015 generated additional revenue that was sufficient to defer further fee increases in 2016/17, while still allowing Council to achieve its goals and objectives to protect public health and safety.

REVIEW OF REGISTRATION PROCESSES

In September 2015, the Audit Committee considered the results of a review of the registration process undertaken to grant a doctor both a special purpose (locum tenens) and a provisional vocational scope of practice.

The Audit Committee considered a number of ways in which Council processes may be able to be strengthened or changed to prevent a recurrence of a similar situation in future.

To assist this process, the Council's Chairperson, Mr Andrew Connolly, Chief Executive Officer, Mr Philip Pigou, and General Manager, Core Services, Ms Valencia van Dyk, visited the Educational Commission for Foreign Medical Graduates (ECFMG) in Philadelphia, United States, in October 2015. The purpose of the visit was to find out more about their Electronic Portfolio of International Credentials (EPIC) service.

By requiring that applicant doctors use EPIC to demonstrate the authenticity of their medical credentials, Council would have the confidence of knowing that those credentials have been primary-source verified by ECFMG, at no cost to Council.

Council is expected to make a decision on whether to use EPIC some time in 2016.

HEALTH AND SAFETY

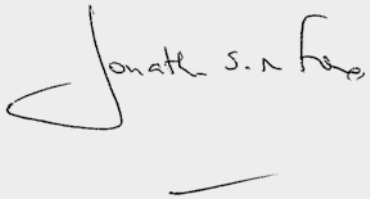
Council has moved to comply with the requirements of the Health and Safety at Work Act 2015.

Compliance with the new health and safety legislation is now a permanent item on the Audit Committee agenda, and its deliberations are reported directly to Council.

Actions taken by Council and Council staff in the lead-up to and after the introduction of the legislation include the following:

- The implementation of a health and safety module using Greentree (Council's general ledger and leave management system). This system has been rolled out to all staff members, who are now able to register incidents and accidents by the eHR system. Any items logged via eHR will be actively managed via the Council's health and safety representatives.
- The implementation of the WhosOnLocation system. This system went live in April 2016. The system allows us to know who is or is not on site in the event of an emergency. All staff members are actively being encouraged to log in and out of the system during a working day, and we are following up with those who are not signing in about the requirement to do so. All visitors to the office are also required to sign in to the system.
- In addition to the work being launched to improve systems, work has also been undertaken in relation to policies. Three policies have been written and reviewed and will be presented to the Human Resources Committee and management team meeting in the near future before being submitted to Council for its consideration. The three policies are a general policy on health and safety at work, a policy on reducing workplace bullying and a policy on reducing workplace stress.
- Work has also been undertaken on further earthquake resilience within the office such as securing office furniture and developing the skills of staff involved in implementing Council's Crisis Incident Management System processes.

I would like to acknowledge the work and contributions of the Audit Committee and staff members alike.



Dr Jonathan Fox
Chairperson
Audit Committee
Medical Council of New Zealand

EDUCATION COMMITTEE REPORT

The Education Committee is a standing committee of the Council

HOSPITAL ACCREDITATION VISITS

The purpose of accreditation of training providers for prevocational medical training is to ensure that standards have been met for the provision of education and training for interns. Prevocational medical training spans the 2 years following graduation from medical school and includes both postgraduate year 1 and postgraduate year 2. Doctors undertaking this training are referred to as interns. Prevocational medical training applies to all graduates of New Zealand and Australian accredited medical schools and doctors who have sat and passed NZREX Clinical.

Hospital accreditation visits have been undertaken at:

- Waitemata District Health Board, October 2015
- Auckland District Health Board, August 2015
- Whanganui District Health Board, March 2016
- Southern District Health Board, April 2016
- Hawke's Bay District Health Board, May 2016
- Nelson Marlborough District Health Board, May 2016
- Counties Manukau District Health Board, June 2016
- MidCentral District Health Board, June 2016
- Southern District Health Board, June 2016.

REVIEW OF PREVOCATIONAL TRAINING

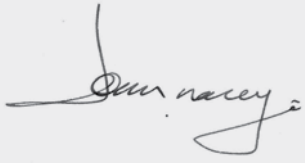
The staged implementation of the changes to prevocational medical training began in November 2014, with further changes being implemented in November 2015. To date, initiatives that have been implemented include:

- accreditation of over 900 clinical attachments
- accreditation of 10 training providers (DHBs)
- development of community-based attachments – 35 community-based attachments have been accredited
- implementation of advisory panel functions
- holding 11 training workshops for clinical supervisors of interns – a total of 23 workshops have been held over the past 2 years
- holding three annual meetings for prevocational educational supervisors
- initiating a review of the implementation of the prevocational medical training programme
- ongoing refinement of ePort functionality.

The focus for the 2016/17 business year is:

- training for accreditation team members
- further development of community-based attachments
- completing the review of the implementation of the prevocational medical training programme
- implementation of a national tool to collect intern feedback about each clinical attachment
- implementation of a multisource feedback tool in ePort
- development of an app for ePort.

I would like to thank members of the Education Committee and staff members for their commitment to achieving the goals of the Committee's work.



Professor John Nacey
Chairperson
Education Committee
Medical Council of New Zealand

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2015 to 30 June 2016

DR KATE BADDOCK

MB ChB 1981 Otago, Dip Obst 1983 Auckland, MRCGP 1986, M 1994 F 1998 RNZCGP

Dr Baddock was elected to Council in 2015. Dr Baddock qualified with an MB ChB from Otago in 1981, and after completing a Diploma in Obstetrics and Gynaecology, she travelled overseas for a number of years. While in the United Kingdom, she completed her postgraduate training in general practice and obtained Membership of the Royal College of General Practitioners. After her return to New Zealand in 1988, she joined a rural practice in Warkworth and has been working there full-time for the past 28 years. In 1998, she obtained her Fellowship of the Royal New Zealand College of General Practitioners.

Dr Baddock is part of a teaching practice that has grown steadily over the last decade and now has 13 doctors including registrars and postgraduate doctors as well as medical and nursing students. She has also been involved at a regional level in health organisations and has served on the board of Waitemata Primary Health Organisation for the past decade. Prior to that, she was the chair of one of the first independent practitioner associations in New Zealand for 12 years.

In terms of national roles, Dr Baddock has been the Chair of the General Practitioner Council of the New Zealand Medical Association for the past 6 years and is currently the Deputy Chair of the New Zealand Medical Association. She also sits on the Executive Board of General Practice New Zealand, is a member of the General Practice Leaders Forum and is also a member of the Ministerial Medicines Classification Committee.

In her spare time, Dr Baddock is a Swimming New Zealand referee. She also enjoys landscaping, reading and travelling.

Dr Baddock is a member of the Audit Committee.

MR ANDREW CONNOLLY

MB ChB 1987 Auckland, FRACS 1994

Appointed to Council in November 2009, Mr Connolly was elected Deputy Chairperson of Council in February 2012 and Chairperson in February 2014. Mr Connolly was re-elected as Chairperson in February 2016.

Mr Connolly is a general and colorectal surgeon, employed full-time at Counties Manukau District Health Board.

He has a strong interest in governance, education and clinical leadership and has been the Head of Department of General and Vascular Surgery since 2003. He served on the Ministerial advisory group that was responsible for the *In Good Hands* document. In 2016, he was part of the Ministry of Health Capability and Capacity Review of the Health Sector.

Mr Connolly has served on various national committees, including the New Zealand Guidelines Group for the screening of patients with an increased risk of colorectal cancer.

He has previously held the role of Presiding Member of the Lotteries Health Research Distribution Committee, he recently chaired a Ministerial review of the impact of the elective waiting times policy and he was a member of the review panel of the New Zealand Cancer Registry.

Outside of medicine, he has a passion for military history, particularly the First World War.

As Council Chairperson, Mr Connolly is an ex officio member of Council's Audit, Education and Health Committees.

DR T LU'ISA FONUA-FAEAMANI

MB ChB 1998 Otago, FRNZCGP 2007

Appointed to Council in July 2014, Dr Lu'isa Fonua-Faeamani is a general practitioner (GP) and clinical director for The Fono – Health and Social Services based in West Auckland. The Fono provides affordable healthcare services including medical, dental, pharmacy, health awareness and community support services and delivers a combination of these services across four Auckland locations.

Dr Fonua-Faeamani has worked with Pacific health providers in Central and West Auckland as a GP providing care for this high-needs population.

Dr Fonua-Faeamani graduated from Otago Medical School in 1998. She returned to Tonga for 3 years to work at Vaiola Hospital and was posted to the outer island of 'Eua as the only doctor for 8 months, before returning to New Zealand for advanced training.

Dr Fonua-Faeamani is particularly interested in Pacific health and the development of Pacific GPs and the Pacific primary health workforce.

Dr Fonua-Faeamani is a member of Council's Health Committee.

DR JONATHAN FOX

MB BS 1974 Lond, MRCS Eng LRCP Lond 1974, MRCGP 1981, FRNZCGP 1998 C MinstD

Dr Fox was elected to Council by the profession and appointed to Council in June 2009. He has been re-elected twice since.

Dr Fox is a general practitioner (GP) based in Auckland. He is a past President of the Royal New Zealand College of General Practitioners (RNZCGP) and past Chair of the Council of Medical Colleges in New Zealand. He is a board member of ProCare Health Limited – the Auckland GP network. He is also a member of various charitable and research trusts in the Auckland region.

Dr Fox was awarded a Distinguished Fellowship of the Royal New Zealand College of General Practitioners in 2010. He has also been awarded an Honorary Fellowship by the Royal Australian College of General Practitioners.

His previous positions included membership of the board and General Practitioner Council of the New Zealand Medical Association and the Competence Advisory Team of the Medical Council, Medical Officer to Kings College Auckland and many RNZCGP Auckland Faculty positions.

Dr Fox qualified from Guys Hospital Medical School, London, in 1974. He then spent 7 years working as a medical officer in the Royal Navy before completing his vocational training in the United Kingdom. After leaving the Navy, he spent 8 years as a GP in Rugby, UK, where he was also medical officer to Rugby School.

He came to New Zealand in 1990 with his GP wife and their children. Over the last 26 years, their practice has grown and is now a seven-doctor practice in Meadowbank, Auckland.

Dr Fox is Chairperson of Council's Audit Committee and Deputy Chairperson of the Education Committee.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2014 to 30 June 2016

DR ALLEN FRASER

MB ChB 1969 Otago, DPM 1973 Otago, MRCPsych 1976, M 1978 F 1980 RANZCP

Dr Fraser was appointed to Council in August 2008.

Dr Fraser went to medical school in Dunedin in the 1960s and subsequently trained as a psychiatrist in Auckland and at St Thomas' Hospital in London. He was appointed as a consultant psychiatrist in South Auckland in 1977, where he led the development of community-based mental health services, at the same time continuing what has been a career-long commitment to the acute care of the seriously mentally ill.

He has been involved in many local, national and international professional organisations, including the Royal Australian and New Zealand College of Psychiatrists (RANZCP) since 1980. Dr Fraser was chair of the RANZCP's New Zealand Committee for 4 and a half years. He has been a union leader (President of the Association of Salaried Medical Specialists for 4 years and is now a life member) and a chief medical officer.

Dr Fraser has ceased private consulting practice and presently works as a locum consultant psychiatrist in adult psychiatry for Waitemata District Health Board and occasionally elsewhere. He remains available for occasional assessments.

Dr Fraser is Chairperson of Council's Health Committee.

DR PAMELA HALE

MB ChB Otago 1982, FRACP 1991

Dr Hale was appointed to Council in July 2015.

She graduated from Otago University in 1982 and completed medical training in several hospitals in Christchurch, Tauranga, Hamilton, Dunedin and the UK, becoming a Fellow of the Royal Australasian College of Physicians in 1991.

