Medical Council
OF★NEW★SOUTH★WALES

ANNUAL REPORT 2014

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Contents

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> about the **medical council of new south wales**

The Medical Council of New South Wales (the Medical Council) is a statutory authority established to manage complaints and notifications in relation to conduct, performance and health matters about registered medical practitioners in NSW. It also manages notifications and complaints about health and conduct matters relating to registered students training in NSW.

The Medical Council undertakes its regulatory functions in partnership with the Health Care Complaints Commission (HCCC), which is a separate statutory authority, established under the *Health Care Complaints Act 1993*.

The Medical Council is one of 14 health professional councils operating in NSW. The Health Professional Councils Authority (HPCA) provides secretariat and corporate services to the NSW councils to assist them in carrying out their regulatory responsibilities.

> **charter**

The Medical Council is a statutory body constituted under the *Health Practitioner Regulation National Law (NSW).* The Medical Council exercises the powers, authorities, duties and functions conferred on it by the *Health Practitioner Regulation National Law (NSW).* The object of the *Health Practitioner Regulation National Law (NSW)* is to establish the National Registration and Accreditation Scheme (the National Scheme). The objectives of the National Scheme are:

a) To provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
b) To facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction;
c) To facilitate the provision of high quality education and training of health practitioners;
d) To facilitate the rigorous and responsive assessment of overseas-trained health practitioners;
e) To facilitate access to services provided by health practitioners in accordance with the public interest; and
f) To enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

> aims and **objectives**

The purpose of the Medical Council is to act in the interests of the public by ensuring that registered medical practitioners are fit to practise and medical students are fit to have contact with members of the public while they undertake approved programs of study. In the exercise of functions under *Health Practitioner Regulation National Law (NSW),* the protection of the health and safety of the public must be the Medical Council's paramount consideration.

The Medical Council manages a range of programs, services and procedures to achieve its purpose. As a result, members of the public can be assured that registered medical practitioners are required to maintain suitable and appropriate standards of conduct and professional performance.

Medical Council
OF NEW SOUTH WALES

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20 October 2014

The Hon Jillian Skinner MP
Minister for Health
Minister for Medical Research
GPO Box 5341
SYDNEY NSW 2001

Dear Minister,

We have the pleasure of forwarding to you the Annual Report of the Medical Council of New South Wales for the year ending 30 June 2014.

The report has been prepared in accordance with the provisions of the *Annual Reports (Statutory Bodies) Act 1984* and the *Public Finance and Audit Act 1983*.

We trust that this Report clearly demonstrates the Medical Council's commitment to ensuring that it meets its charter of protecting the people of NSW through efficient and effective administration of the *Health Practitioner Regulation National Law (NSW)*.

Yours sincerely,

P G Procopis
President

G J Kesby
Deputy President

> president's **report**

In the four years since the creation of the National Registration and Accreditation Scheme (NRAS), the number of registered medical practitioners in NSW has increased by 12.9% (3,583). There are now 31,269 registered medical practitioners in NSW and the great majority of medical practitioners provide a highly professional service to their patients.

The Medical Council's activities revolve around the minority of medical practitioners whose conduct, performance or health is called into question because a complaint has been made and the matter is subsequently assessed as suitable for referral to the Council.

This reporting year 5.8% (1,798) of NSW practitioners found themselves the subject of a complaint. A total of 1,697 complaints were assessed by the Health Care Complaints Commission, who consults with the Council about all complaints received, of which 56% were discontinued at assessment. Only 2% were considered serious enough to be referred for investigation by the Commission. More detail as to why a decision is made to discontinue or investigate a complaint can be found in the Health Care Complaints Commission's annual report. Only a very small percentage of practitioners will find themselves responding to serious complaints prosecuted by the Health Care Complaints Commission before a Tribunal. This year 16 Tribunal hearings were finalised, which represents 0.05% of NSW medical practitioners.

The Medical Council's regulatory activities focus on the complaints that suggest the practitioner may be impaired, may need to improve his or her performance, or might benefit from counselling about conduct that appears to be below expected standards (but does not warrant prosecution of a complaint by the Commission) and on monitoring practitioners who have conditions on their registration or orders to be complied with. This year 66 practitioners were referred to Impaired Registrant Panel hearings (0.21% of NSW practitioners). 99 practitioners were either referred to or took part in formal performance assessment and performance review processes (0.3% of NSW practitioners). 43 practitioners attended a counselling interview (0.13% of NSW practitioners). And 244 NSW practitioners have conditions on their registration that the Council is currently monitoring (0.8% of NSW practitioners).

Being a protective jurisdiction, the Medical Council processes generally focus on the practitioner and on the future safety of the public, and less on the complaint (or complaints) that caused the practitioner to come to the Medical Council's attention in the first place. The Council's focus is not to resolve the complaint, but rather to use the complaint as an illustration of aspects of practice that might need improvement.

This creates challenges when the Medical Council communicates with complainants at the end of its processes. There is considerable tension between the transparency the public expects of organisations like the Medical Council, and the privacy accorded to practitioners who are the subject of complaints. These tensions between confidentiality and transparency mean the Medical Council's somewhat general responses can appear unsatisfying for individual complainants. Plans are underway to provide more detailed information to notifiers about the outcome of their complaint.

The Medical Council is also responsible for taking urgent action (suspension or conditions) in cases where an interim measure is needed. Typically, interim action is taken when the safety of the public needs addressing while the Commission investigates a matter, or whilst a practitioner is too unwell to cooperate with the Medical Council in managing their impairment safely. This year 55 practitioners were the subject of section 150 urgent interim action (0.2% of NSW practitioners). These urgent action hearings are a very important mechanism in ensuring public safety because they can be conducted quickly and can implement effective measures while other regulatory activities are taking place.

The legislation stipulates that all the Medical Council's complaints handling activities are confidential. As this report was being prepared, the Dr Suresh Nair case had been the subject of public discussion, due to a 4 Corners story in August 2014. The Dr Nair case illustrates the challenges in trying to safely manage impaired practitioners with serious addictions (not just by the Medical Council, but by employers and the community in general) and highlights the very real tensions between transparency and confidentiality.

As I write this