For many years, Dr Hale worked part-time while busy with her family.

Dr Hale has been a specialist physician in Nelson for 23 years developing the diabetes and endocrinology service and has had other roles including being an intern supervisor. She is currently Head of the Department of Medicine and a Clinical Senior Lecturer for the University of Otago with respect to the Nelson trainee interns.

Dr Hale has always been interested in professionalism and ethical behaviour and has led annual tutorials on this with resident medical officers.

Her interests include acute general medicine and the holistic management of type 1 diabetes and, outside of work, her family.

She is a member of Council's Health Committee.

MS SUSAN HUGHES QC

BA, LLB, GDip Bus Studs, MMgt

Appointed in May 2013 as a Council layperson, Ms Hughes was a partner in the New Plymouth law firm of Govett Quilliam for 18 years, leaving in 2006 to commence practice at the independent Bar. She was appointed Queen's Counsel in 2007 and continues her practice in New Plymouth – a broad-based litigation practice spanning diverse jurisdictions of the Courts.

Ms Hughes has held a number of Government appointments over the years. Most recently, she was a Director of the Civil Aviation Authority and the Aviation Security Service from 2004 to 2011.

Ms Hughes has now practised law for more than 30 years, which has honed her interest in matters of process and the effective resolution of disputes.

Ms Hughes is a member of Council's Audit Committee.

MS LAURA MUELLER

BA Psych (Calif) 1992, Juris Doctor (Calif) 1996

Appointed in October 2009, as a Council layperson, Ms Mueller was elected Council's Deputy Chairperson in February 2015 and again in February 2016.

Ms Mueller was appointed as a judicial officer for the Ministry of Justice in 1999, and she sits as a Referee in the Disputes Tribunal at the Tauranga District Court. Ms Mueller has 20 years of business experience, including management of a large accounting and tax practice and experience as a medical insurance underwriter.

With a keen interest in governance and leadership, Ms Mueller has served on the Disputes Tribunal's National Education Committee for more than 7 years. She has served as Treasurer on the Disputes Tribunal's Referees Association Executive and is a mentor for new Referees.

Ms Mueller is a member of Council's Complaints Triage Team and the Audit, Education and Health Committees and is also the Council's liaison member on the Health and Disability Commissioner's Consumer Advisory Group.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2014 to 30 June 2016

PROFESSOR JOHN NACEY

MB ChB 1977 Otago, FRACS 1985, MD 1987 Otago, MBA

Professor Nacey was appointed to Council in March 2010.

Professor Nacey graduated from the University of Otago in 1977. After completing specialist training in urology, which included an appointment as Chief Resident in Surgery at the Flinders University Medical Centre, Adelaide, Australia, he returned to New Zealand to take up a joint hospital/university position in Wellington. In 1998, he was appointed Dean and Head of Campus at the University of Otago's Wellington School of Medicine, a position he held for 10 years.

With an interest in prostate disease, Professor Nacey has published extensively on this subject. He acts as referee for several major international journals and has chaired the recent Government Prostate Cancer Taskforce. As past examiner for the Royal Australasian College of Surgeons, he has maintained his interest in teaching undergraduate medical students and postgraduate surgical trainees.

Professor Nacey currently holds the position of Professor of Urology at the Wellington School of Medicine.

He has widespread community involvement including the position of President of the Wellington Medical Research Foundation and Chairman of the Board of Management. He remains a strong advocate for promoting men's health.

Professor Nacey is Chairperson of Council's Education Committee.

KIM NGĀRIMU

BBS

Appointed in August 2014 as a Council lay person, Ms Ngārimu is a director of Tāua Limited, a consulting company specialising in the provision of public policy and management advice and relationships with iwi and Māori communities.

She held the position of Deputy Secretary Policy with Te Puni Kōkiri from March 2007 until December 2013.

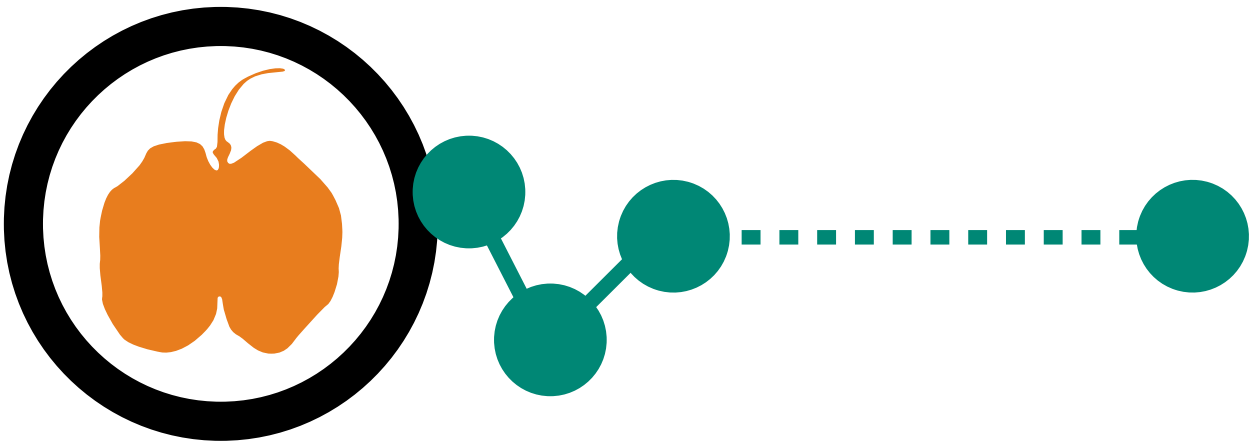
Ms Ngārimu has also held positions as Acting Chief Executive of the Ministry of Women's Affairs and Acting Director for the Waitangi Tribunal.

Following the completion of her university studies, Ms Ngārimu worked for Te Rūnanga o Ngāti Porou, gaining a solid grounding in Māori community dynamics and aspirations. Following this, she first joined Te Puni Kōkiri in 1992 and worked in various senior management, policy management and regional roles until 1999. She left Te Puni Kōkiri in 1999 to take up a sector manager role at the Office of the Controller and Auditor-General.

In the 7 years before rejoining Te Puni Kōkiri, Ms Ngārimu continued to build her experience in policy, strategic management, business and governance through co-directorship of her management and public policy consulting company.

Ms Ngārimu's tribal affiliation is Te Aitanga ā Mate, Ngāti Porou.

Ms Ngārimu is a member of Council's Education Committee.



MS JOY QUIGLEY JP

QSO (2008)

Ms Quigley was appointed as a Council as a layperson in August 2011.

Ms Quigley served as a National Member of Parliament from 1990 to 1999, chairing the Māori Affairs, Foreign Affairs and Defence, and Social Services Select Committees during that time. After retiring from Parliament, she became the Executive Director of Independent Schools of New Zealand until 2008 and is currently a director, with her husband, of a consultancy business based in Ohope.

Ms Quigley graduated from the School of Physical Education, University of Otago in 1967 and subsequently from Christchurch Teachers College. She has been involved with a wide range of local, regional and national voluntary organisations during her adult life. In 2008, she became a Companion of the Queen's Service Order recognising her public and community service.

During 2009 and 2010, Ms Quigley was a member of the Government-appointed panel considering New Zealanders' access to high-cost, highly specialised drugs.

Ms Quigley is a member of Council's Audit and Education Committees and an alternative layperson member on Council's Health Committee.

DR CURTIS WALKER

MB ChB 2007 Auckland, FRACP 2015

Dr Walker was elected to Council in 2015.

Ko Whakatōhea rāua ko Ngāti Porou ngā iwi.

Formerly a veterinarian, Dr Walker retrained in human medicine and qualified from Auckland in 2007. He started work as a house officer at Waikato Hospital and commenced internal medicine training there before moving to Palmerston North and Wellington to complete his Fellowships in Nephrology and General Medicine (Fellow of the Royal Australasian College of Physicians) in 2015 and 2016 respectively.

During his time as a resident doctor, he was President of the New Zealand Resident Doctors' Association for 5 years and also served on the board of the Māori Medical Practitioners Association (Te ORA). These roles reflect the strong commitment that Dr Walker has to improving health outcomes for Māori and to supporting doctors during the long and challenging years spent in specialist training.

Dr Walker commenced work as a renal and general physician in 2015 at MidCentral DHB and loves living in Palmerston North with his wife and two young children.

Dr Curtis is a member of Council's Education Committee.

CHIEF EXECUTIVE'S REPORT

OUR PRINCIPLES

- In undertaking all its functions, Council will focus primarily on achieving its purpose of protecting the health and safety of the public.
- Council will be accountable to the public, Parliament and the Minister of Health for its decisions and to the profession in relation to the efficient use of funds to achieve Council's purpose under the Health Practitioners Competence Assurance Act.
- Council will make its decisions as an independent regulator of the medical profession free of influence from external bodies.
- Council will operate as a right touch regulator, ensuring the most effective, efficient, consistent and proportionate regulation for the profession.
- Council will consider whether there is a risk of harm or risk of serious harm to the public when managing doctors with competence, conduct and/or health concerns.
- Council will work in a collaborative and constructive manner with all key stakeholders and continue to foster mutual trust and respect in all our relationships.
- Council will aim for excellence in everything that we do and will focus on continually improving our performance.
- Council will promote the Treaty of Waitangi principles of partnership, participation and protection.
- Council will work to improve cultural competence within the medical profession with the aim of improving health equity for disadvantaged groups within New Zealand.
- Council will aim for excellence in our people and will focus on being an employer of choice and applying best-practice human resource policy and practice.
- Council will make decisions within a transparent, natural justice-based decision-making framework.
- Council will work with other international medical regulators to promote national and international best practice in medical regulation.
- Council will work with other health regulators in New Zealand promoting greater collaboration to support an effective and efficient regulatory environment.
- Council will set standards that signify a high and readily attainable level of medical practice.

OUR STRATEGIC GOALS

Goal one – Optimise mechanisms to ensure doctors are competent and fit to practise.

Goal two – Improve Council's relationship and partnership with the public, the profession and stakeholders to further Council's primary purpose – to protect the health and safety of the public.

Goal three – Promote good regulation of the medical profession by providing standards of clinical competence, cultural competence and ethical conduct and ensuring that the standards reflect the expectations of the public, the profession and stakeholders.

Goal four – Improve medical regulatory and workforce outcomes in New Zealand by registering doctors who are competent and fit to practise and ensure their successful integration into the health service.

COUNCIL OF MEDICAL COLLEGES PROJECT – *A BEST PRACTICE GUIDE FOR CONTINUOUS PRACTICE IMPROVEMENT*

Senior Council staff have been involved in a project being undertaken by the Council of Medical Colleges, in partnership with the Ministry of Health, the National District Health Board Chief Medical Officers Group, the Royal New Zealand College of General Practitioners and Council, looking at links between various tools used in the assessment of doctors, with a focus on continuous practice improvement. The project takes into account credentialling, performance appraisal, recertification and regular practice review standards for their practice.

MEDSYS ONLINE CAPABILITY TO FACILITATE APPLICATIONS FOR PRACTISING CERTIFICATES AND REGISTRATION

MedSys online (myMCNZ) has been in operation for 18 months allowing doctors to renew their practising certificates online.

In the last 12 months, work has focused on minor fixes to the existing processes. Shortly, work will begin to develop the next phase of this project, which will include applications for new registrations.

ACCREDITATION OF NEW ZEALAND SPECIALIST COLLEGES

A new standard for the accreditation of New Zealand specialist educational institutions was completed in 2014. Any future accreditation application will be measured against this standard. The New Zealand College of Public Health Medicine has already submitted its application in line with the standard.

A workshop with relevant stakeholders is being arranged in the first half of 2016, with the aim to train relevant institutions on the preparation of an accreditation application.

COUNCIL'S VISION AND PRINCIPLES FOR RECERTIFICATION

In August 2015, a consultation with stakeholders was undertaken on Council's vision and principles for recertification. The final *Vision and principles for recertification for doctors in New Zealand* was approved by Council in February 2016. This has been published on Council's website and circulated to stakeholders.

A review of Council's current recertification requirements to ensure they align with the *Vision and principles for recertification for doctors in New Zealand* is a priority for the 2016/17 year.

MEMORANDA OF UNDERSTANDING WITH STAKEHOLDERS

Memoranda of understanding with Primary Health Organisations and medical colleges (or vocational and educational advisory bodies) have been signed.

The memoranda of understanding are an important tool for Council as they facilitate the sharing of information with stakeholders about doctors'

registration (including obtaining advice) and about doctors who may have competence, conduct or health concerns, as well as establishing good relationships that support policy and strategy development. The roles and responsibilities of Council and the corresponding other party are clearly outlined in each memorandum of understanding.

Council's memorandum of understanding with District Health Boards was also reviewed.

MEMORANDUM OF UNDERSTANDING WITH NEW ZEALAND POLICE

The Council's Registrar and senior staff at New Zealand Police have reached in-principle agreement over the format and content of the draft memorandum of understanding.

New Zealand Police managers have been asked to review the draft memorandum of understanding, and it is expected that the document will be signed in the coming year.

CONSUMER ADVISORY GROUP

The Health and Disability Commissioner has agreed that Council may use the services of its Consumer Advisory Group twice a year. The purpose of the Consumer Advisory Group is to gather feedback from a consumer's perspective on Council's strategic and policy development.

Topics discussed during the year by the Consumer Advisory Group were:

- the research findings of *Consumer attitudes towards and experiences with doctors in New Zealand,* which focused on the consumer experience
- *Choosing Wisely,* which focused on promoting a culture where inappropriate clinical interventions are avoided and quality of care for patients is improved.

The Consumer Advisory Group also provided feedback on Council's:

- *Statement on telehealth*
- *Statement on advertising*
- *Statement on good prescribing practice*
- *Statement on providing care to yourself and those close to you.*

ANNUAL MEETING OF THE MEDICAL COLLEGES

The annual meeting of the medical colleges was held in August 2015 in Wellington. The meeting was attended by representatives from the colleges and some of their Australian counterparts including executives and fellows.

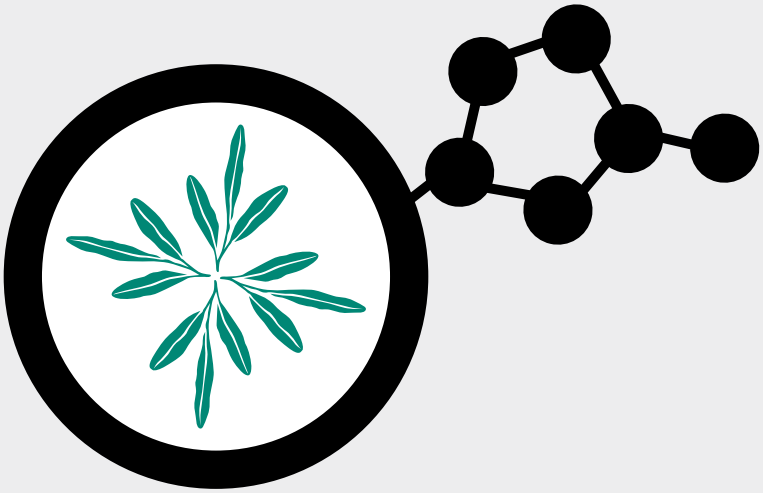
Topics included:

- cultural competence – eliminating inequity and health equity
- Council's vision and principles for recertification
- risk factors (ageing doctors and doctors working in isolation)
- regular practice review evaluation programme
- the Council of Medical Colleges *A Best Practice Guide for Continuous Practice Improvement*
- college notifications and accreditation.

THANKS

I would like to thank Mr Andrew Connolly, all Council members and staff for their continued support and commitment to achieving Council's goals and strategic directions.

Philip Pigou
Chief Executive



REGISTRAR'S REPORT

CHANGES TO REQUIRED QUALIFICATION FOR REGISTRATION IN GENERAL SCOPE OF PRACTICE

As mentioned in Professor Nacey's report, the staged implementation of the changes to prevocational medical training, which began in November 2014, led to further changes being implemented in November 2015.

Reflecting these changes, from 24 November 2015, the prerequisite for obtaining general registration changed for all graduates of New Zealand and Australian accredited medical schools and doctors who have sat and passed the New Zealand Registration Examination – NZREX Clinical.

Instead of a core requirement of satisfactory completion of three consecutive runs, applicants are now required to satisfactorily complete four accredited clinical attachments and to substantively attain the learning outcomes in the New Zealand Curriculum Framework for Prevocational Medical Training. They must also be recommended for registration in the general scope of practice by a Council-approved advisory body.

Aligned with this is a requirement for postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2) doctors to develop and maintain a personalised professional development plan (PDP). Each intern, in conjunction with a prevocational educational supervisor, must develop a PDP at the start of PGY1. The PDP sets overarching goals for the intern, taking into account the intern's prior learning and their mix of clinical attachments. The PDP will focus on what the intern needs to learn, what they need to consolidate and what they want to learn that may relate to future vocational aspirations.

MANAGING THE USE OF PRACTITIONER INFORMATION WITHIN COUNCIL

Council is committed to managing doctors' privacy and personal information according to best practice and in a way that both respects the privacy rights of doctors and other individuals and is consistent with the Health Practitioners Competence Assurance Act 2003, the Privacy Act 1993 and the Health Information Privacy Code 1994.

Council also has a statutory obligation to ensure that doctors are competent and fit to practise. On occasion, this may involve Council reviewing different aspects of a doctor's practice or circumstances.

Council recognises the need to ensure that doctors are fully informed about how their personal information is managed and used within Council and is developing additional website information to explain this. It is hoped that this will be published in late 2016.

It will provide greater detail about how the Health Committee and Council manage personal information held about doctors and what limits there are on the availability and use of the information and, similarly, how personal information obtained by Council's Professional Standards team relating to competence and conduct concerns is managed in relation to other Council processes.

David Dunbar
Registrar

REGISTRATION OF DOCTORS AND PRACTISING CERTIFICATES

Principal activities: maintaining the medical register, considering applications for registration, issuing practising certificates and certificates of good standing and developing registration policy.

All doctors who practise medicine in New Zealand must be registered by Council and hold a practising certificate. Registration ensures that a doctor is fit to practise medicine and that the doctor has met the required standards of competence to practise safely. Registered doctors must comply with Council's recertification requirements each year to maintain their registration (including continuing professional development).

Confirmation of eligibility for doctors seeking registration in general and special-purpose scopes of practice is provided within 20 working days of receiving a completed application. Eligibility for registration within a vocational scope of practice is provided after consultation with the relevant vocational education and advisory body and takes, on average, 6 months.

Table 1 SCOPES OF PRACTICE – SUMMARY OF REGISTRATION STATUS

At 30 June 2016

Provisional general	3,413
General	8,144
Provisional vocational	223
Vocational	11,107
Special purpose	239
Total on register	**23,126**
Total practising	15,142
Suspended	11

Note: Doctors holding more than one scope of practice concurrently have been counted once for this table.

Table 2 REGISTRATION ACTIVITIES

1 July 2015 to 30 June 2016

	Number
Provisional general/vocational issued	
New Zealand graduates (interns)	425
Australian graduates (interns)	5
Passed NZREX	30
Graduate of competent authority accredited medical school	428
Worked in comparable health system	198
New Zealand and international medical graduates reregistration (following erasure)	-
Transitional	-
Non-approved postgraduate qualification – vocational assessment	78
Non-approved postgraduate qualification – vocational eligible	66
Special scope issued	
Visiting expert	12
Research	2
Postgraduate training or experience	34
Locum tenens in specialist post	95
Emergency or other unpredictable short-term situation	-
Teleradiology	2
General scope after completion of supervised period	
New Zealand/Australian graduates (interns)	413
Passed NZREX Clinical	27
Graduate of competent authority accredited medical school	257
Worked in comparable health system	59
Transitional	-
Vocational scope after completion of supervised period	
Non-approved postgraduate qualification – vocational assessment	39
Non-approved postgraduate qualification – vocational eligible	50
Approved vocational education and advisory body (VEAB) training programme	5
General scope issued	
New Zealand graduates	3
Overseas graduates	58
Restorations	16
Vocational scope issued	
Approved postgraduate qualification	490

Suspensions	
Suspended or interim suspension	6
Revocation of suspension	4

Conditions	
Imposed	103
Revoked	52

Cancellations under the Health Practitioners Competence Assurance Act	
Discipline order – s 101 (1)(a)	1
At own request – s 142	146
Death – s 143	35
Revision of register – s 144 (5)	799
False, misleading or not entitled – s 146	1

Table 3

DOCTORS REGISTERED IN VOCATIONAL SCOPES

1 July 2015 to 30 June 2016

Vocational scope	Vocational registration at 30/6/2015[1]	Added 2015/2016	Removed 2015/2016	Net change	Vocational scope at 30/6/2016[1,2]
Anaesthesia	899	52	21	31	930
Cardiothoracic surgery	36	1	-	1	37
Clinical genetics	14	2	-	2	16
Dermatology	71	4	1	3	74
Diagnostic and interventional radiology	568	30	15	15	583
Emergency medicine	290	31	3	28	318
Family planning and reproductive health	32	-	-	-	32
General practice	3,970	208	33	175	4,145
General surgery	358	21	16	5	363
Intensive care medicine	93	9	1	8	101
Internal medicine	1,206	79	17	62	1,266
Medical administration	34	5	2	3	37
Musculoskeletal medicine	23	-	1	-1	22
Neurosurgery	28	-	1	-1	27
Obstetrics and gynaecology	370	17	15	2	372
Occupational medicine	66	3	2	1	67
Ophthalmology	167	6	8	-2	165
Oral and maxillofacial surgery	20	4	1	3	23
Orthopaedic surgery	315	15	6	9	324
Otolaryngology head and neck surgery	129	4	-	4	133
Paediatric surgery	22	1	-	1	23
Paediatrics	420	22	-	22	442
Pain medicine	23	2	-	2	25
Palliative medicine	67	4	1	3	70
Pathology	340	15	4	11	351
Plastic and reconstructive surgery	76	3	-	3	79
Psychiatry	736	31	4	27	763
Public health medicine	207	8	2	6	213
Radiation oncology	71	6	-	6	77
Rehabilitation medicine	28	-	1	-1	27
Rural hospital medicine	109	5	-	5	114
Sexual health medicine	20	1	-	1	21
Sports medicine	29	-	-	-	29
Urgent care	163	26	2	24	187
Urology	78	2	1	1	79
Vascular surgery	40	-	-	-	40
Total	**11,118**	**617**	**158**	**459**	**11,575**

Notes:

[1] Includes doctors who may currently be inactive (have no practising certificate).

[2] Includes 451 doctors with registration in two vocational scopes and seven doctors with registration in three vocational scopes.

Table 4

REGISTRATIONS ISSUED, BY COUNTRY OF PRIMARY QUALIFICATION

1 July 2015 to 30 June 2016

	Provisional general	Provisional vocational	Special purpose	Total
England	244	27	20	291
United States of America	72	41	56	169
Scotland	72	4	5	81
Ireland	72	1	2	75
India	24	15	11	50
Wales	30	-	3	33
Canada	12	3	6	21
Australia	5	7	6	18
Netherlands	12	5	1	18
Northern Ireland	11	2	2	15
Germany	7	7	-	14
South Africa	6	5	2	13
Sweden	6	4	1	11
Fiji	-	-	9	9
Denmark	5	1	2	8
Other[3]	83	25	18	126
New Zealand	425	1	1	427
Total	**1,086**	**148**	**145**	**1,379**

[3] Other represents 49 countries that had fewer than seven registrations in the reporting period.

Table 5

VOCATIONAL SCOPES GRANTED TO DOCTORS, BY VOCATIONAL SCOPE OF PRACTICE

1 July 2015 to 30 June 2016

Vocational scope	New Zealand	Overseas	Total
Anaesthesia	28	24	52
Cardiothoracic surgery	1	-	1
Clinical genetics	1	1	2
Dermatology	4	-	4
Diagnostic and interventional radiology	10	20	30
Emergency medicine	9	22	31
General practice	127	81	208
General surgery	8	13	21
Intensive care medicine	6	3	9
Internal medicine	41	38	79
Medical administration	3	2	5
Obstetrics and gynaecology	4	13	17
Occupational medicine	1	2	3
Ophthalmology	3	3	6
Oral and maxillofacial surgery	1	3	4
Orthopaedic surgery	9	6	15
Otolaryngology head and neck surgery	3	1	4
Paediatric surgery	-	1	1
Paediatrics	10	12	22
Pain medicine	1	1	2
Palliative medicine	2	2	4
Pathology	5	10	15
Plastic and reconstructive surgery	-	3	3
Psychiatry	6	25	31
Public health medicine	6	2	8
Radiation oncology	3	3	6
Rural hospital medicine	2	3	5
Sexual health medicine	-	1	1
Urgent care	9	17	26
Urology	2	-	2
Total	**305**	**312**	**617**

Table 6

OUTCOMES OF APPLICATIONS FOR VOCATIONAL REGISTRATION ASSESSMENTS

1 July 2015 to 30 June 2016

Branch	Incomplete applications	Pending	Withdrawn/ lapsed	Vocational eligible	Vocational assessment	NZREX	Total
Anaesthesia	11	4	10	3	8	2	38
Cardiothoracic surgery	-	-	1	-	-	-	1
Dermatology	1	1	-	1	2	2	7
Diagnostic and interventional radiology	5	4	-	16	6	-	31
Emergency medicine	8	9	3	-	11	-	31
General practice	6	4	2	-	15	-	27
General surgery	7	1	5	5	6	2	26
Intensive care medicine	3	2	-	-	1	-	6
Internal medicine	8	13	12	6	11	2	52
Medical administration	1	-	-	-	-	-	1
Neurosurgery	1	-	2	-	1	-	4
Obstetrics and gynaecology	5	4	1	4	3	1	18
Occupational medicine	-	1	1	-	-	1	3
Ophthalmology	3	-	1	1	4	1	10
Oral and maxillofacial surgery	-	-	-	1	-	-	1
Orthopaedic surgery	3	3	3	-	3	-	12
Otolaryngology head and neck surgery	5	1	1	1	1	-	9
Paediatric surgery	1	-	2	-	2	-	5
Paediatrics	1	4	2	1	2	-	10
Pain medicine	-	-	-	-	1	-	1
Palliative medicine	-	3	1	1	2	1	8
Pathology	1	3	-	7	1	-	12
Plastic and reconstructive surgery	1	1	1	1	-	-	4
Psychiatry	19	10	4	19	13	1	66
Public health medicine	-	-	1		1	-	2
Rehabilitation medicine	-	-	1	-	-	-	1
Sexual health medicine	-	-	-	1	-	-	1
Sports medicine	-	-	-	-	1		1
Urology	1	1	-	1	1	-	4
Vascular surgery	-	1	-	-	-	-	1
Total	**91**	**70**	**54**	**69**	**96**	**13**	**393**
Percentages based on total number of outcomes (%)				38.8	53.9	7.3	

Table 7

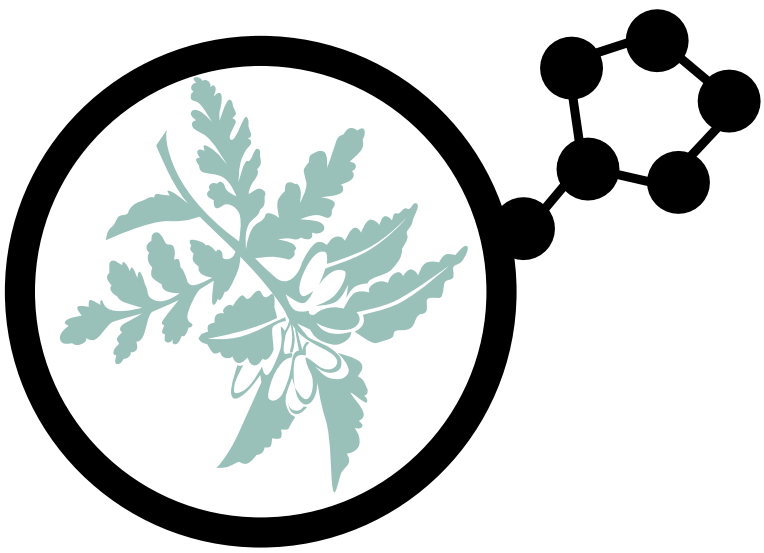
DOCTORS ON THE NEW ZEALAND MEDICAL REGISTER, BY COUNTRY OF PRIMARY QUALIFICATION

1 July 2015 to 30 June 2016

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
England	1,072	1,327	19	1,394	27	**3,839**	1,915
United States of America	504	116	69	297	112	**1,098**	370
South Africa	63	179	8	765	4	**1,019**	710
Scotland	250	360	6	385	3	**1,004**	523
Australia	10	445	-	379	1	**835**	450
India	78	218	21	410	14	**741**	488
Ireland	189	234	2	78	3	**506**	225
Germany	76	82	16	141	-	**315**	176
Wales	116	118	-	63	6	**303**	111
Sri Lanka	10	70	1	171	6	**258**	136
Canada	120	24	4	69	15	**232**	70
Netherlands	91	39	12	47	-	**189**	87
Iraq	5	59	1	103	-	**168**	108
Pakistan	17	63	2	41	1	**124**	73
China	6	39	-	59	-	**104**	75
Bangladesh	3	30	1	68	-	**102**	45
Northern Ireland	32	34	1	29	1	**97**	48
Sweden	53	12	11	13	1	**90**	13
Egypt	12	22	2	48	1	**85**	50
Fiji	1	16	-	45	17	**79**	73
Russia	6	31	2	19	2	**60**	47
Philippines	4	24	1	28	-	**57**	40
Poland	15	20	3	17	-	**55**	28
Singapore	10	15	-	22	-	**47**	24
Belgium	19	13	2	10	-	**44**	17
Zimbabwe	1	5	-	36	1	**43**	36
Denmark	21	11	3	6	1	**42**	12
Nigeria	9	16	2	12	1	**40**	20
Romania	5	13	1	16	-	**35**	19
Serbia	1	9	1	24	-	**35**	21
Italy	11	6	4	13	-	**34**	19
Austria	13	9	2	3	-	**27**	11
Czech Republic	8	9	-	8	1	**26**	17
Hungary	7	6	1	12	-	**26**	15

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
Myanmar	3	8	-	14	1	**26**	15
Switzerland	12	5	2	7	-	**26**	13
Spain	7	5	2	11	-	**25**	20
France	7	8	1	7	-	**23**	15
Ukraine	3	12	1	6	-	**22**	18
Malaysia	-	9	-	8	1	**18**	14
Mexico	5	1	1	6	4	**17**	10
Bulgaria	-	7	-	9	-	**16**	12
Croatia	1	4	-	10	-	**15**	10
Iran	3	6	1	4	1	**15**	8
Israel	3	3	1	5	2	**14**	9
Syria	3	5	2	3	-	**13**	10
Zambia	1	6	-	6	-	**13**	8
Finland	3	7	1	1	-	**12**	7
Netherlands Antilles	8	3	-	1	-	**12**	6
Norway	4	-	-	8	-	**12**	9
Papua New Guinea	2	-	-	9	1	**12**	8
Sudan	3	6	-	3	-	**12**	10
Brazil	2	3	2	4	-	**11**	6
Colombia	1	5	-	4	1	**11**	6
Dominica	5	2	-	1	2	**10**	3
Other[1]	40	68	11	76	8	**203**	122
New Zealand	**459**	**4,297**	**-**	**6,073**	**-**	**10,829**	**8,731**
Total	**3,413**	**8,144**	**223**	**11,107**	**239**	**23,126**	**15,142**

[1] Other represents 57 countries with fewer than 10 registered doctors.



PROFESSIONAL STANDARDS

Principal activities: receiving referrals of concerns, administering the complaints triage team, undertaking performance assessments, establishing individual education programmes and recertification programmes, maintaining assessment tools, developing policy on performance assessment, setting up professional conduct committees and monitoring doctors who are subject to conditions arising from competence and conduct concerns and disciplinary action.

Table 8

REFERRAL SOURCES TO FULL COUNCIL MEETING FOR PERFORMANCE PROCESSES

1 July 2015 to 30 June 2016

ACC	6
Employer (DHB)	10
Employer (private hospital or general practice)	10
Member of public or patient	1
Health and Disability Commissioner (HDC)	24
Medical practitioner colleague	7
Pharmacy	1
Professional conduct committee	1

Table 9

REFERRAL SOURCES TO FULL COUNCIL MEETING FOR CONDUCT PROCESSES

1 July 2015 to 30 June 2016

Employer (DHB)	7
Employer (private hospital or general practice)	6
Member of public or patient	3
HDC	6
Internally referred within Council	3
Medical practitioner colleague	1
Pharmacist	2
Ministry of Health	2
Media	1
Courts	2
Self-disclosure	5
Professional conduct committee	1

PERFORMANCE

Council seeks to implement mechanisms to ensure doctors are competent to practise. When receiving referrals that relate to a doctor's competence to practise, Council does not investigate specific incidents (that is the HDC's role) but considers whether the circumstances raise questions about deficiencies in the doctor's competence.

Table 10 shows the number of cases considered by Council during the year that related to a doctor's competence to practise and Council's decisions as to how those cases should be addressed. The table shows the number of Council's processes during the year rather than the number of individual doctors. Many doctors will have been the subject of more than one decision or process because the numbers reflect processes during the year. The numbers include processes that commenced before the year commencing 1 July 2015 and processes that continued after 30 June 2016 and illustrates the volume of Council's work during the year in this area.

Table 10 COMPETENCE-RELATED COUNCIL PROCESSES

1 July 2015 to 30 June 2016

No further action or educational letter on first consideration	11
Await HDC after first consideration	1
Defer – request further information after first consideration	3
Recertification programme ordered on first consideration	10
Referral to performance assessment committee (PAC)[1]	35
Conditions ordered before PAC (section 39)	1
Doctor meets required standard of competence following PAC	9
Doctor does not meet required standard of competence following PAC	7
Recertification programme ordered after PAC (section 41)	4
Educational programme ordered after PAC (section 38)	6
Conditions ordered after PAC (section 38)	1
Conditions ordered after PAC (section 39)	1
Further action after PAC deferred (doctor not working, retired)	1
Recertification programme completed satisfactorily	7
Educational programme completed satisfactorily	9
Did not complete recertification programme satisfactorily	-
Did not complete educational programme satisfactorily	2
Recertification programme ordered after educational programme	-

[1] Council's processes can extend over 12 months, so the number of referrals to PACs may not necessarily correlate with outcomes within the same year.

CONDUCT

Where Council receives information that raises one or more questions about the appropriateness of the conduct or the safety of the practice of a doctor, it may refer any or all of those questions to a professional conduct committee (PCC).

Table 11 shows the number of cases considered by Council during the year that related to a doctor's conduct and Council's decisions as to how those cases should be addressed. The table shows the number of Council's processes during the year rather than the number of individual doctors. Many doctors will have been the subject of more than one decision or process because the numbers reflect processes during the year. The numbers include processes that started before the year commencing 1 July 2015 and processes that continued after 30 June 2016 and illustrates the volume of Council's work in this area.

Council is prevented by statute from referring a doctor to a professional conduct committee while the HDC is conducting an investigation in relation to a consumer complaint. Council may, however, make an order for interim suspension or impose conditions on the doctor's practice if it considers that the doctor poses a risk of serious harm to the public.

When a doctor is convicted of any offence punishable by imprisonment for a term of 3 months or longer or of an offence under certain specified Acts, the doctor is automatically referred to a professional conduct committee. It is not a Council decision. Table 12 shows the PCCs that were commenced as a result of a conviction.

Table 11

CONDUCT-RELATED COUNCIL PROCESSES

1 July 2015 to 30 June 2016

No further action or educational letter on first consideration	8
Recertification programme ordered on first consideration	3
Referral to professional conduct committee (PCC)[1]	18
Refer new information to existing PCC	1
Interim conditions ordered (section 69)	1
Interim suspension ordered (section 69)	1
Cancellation of registration (section 146)	1
PCC determined charge be brought in the Health Practitioners Disciplinary Tribunal	5
PCC recommended no further action and Council endorses	9
PCC recommended counselling or mentoring and Council endorses	6
PCC recommended review of fitness to practise and Council endorses	1
PCC recommended review of competence to practise and Council endorses	2

[1] Council's processes can extend over 12 months, so the number of referrals to PCCs may not necessarily correlate with outcomes within the same year.

Table 12

PROFESSIONAL CONDUCT COMMITTEE AS A RESULT OF A CONVICTION

1 July 2015 to 30 June 2016

Professional conduct committee as a result of a conviction	6

DOCTORS' HEALTH

Principal activities: considering the cases of doctors with possible health conditions, establishing treatment and monitoring programmes for doctors whose health conditions affect their fitness to practise and promoting doctors' health.

Council aims to protect patients by appropriately managing doctors who may not be fit to practise because of a mental or physical condition.

Doctors, like the general population, can suffer from various afflictions, including drug and alcohol dependence, psychiatric problems and a wide range of physical disorders, any of which can affect their performance.

Table 13 NOTIFICATIONS OF INABILITY TO PERFORM REQUIRED FUNCTIONS DUE TO MENTAL OR PHYSICAL (HEALTH) CONDITION

1 July 2015 to 30 June 2016

Source	HPCAA				
		Existing	New	Closed	Still active
Health service	s 45 (1)(a)	-	-	-	-
Health practitioner	s 45 (1)(b)	-	35[1]	7	28
Employer	s 45 (1)(c)	-	11	2	9
Medical Officer of Health	s 45 (1)(d)	-	-	-	-
Any person	s 45 (3)	-	6	1	5
Person involved with education	s 45 (5)	-	-	-	-
Total		-	**52**	**10**	**42**

[1] 26 of the 35 were self referred.

Table 14 OUTCOMES OF HEALTH NOTIFICATIONS

1 July 2015 to 30 June 2016

Outcomes	HPCAA	Number[1]
No further action		10
Order medical examination	s 49 (1)	170[2]
Interim suspension	s 48 (1)(a)	12[3]
Conditions	s 48 (1)(b)	-
Restrictions imposed	s 50 (3) or (4)	See note [4]

[1] There may be more than one outcome.

[2] 36 assessments agreed voluntarily (two of which are pending) and 134 reports from treating clinicians, occupational physicians and so forth.

[3] Achieved through voluntary agreement.

[4] Requisite monitoring for 42 doctors still active achieved through informal agreement without use of statutory provisions of the Health Practitioners Competence Assurance Act 2003.

EXAMINATIONS

Principal activity: ensuring that international medical graduates who wish to be registered in New Zealand are safe to practise medicine.

NEW ZEALAND REGISTRATION EXAMINATION – NZREX CLINICAL

New Zealand's health system requires all doctors to meet practice standards defined by Council.

Doctors that qualified outside New Zealand and Australia must pass Council's medical registration exam, NZREX Clinical, if they wish to be registered in New Zealand and do not satisfy the criteria for other registration pathways. This examination is set at the level of a recent New Zealand graduate.

NZREX Clinical is a 16-station objective structured clinical examination that tests various competencies including history, clinical examination, investigating, management, clinical reasoning, communication and professionalism.

The prerequisites for applying to sit NZREX Clinical are:

- a medical degree listed in the World Directory of Medical Schools
- meeting Council's English language policy
- within the last 5 years having passed United States Medical Licensing Examination (USMLE) Steps 1 and 2 (Clinical Knowledge) or having passed the Australian Medical Council multi-choice examination or having passed Professional and Linguistic Assessments Board (PLAB) Part 1.

Table 15

CANDIDATES SITTING AND PASSING NZREX CLINICAL

1 July 2015 to 30 June 2016

		Attempts						Passes				
COUNTRY	**Number sitting**	**1**	**2**	**3**	**4**	**5**	**Number passed**	**1**	**2**	**3**	**4**	**5**
Bahrain	**1**	1	-	-	-	-	**1**	1	-	-	-	-
Bangladesh	**4**	2	2	-	-	-	**1**	-	1	-	-	-
China	**8**	5	2	1	-	-	**4**	1	2	1	-	-
Iceland	**1**	1	-	-	-	-	**1**	1		-	-	-
India	**17**	11	4	1	1	-	**6**	3	3	-	-	-
Iran	**3**	2	1	-	-	-	**1**	-	1	-	-	-
Iraq	**8**	5	3	-	-	-	**4**	2	2	-	-	-
Kosovo	**1**	-	-	1	-	-	**-**	-	-	-	-	-
Nigeria	**1**	-	1	-	-	-	**-**	-	-	-	-	-
Pakistan	**12**	5	6	1	-	-	**7**	3	4	-	-	-
Philippines	**7**	1	6	-	-	-	**2**	-	2	-	-	-
Russia	**6**	5	1	-	-	-	**5**	4	1	-	-	-
Samoa	**2**	2	-	-	-	-	**1**	1	-	-	-	-
Seychelles	**1**	-	1	-	-	-	**1**	-	1	-	-	-
St Maarten	**1**	1	-	-	-	-	**-**	-	-	-	-	-
South Africa	**2**	2	-	-	-	-	**2**	2	-	-	-	-
Sri Lanka	**1**	1	-	-	-	-	**1**	1	-	-	-	-
St Kitts and Nevis	**1**	-	-	1	-	-	**-**	-	-	-	-	-
Ukraine	**2**	2	-	-	-	-	**1**	1	-	-	-	-
United Arab Emirates	**1**	-	1	-	-	-	**-**	-	-	-	-	-
Zimbabwe	**1**	1	-	-	-	-	**-**	-	-	-	-	-
Total	**81**	**47**	**28**	**5**	**1**	**-**	**38**	**20**	**17**	**1**	**-**	**-**

HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL (HPDT)

Principal activities: disciplinary proceedings brought against doctors are heard and determined by the Health Practitioners Disciplinary Tribunal (Health Practitioners Competence Assurance Act 2003).

MEDICAL CHARGES BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

During the year, the HPDT received 11 charges relating to eight doctors – all 11 charges were received from a professional conduct committee.

The HPDT sat during the year to hear 12 charges relating to eight doctors over 19 days. Eleven of the 12 charges were received in 2014/2015. One charge was received in 2015/2016. Ten charges received during 2015/2016 are yet to be heard.

Table 16

MEDICAL CHARGES BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

1 July 2015 to 30 June 2016

Nature of charges	
Professional misconduct 2014/2015	11
Conviction 2014/2015	1
Professional misconduct 2015/2016	11
Total	**23**

Source	
Prosecution of charges brought by professional conduct committee 2014/2015	9
Prosecution of charges brought by the director of proceedings 2014/2015	3
Prosecution of charges brought by professional conduct committee 2015/2016	1
Charges brought by professional conduct committee yet to be heard	10
Total	**23**

Outcome of hearings	
Guilty – professional misconduct 2014/2015	9
Guilty – conviction 2014/2015	1
Not guilty – professional misconduct 2014/2015	2
Guilty – professional misconduct 2015/2016	1
Yet to be heard 2015/2016	10
Total	**23**

Further information about these statistics can be found on the Tribunal's website www.hpdt.org.nz.

CORPORATE GOVERNANCE

Role of Council: Members of Council set the strategic direction of the organisation, monitor management performance and ensure Council meets the requirements of the Health Practitioners Competence Assurance Act 2003.

Council is accountable for its performance to Parliament, the Minister of Health, the medical profession and the public.

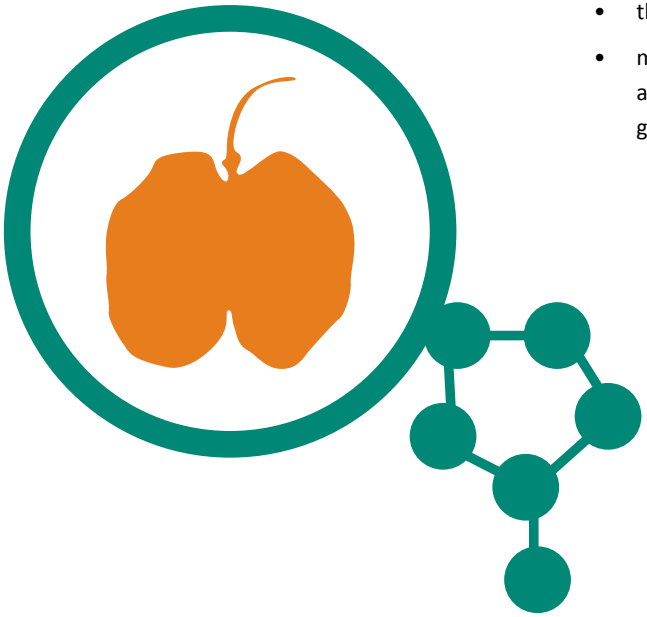
COUNCIL MEMBERSHIP

Council aims to have members who represent:

- a range of age, gender and ethnic groups
- a broad mix of the medical profession, New Zealand society as a whole and people with a wide general knowledge and breadth of vision and who also have one of the following:
  - Broad health sector knowledge.
  - Experience in one of the main vocational scopes of practice.
  - Experience in health service delivery in a variety of provincial and tertiary settings.
  - Experience in medical education and assessment.

COUNCIL COMMITTEE STRUCTURE

Council operates three standing committees – Audit, Education and Health. Members of these committees are listed on page 36. Council receives committee meeting minutes at its formal meetings and, in approving those minutes, confirms the decisions made. Delegation limits are established.



LINKING WITH STAKEHOLDERS

We have continued to be actively involved with registration bodies overseas. We share ideas for future developments and maintain contact with organisations including:

- Australian registration boards
- the International Association of Medical Regulatory Authorities
- the Federation of State Medical Boards and the Educational Commission for Foreign Medical Graduates (United States of America)
- the Medical Council of Canada
- the General Medical Council (United Kingdom)
- the Irish Medical Council.

As in previous years, Council has had regular meetings with key stakeholders to discuss matters of mutual interest. Those stakeholders include:

- the Accident Compensation Corporation
- medical colleges and associations
- chief medical officers of District Health Boards
- the Council of Medical Colleges
- the Health and Disability Commissioner
- the Independent Practitioners Association Council of New Zealand
- the Medical Protection Society
- the Minister of Health
- the Ministry of Health
- the New Zealand Medical Association
- members of the profession, other regulatory authorities, medical students and community groups.

COUNCIL COMMITTEES

Council standing committees at 30 June 2016

CHAIRPERSON

Mr Andrew Connolly

DEPUTY CHAIRPERSON

Ms Laura Mueller

AUDIT COMMITTEE

Mr Andrew Connolly (ex officio)[1]

Dr Jonathan Fox (Chairperson)

Dr Kate Baddock

Ms Susan Hughes QC

Ms Laura Mueller

Ms Joy Quigley

Mr Roy Tiffin

HEALTH COMMITTEE

Dr Allen Fraser (Chairperson)

Mr Andrew Connolly (ex officio)[1]

Dr Pamela Hale

Ms Laura Mueller

Dr Lu'isa Fonua-Faeamani

Ms Joy Quigley (alternative layperson)

EDUCATION COMMITTEE – COUNCIL MEMBERS

Professor John Nacey (Chairperson)

Dr Jonathan Fox (Deputy Chairperson)

Ms Laura Mueller

Ms Kim Ngārimu

Ms Joy Quigley

Dr Curtis Walker

Mr Andrew Connolly[1]

EDUCATION COMMITTEE – NON-COUNCIL MEMBERS

Dr Andrew Curtis	Intern member
Professor Peter Ellis	Nominee of Medical Schools in New Zealand or intern member
Dr Liza Lack	Nominee of appropriate college or branch advisory body – Royal New Zealand College of General Practitioners
Dr Sarah Nicolson	Nominee of appropriate college or branch advisory body – Australian and New Zealand College of Anaesthetists
Dr Greig Russell	Nominee of appropriate college or branch advisory body – Royal New Zealand College of Urgent Care Physicians
Dr John Thwaites	Nominee of appropriate college or branch advisory body – Royal Australasian College of Physicians
Dr Ian Wallace	Prevocational educational supervisor, Waitemata District Health Board
Dr Thomas Wilkinson	Intern member

[1] The Chairperson is an ex officio member of all committees. External members of committees are recognised by Council as being desirable on some committees although a minimum of two Council members and at least one public member must sit on each committee.

COUNCIL OFFICE

OFFICE OF THE COUNCIL AT 30 JUNE 2016

Chief Executive	Philip Pigou
Registrar	David Dunbar
Deputy Registrar	Susan Yorke
Executive Assistant	Dot Harvey
Project Manager	Sidonie
Senior Legal Adviser	Aleyna Hall
Legal Adviser	Emily Bergin
Legal Administrator	Elliot Foxall (part-time)

ADVISER GROUP

Communications Manager	George Symmes (part-time)
Human Resources Adviser	Shannon Michl (part-time)
Medical Adviser	Dr Steven Lillis (part-time)
Medical Adviser	Dr Kevin Morris (part-time)
Senior Policy Adviser	Kanny Ooi

CORPORATE SERVICES

Chief Financial Officer	Peter Searle
ICT Team Leader	Bill Taylor
Business Analyst	Diane Latham
Business Process Analyst	Carolyn Berry (part-time)
Senior ICT Systems Analyst	Andrew Cullen
ICT Systems Analyst	Alecia Thompson (part-time)
ICT Systems Analyst	Ray van der Veen

Accountant	Jim Peebles
Assistant Accountant	Atish Pathak
Finance Officer	Marika Puleitu
Senior Office Administrator	Dianne Newport
Office Administrator	Melissa Baldwin
Office Administrator	Leanne Nightingale (part-time)
Office Administrator	Jennifer Porter

HEALTH

Health Manager	Lynne Urquhart
Health Case Manager	Meredith Baron
Health Case Manager	Constance Hall (parental leave)
Health Case Manager	Jo Hawken
Health Case Manager	Hollie Bennett
Health Case Manager	Jasmine Walker
Health Case Manager	Garth Wyatt
Health Administrator	Viv Coppins

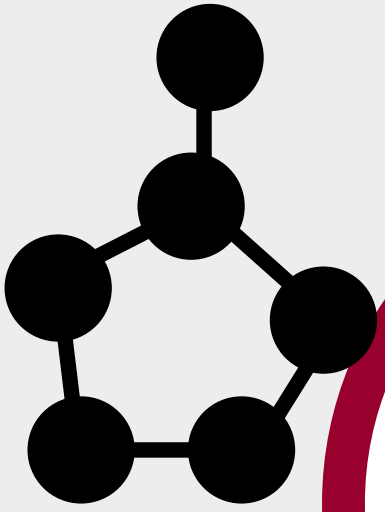
HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL (HPDT) FOR MEDICAL PRACTITIONERS

HPDT Manager	Gay Fraser
Legal Officer	Kim Davis
Executive Officer HPDT	Debra Gainey
Personal Assistant to HPDT Manager	Deborah Harrison

CORE SERVICES

General Manager, Core Services	Valencia van Dyk
Registration Team Manager – General	Kylie Johnston (parental leave)
Acting Registration Team Manager – General	Anastasia Appleyard
Registration Coordinator – General	Trudy Clarke
Registration Coordinator – General	Emma Fisher
Registration Coordinator – General	Martyn Hall
Registration Coordinator – General	Prakash Joseph
Registration Coordinator – General	Rowan Manhire-Heath
Registration Coordinator – General	Patrick McKane
Registration Coordinator – General	Devan Menon
Registration Team Manager – Practising Certificate	Helen Vercoelen
Practising Certificate Coordinator	Bronwyn Courtney
Practising Certificate Coordinator	Alastair Gibbons
Practising Certificate Audit Coordinator	Sharon Mason
Registration Team Manager – Vocational	Laura Lumley
Registration Coordinator – Vocational	Sandra Clark
Registration Coordinator – Vocational	Francesca Dalli-Niven
Registration Coordinator – Vocational	Imojini Kotelawala
Registration Coordinator – Vocational	Geethanjali Raghunath
Registration Coordinator – Vocational	Madeleine West
Registration Coordinator – Vocational	Sandra Tam
Professional Standards Team Manager	Charlotte Provan (parental leave)
Acting Professional Standards Team Manager	Anna Yardley
Professional Standards Coordinator	Miriam Brown
Professional Standards Coordinator	Maria Bernal
Professional Standards Coordinator	Fiona Johnston
Professional Standards Coordinator	Danielle Lee
Professional Standards Coordinator	Angela Pigott
Professional Standards Coordinator	Nikita Takai (parental leave)
Education Coordinator	Eleanor Quirke

APPENDICES – FINANCE



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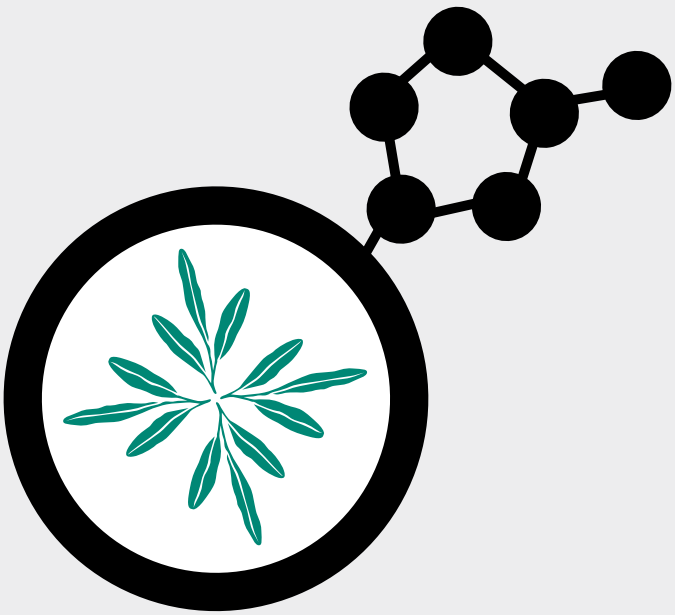
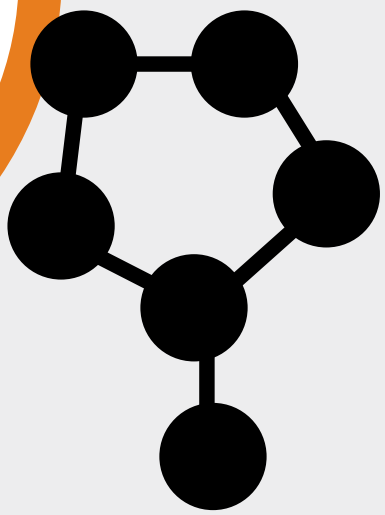
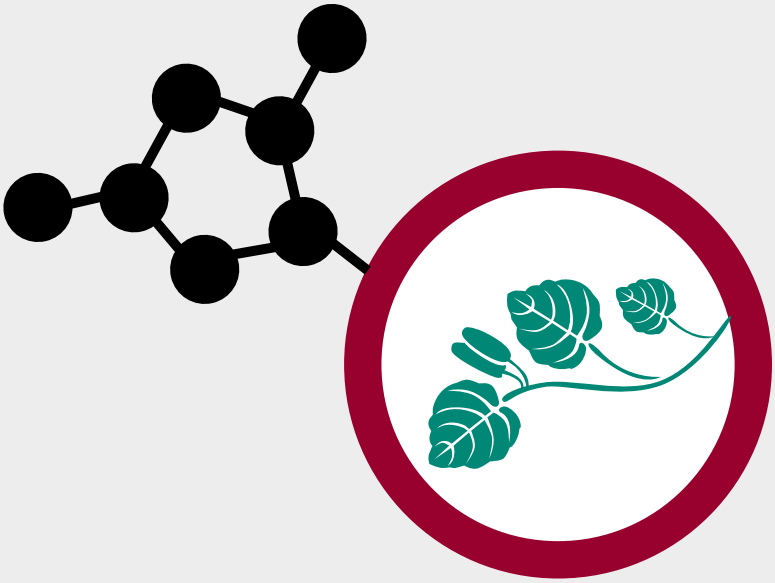


FINANCIAL STATEMENTS 2016





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staplesrodway
CHARTERED ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT TO THE READERS OF MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

The Auditor-General is the auditor of Medical Council of New Zealand (the Council). The Auditor-General has appointed me, Robert Elms, using the staff and resources of Staples Rodway Wellington, to carry out the audit of the financial statements of the Council on her behalf.

We have audited the financial statements of the Council on pages 1 to 16, that comprise the statement of financial position as at 30 June 2016, the statement of comprehensive income, statement of movements in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information.

Opinion

In our opinion the financial statements of the Council on pages 1 to 16:

- fairly reflect the Council's:
  - financial position as at 30 June 2016; and
  - financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards – Reduced Disclosure Regime.

Our audit was completed on 19 October 2016. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Council and our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Council's financial statements that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Council's internal control.

staplesrodway
CHARTERED ACCOUNTANTS

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Council;
- the adequacy of all disclosures in the financial statements; and
- the overall presentation of the financial statements.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements. Also we did not evaluate the security and controls over the electronic publication of the financial statements.

We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Council

The Council is responsible for preparing financial statements that:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Council's financial position, and financial performance and cash flows.

The Council is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Council is also responsible for the publication of the financial statements, whether in printed or electronic form.

The Council's responsibilities arise from the Health Practitioners Competence Assurance Act 2003.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and section 134(1) of the Health Practitioners Competence Assurance Act 2003.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

Other than the audit, we have no relationship with or interests in the Council.

Robert Elms
Staples Rodway Wellington
On behalf of the Auditor-General
Wellington, New Zealand

MEDICAL COUNCIL OF NEW ZEALAND
Statement of financial position
as at 30 June 2016

	Notes	2016	2015
Current assets			
Petty cash		600	600
Bank accounts		730	14,857
GST	6	0	43,777
Receivables	6	420,613	253,104
Interest accrued		36,086	41,295
Investments	7	5,621,550	4,190,000
Total current assets		$6,079,579	$4,543,633
Term assets			
Property, plant and equipment	8	845,374	928,207
Intangibles	9	3,586,001	3,873,463
Total term assets		$4,431,375	$4,801,670
Current liabilities			
GST		100,538	0
Sundry creditors		753,049	869,460
Employee entitlements		507,627	410,821
Lease rent free liability		34,927	34,927
Payments received in advance		395,788	355,074
Total current liabilities		$1,791,929	$1,670,282
Term liabilities			
Employee entitlements		34,346	62,216
Lease rent free liability		209,562	245,292
Total term liabilities		$243,908	307,508
TOTAL NET ASSETS		**$8,475,117**	**$7,367,513**
CAPITAL ACCOUNT			
General Fund		6,193,497	5,179,902
Complaints Investigation and Prosecution Fund		1,855,330	1,721,352
Examination Fund		426,290	466,259
Total capital account		**$8,475,117**	**$7,367,513**

Authorised for issue for and on behalf of the Council.

Andrew Connolly
Chairperson
Dated: 11/10/16.

Philip Pigou
Chief Executive
Dated: 11/10/16

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND
Statement of comprehensive income
for the year ended 30 June 2016

	Notes	2016	2015
Income			
Exchange Income			
Fees received		1,595,756	1,016,243
Vocational registration income		400,074	392,982
Interest received		163,070	170,044
Recovery of staff costs		86,944	85,697
Other income		797	1,560
		2,246,641	1,666,526
Non Exchange Income			
APC Fees		10,213,226	9,286,629
Recovered legal costs		272,467	40,839
Fines received		14,000	7,500
		10,499,693	9,334,968
		$12,746,334	$11,001,494
Expenditure			
Employee benefits		5,840,948	5,412,436
Legal prosecutor		224,187	255,432
Depreciation and amortisation	10	1,003,499	928,959
Loss on disposal of assets		0	(1,877)
Fees paid to members of Council and standing committees		600,166	521,192
Medsys service level agreement		25,678	85,612
Debt collection costs and debt impairment expense		58,372	49,999
Rent		519,419	524,925
Intern supervisors payments		461,070	285,422
Health Practitioners Disciplinary Tribunal fees		232,060	138,306
Vocational registration expenses		350,011	368,145
Reports and health assessments		143,696	132,411
Credit card fees and commissions		6,664	5,546
Professional Conduct Committees fees		197,555	145,318
Other Legal & advisors		0	4,850
Advice and consultancy		113,971	44,232
Repairs and maintenance office equipment		131,952	138,834
Archives		77,765	61,057
Information brochures and notices		15,221	5,966
Audit fees		28,777	31,168
Other administrative costs		1,607,719	1,823,582
		$11,638,730	$10,961,515
Net surplus / (deficit) for year		$1,107,604	$39,979
Other comprehensive income		0	0
Total comprehensive income		$1,107,604	$39,979

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND
Statement of movements in equity
for the year ended 30 June 2016

	Notes	2016	2015
A) ACCUMULATED FUNDS AND RESERVES			
Balance brought forward		7,367,513	7,327,534
Total comprehensive income		1,107,604	39,979
Closing balance		$8,475,117	$7,367,513
B) ANALYSIS OF INDIVIDUAL FUNDS			
1) General Fund			
Balance brought forward		5,179,902	5,094,936
Total comprehensive income	2	1,013,595	84,966
Closing balance		$6,193,497	$5,179,902
2) Complaints Investigation and Prosecution Fund			
Balance brought forward		1,721,352	1,744,217
Total comprehensive income	3	133,978	(22,865)
Closing balance		$1,855,330	$1,721,352
3) New Zealand Registration Examination Fund			
Balance brought forward		466,259	488,381
Total comprehensive income	4	(39,969)	(22,122)
Closing balance		$426,290	$466,259

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND
Statement of cash flows
for the year ended 30 June 2016

	Notes	2016	2015
Cash flows from operating activities			
Cash was provided from:			
Receipts pertaining to statutory functions		12,454,323	10,801,915
Cash was distributed to:			
Council fees, disbursements and office expenses		(10,567,735)	(9,462,927)
Net cash flows from operating activities		1,886,588	1,338,988
Cash flows from investing activities			
Cash was provided from:			
Interest received		168,279	199,579
Short-term investments		318,450	1,000,000
		486,729	1,199,579
Cash was applied to:			
Purchase of assets		(637,444)	(1,283,893)
Short-term investments		(1,750,000)	(1,248,722)
		(2,387,444)	(2,532,615)
Net cash flows from investing activities		(1,900,715)	(1,333,036)
Net increase / (decrease) in cash and cash equivalents		(14,127)	5,952
Opening cash brought forward		15,457	9,505
Ending cash carried forward		$1,330	$15,457
Represented by:			
Petty cash		600	600
ASB bank account		730	14,857
		$1,330	$15,457

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND

Notes to and forming part of the financial statements
For the year ended 30 June 2016

1. Statement of accounting policies

Basis of preparation

The Medical Council of New Zealand ('Council') is a statutory body constituted under the Health Practitioners Competence Assurance Act 2003.The Council is a public benefit entity (PBE).

The Council has elected to apply New Zealand Tier 2 Public Sector Public Benefit Entity accounting Standards (PBE Accounting Standards). The Council is eligible to report in accordance with Tier 2 PBE Standards as the Council does not:

- Have public accountability in respect of issuing debt or equity instruments
- Hold assets in a fiduciary capacity for a broad group of outsiders
- Have expenses over $30 million per annum.

The financial statements have therefore been prepared in accordance with Tier 2 PBE Standards under which certain disclosure concessions are available. The Council has chosen to continue to disclose the following information for which a disclosure concession is available:

- Reconciliation of Plant, Property and Equipment movements for the prior year (Note 8)
- Reconciliation of Intangible Assets for the prior year (Note 9)
- The nature and extent of exposures to credit risk, liquidity risk and market risk (Note 14)
- Capital management note (Note 16).

In the previous financial statements the Council chose to continue to disclose the reconciliation of net surplus with the net cash flow from operating activities for which a disclosure concession was available. The Council has chosen to not continue to disclose this information in these financial statements.

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest dollar. They are prepared on the historical cost basis.

Statement of compliance

These financial statements are a general purpose financial report as defined in the External Reporting Board's Framework, and are prepared in accordance with Public Sector Public Benefit Entity Accounting Standards and Generally Accepted Accounting Practice in New Zealand (NZGAAP).

Measurement base

The accounting principles recognised as appropriate for the measurement and reporting of financial performance and financial position on a historical cost basis are followed by the Council.

Specific accounting policies

The following specific accounting policies which materially affect the measurement and reporting of financial performance and financial position have been applied:

(a) **Revenue –** Practising certificate (PC) revenue is recognised in full upon the commencement of the practising year to which it relates. Revenue from the provision of other services is recognised when the service has been provided. Where provision of services is extended over a period of time the stage of completion is estimated and revenue recognised when the degree of service has been provided.

New Zealand registration examination revenue is recognised at the time the exam is held.

Vocational registration income is recognised at the time of invoicing. However a value equivalent to three month's invoicing (the average time taken to process applications) is assessed and held in payments made in advance

(b) **Depreciation** – Property, plant and equipment have been depreciated on a straight line basis at the following rates:
Furniture and fittings 10%pa
Office alterations..... 10%pa
Office equipment 20%pa
Computer hardware..... 33%pa

(c) **Property, plant and equipment** – is shown at cost less accumulated depreciation (Note 8).

(d) **Goods and services tax** – These financial statements have been prepared on a GST exclusive basis except for receivables and sundry creditors which include GST.

(e) **Fines and costs recovered** – Fines and recovery of legal costs have been accounted for on an accrual basis from the date of judgement.

(f) **Income tax** – The Council is not subject to income tax (Note 5).

(g) **Receivables** – Receivables are valued at the amount expected to be realised (Note 6).

(h) **Interest received** – Interest owing at balance date has been accrued.

(i) **Payments received in advance** – The outstanding balance at 30 June 2016 represents payments in advance or deposits made by debtors for services to be provided but not yet completed by the Council at balance date.

(j) **Salaries, holiday pay accrual, long service leave**– An accrual is made for any salaries relating to the current financial period paid after balance date. Holiday pay owing at balance date is valued at the applicable salary rate applying at the date of valuation. Long service leave is valued at the salary rate applicable at valuation date and discounted on an actuarial basis recognising the probability that the employee will reach entitlement as well as discounting for expected inflation and expected salary increases

(k) **Leases** – The value of the leases are recognised in the statement of commitments at the current negotiated value of the annual lease. At balance date, the Council occupies leased office space at 80 The Terrace, Wellington. The Council has signed a long term lease on these premises effective from July 2014.

(l) **Intangible assets** – Intangible assets comprise software development costs, intellectual property costs and software licences. The external costs for the development of registration software is capitalised and disclosed as an intangible asset in the statement of financial position. Intangible assets under construction are not amortised until they are available for use.
Intangible assets have a finite useful life and are amortised on a straight line basis at 10% and 33% per annum.

(m) **Provisions** – A provision is made for the amount of accounts receivable that are expected not to be received. This provision is created by reviewing all outstanding amounts at the end of the year and assessing the likelihood of payment. Where a payment plan is in place amounts scheduled to be recovered after 5 years are provided in full and other balances are provided for after assessment of the likelihood of collection.

(n) **Statement of cash flows**

'Cash' refers to amounts held in banks, net of bank overdraft. It also includes short term deposits held as part of day-to-day cash management but excludes short term cash investments held for the intention of investing.

'Operating activities' are amounts received for the supply of services by the Council, and payments made to employees and suppliers necessary to support those services. Operating activities also include any transactions or events that are not investing or financing activities.

'Investing activities' are the acquisition, holding and disposal of property, plant and equipment and investments.

'Investments' include securities not falling within the definition of cash.

'Financing activities' are the receipt and repayment of the principal on borrowings.

Significant changes in accounting policies

There have been no significant changes in accounting policies

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with PBE IPSAS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next year are:

Estimating the useful lives and residual values of intangible assets

At each balance date, Council reviews the useful lives and residual values of intangible assets. Assessing the appropriateness of useful life estimates requires Council to consider the expected period of use of the asset by Council.

An incorrect estimate of the useful life affects the depreciable amount of an asset, therefore affecting the amortisation expense recognised in the surplus or deficit and the asset's carrying amount. Council minimises the risk of this estimation uncertainty by an asset replacement program.

Council has not made any changes to past assumptions concerning useful lives.

Estimating the doubtful debt provision

At each balance date each debtor is reviewed and an assessment is made on the likelihood of collection of the amount owed. Where this assessment indicates that impairment exists, a further assessment is made of the amount of that impairment and a provision is created. Any receivable that is uncollectible is written off against the provision. An impairment will be assessed to exist where there has been no payment received,

no payment schedule has been entered into, an existing payment programme is breached or information is received that would indicate the likelihood of collection is diminished.

Impairment
Asset carrying values are reviewed at the end of each year to determine whether there is any indication that the assets have suffered an impairment loss or increase in fair value. If any such indication exists, the fair value of the asset is estimated in order to determine the extent of the impairment loss or gain.

Administration charge
This is a charge on the Complaints Investigation and Prosecution Fund and the Examination Fund to meet overhead costs incurred by the General Fund. The charge is based on the proportion of staff engaged in the activity. This is an internal charge and is not represented on the statement of comprehensive income.

2.
General Fund
Statement of comprehensive income
for the year ended 30 June 2016

	Notes	2016	2015
REVENUE			
Exchange Income			
Fees received	1	1,288,467	799,923
Vocational registration income		400,074	392,982
Interest received	1	139,164	145,446
Administration fee - Complaints Investigation and Proscecution Fund	1	790,000	775,000
Administration fee - Examination Fund		160,000	90,000
Workforce survey and other income		46,000	46,128
		2,823,705	2,249,479
Non Exchange Income			
APC Fees		8,337,612	7,581,530
		8,337,612	7,581,530
		$11,161,317	$9,831,009
ADMINISTRATION AND OPERATING EXPENSES			
Communications		82,276	189,251
Legal expenses and other consultancies		113,971	44,232
Administration and operating expenses		2,200,120	2,282,333
Staff costs including recruitment and training		5,441,424	5,091,393
Total administration and operating expenses		$7,837,791	$7,607,209
COUNCIL AND COMMITTEE EXPENSES			
Council			
- Fees and expenses		586,990	551,609
- Conference and liaison costs		63,789	74,899
- Strategic directions		48,509	133,077
Audit committee			
- Fees and expenses		13,281	10,835
Health committee			
- Fees and expenses		38,216	44,704
- Independent assessment reports, Doctors' Health Advisory Service, other costs		143,697	134,127
Education committee			
- Fees and expenses		49,430	49,654
- Hospital visits, intern supervisor contracts and other costs		600,114	325,627
Professional standards			
- Performance assessments and other costs		312,253	299,108
Registration			
- Workshops and other costs		453,652	515,194
Total Council and committee expenses		**$2,309,931**	**$2,138,834**
TOTAL EXPENDITURE		$10,147,722	$9,746,043
Net surplus/(deficit) for year and total comprehensive income		**$1,013,595**	**$84,966**

3.

Complaints Investigation and Prosecution Fund
Statement of comprehensive income
for the year ended 30 June 2016

	Notes	2016	2015
Revenue			
Exchange Income			
Recovery of staff costs		86,944	85,697
Interest received		18,046	17,729
		104,990	103,426
Non Exchange Income			
APC Fees		1,875,614	1,705,100
Recovered costs		272,467	40,839
Fines received		14,000	7,500
		2,162,081	1,753,439
Total revenue		$2,267,071	$1,856,865
ADMINISTRATION AND OPERATING EXPENSES			
Administration fee	1	790,000	775,000
Debt impairment expense relating to unpaid penalties and costs		47,685	49,999
General administration and operating expenses		384,586	298,472
Total administration and operating expenses		$1,222,271	$1,123,471
COUNCIL AND TRIBUNAL EXPENSES			
Professional conduct committee costs			
- Fees		197,555	145,317
- Expenses		380,477	406,474
Total professional conduct committee costs		578,032	551,791
Health Practitioners Disciplinary Tribunal			
- Administration fee		100,731	66,162
- Fees and other hearing expenses		232,059	138,306
Total Health Practitioners Disciplinary Tribunal costs		332,790	204,468
Total Council and Tribunal expenses		$910,822	$756,259
TOTAL EXPENDITURE		$2,133,093	$1,879,730
Net surplus/(deficit) for year and total comprehensive income		**$133,978**	**($22,865)**

4.

New Zealand Registration Examination Fund
Statement of comprehensive income
for the year ended 30 June 2016

	Notes	2016	2015
Revenue			
Exchange Income			
NZ Rex candidate fees		260,690	169,999
Interest received		5,860	6,870
Other income		1,395	1,751
		$267,945	$178,620
ADMINISTRATION AND OPERATING EXPENSES			
Administration fee	1	160,000	90,000
Centre costs		55,105	32,602
Examiners' fees and expenses		49,196	30,624
Honorarium, staff costs and other administrative expenses		43,613	47,516
Total administration and operating expenses		$307,914	$200,742
Net surplus/(deficit) for year and total comprehensive income		($39,969)	($22,122)

5. Taxation

The Medical Council is registered as a charity with the Charities Commission and accordingly its transactions for a charitable purpose are exempted from income tax.

6. Receivables

	2016	2015
Debtors	869,984	1,022,474
Provision for impairment	(641,600)	(921,696)
	228,384	100,778
Payments in advance	192,229	152,326
	420,613	253,104
GST	0	43,777
Total debtors and other receivables	**$420,613**	**$296,881**

Fair Value

The carrying value of debtors and other receivables approximates their fair value.

Impairment

The age profile of receivables at year end is detailed below:

	2016			2015		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	64,319	0	64,319	32,797	0	32,797
Past due 1-30 days	29,550	0	29,550	33,298	0	33,298
Past due 31-60 days	6,770	0	6,770	6,591	0	6,591
Past due 61-90days	19,553	(978)	18,575	9,986	0	9,986
Past due >90 days	749,792	(640,622)	109,170	939,802	(921,696)	18,106
Total	**$869,984**	**($641,600)**	**$228,384**	**$1,022,474**	**($921,696)**	**$100,778**

The provision for impairment has been calculated on a review of all debtor balances.

7 Investments

	2016	2015
ASB - Call Account -1.20%	1,121,550	1,440,000
ANZ - Matures 25 July 2016 -4.55%	250,000	250,000
ASB - Matures 8 Nov 2016 - 3.30%	250,000	250,000
ASB - Matures 9 August 2016 - 3.40%	250,000	250,000
ASB - Matures 10 Oct 2016 - 3.30%	250,000	250,000
ASB - Matures 24 Sept 2016 - 3.30%	500,000	0
ASB - Matures 18 Aug 2016 - 3.05%	500,000	0
BNZ - Matures 23 Jul 2016 - 3.30%	500,000	500,000
BNZ - Matures 25 Aug 2016 - 3.00%	250,000	250,000
BNZ - Matures 16 Oct 2016 - 3.20%	250,000	250,000
Westpac - Matures 15 Sept 2016 - 3.35%	250,000	250,000
Westpac - Matures 29 Sept 2016 - 3.25%	250,000	250,000
Westpac - Matures 8 Sept 2016 - 3.05%	250,000	250,000
Westpac - Matures 19 Sept 2016 - 3.25%	250,000	0
Westpac - Matures 20 Sept 2016 - 3.25%	250,000	0
Westpac - Matures 23 Dec 2016 - 3.35%	250,000	0
	$5,621,550	**$4,190,000**
Current	5,621,550	4,190,000
Term	0	0
	$5,621,550	**$4,190,000**

8. Property, plant and equipment

	Computer Hardware	Furniture and Fittings	Office Alterations	Office Equipment	Artwork	TOTAL
Cost						
Balance at 1 July 2014	867,053	338,446	324,697	267,542	7,138	1,804,876
Additions	70,802	45,718	423,185	2,632	0	542,337
Disposals	-381,632	0	$0	(35,020)	0	(416,652)
Balance at 30 June 2015	556,223	384,164	747,882	235,154	7,138	1,930,561
Balance at 1 July 2015	556,223	384,164	747,882	235,154	7,138	1,930,561
Additions	89,485	13,827	12,726	7,134	0	123,172
Disposals						$0
Balance at 30 June 2016	645,708	397,991	760,608	242,288	7,138	2,053,733
Accumulated depreciation and impairment losses						
Balance at 1 July 2014	686,756	282,850	0	246,436	0	1,216,042
Depreciation expense	98,725	15,343	73,160	7,510	0	194,738
Impairment losses	0	0		0	0	0
Disposals	(379,827)	0	$0	(28,599)	0	(408,426)
Balance at 30 June 2015	405,654	298,193	73,160	225,347	0	1,002,354
Balance at 1 July 2015	405,654	298,193	73,160	225,347	0	1,002,354
Depreciation expense	108,674	15,555	75,751	6,025	0	206,005
Impairment losses					0	0
Disposals					0	$0
Balance at 30 June 2016	514,328	313,748	148,911	231,372	0	1,208,359
Carrying amounts						
At 30 June and 1 July 2015	150,569	85,971	674,722	9,807	7,138	928,207
At 30 June 2016	131,380	84,243	611,697	10,916	7,138	845,374

9. Intangibles

	Intangibles
Cost	
Balance at 1 July 2014	5,874,335
Additions	741,762
Disposals	0
Balance at 30 June 2015	6,616,097
Balance at 1 July 2015	6,616,097
Additions	510,032
Disposals	0
Balance at 30 June 2016	7,126,129
Accumulated amortisation and impairment losses	
Balance at 1 July 2014	2,008,413
Amortisation expense	734,221
Impairment losses	0
Disposals	0
Balance at 30 June 2015	2,742,634
Balance at 1 July 2015	2,742,634
Amortisation expense	797,494
Impairment losses	0
Disposals	0
Balance at 30 June 2016	3,540,128
Carrying amounts	
At 30 June and 1 July 2015	3,873,463
At 30 June 2016	3,586,001

Included in Intangible assets is the cost of acquiring Intellectual Property rights in relation to the registration software. These costs are incidental to the construction of the registration software and have not been separately identified so it is not possible to measure their separate carrying value.

10. Depreciation

	2016	2015
Depreciation on Plant, Property and Equipment	206,005	194,738
Depreciation on Intangible Assets	797,494	734,221
Total Depreciation	**$1,003,499**	**$928,959**

11. Related party transactions

	2016	2015
Salaries and other short-term employee benefits	1,472,993	1,416,003
Other long-term benefits	23,267	40,084
Total key management personnel compensation	**$1,496,260**	**$1,456,087**

Key management personnel compensation

Key management personnel include the Chief Executive and the other 8 members (2015: 8) of Council's management team.

There were no other related party transactions.

12. Statement of contingent liabilities

There are no known contingent liabilities (2015: Nil).

13. Statement of commitments

Lease commitments under non-cancellable operating leases;

	2016	2015
Less than one year	542,242	536,850
Between 1 and 5 years	2,711,210	2,684,250
Greater than 5 years	563,381	1,073,700
	$3,816,833	**$4,294,800**

14. Financial instruments

Credit Risk
Financial instruments which potentially subject the Council to credit risk consist principally of bank balances and accounts receivable. The Council places investments with recognised banking institutions within an approved reserves and investment policy to limit exposure to concentrations of credit risk.

The Council's maximum credit risk exposure for each class of financial instrument is represented by the total carrying amount of bank accounts, receivables and investments.

Liquidity Risk
This is the risk that Council will encounter difficulty raising liquid funds to meet commitments as they fall due. Council manages liquidity risk by monitoring forecast and actual cash flow requirements and investment maturities.

Market Risk
The Council is exposed to interest rate risk as interest rate movements will affect the returns generated from investments and related cash flows. At year end the interest rates on term deposits ranged from 3.00% to 4.55% (2015: 3.90% to 4.63%).

The estimated fair values of the financial instruments are as follows:

	2016	2015
Receivables	$456,699	$338,176
Bank balances	$730	$14,857
Investments	$5,621,550	$4,190,000
Sundry creditors	($1,148,837)	($1,224,534)

For financial instruments held at balance date, the Council has no exposure to market risk that give rise to an impact on surplus or deficit.

15. Council members' fees and allowances

Council members receive a daily fee for attending meetings and an hourly rate for any preparatory work for any Council or Committee meeting.

In addition a communications allowance has been approved to cover incidental costs of an internet connection, telephones calls and postage/courier charges.

	2016	2015
Attendance allowance:		
Daily	$916.00	$916.00
Hourly	$114.50	$114.50
Communication allowance:		
Quarterly	$150.00	$150.00
Total fees and allowances paid to members of Council	**$600,166**	**$521,192**

16. Capital management

The Council's capital is its equity, which comprises retained surpluses. Equity is represented by net assets.

Council's equity is largely managed as a by-product of managing revenues, expenses, assets, liabilities, investments and general financial dealings.

The objective of managing Council's equity is to ensure that the Council effectively achieves its objectives and purpose whilst remaining a going concern.

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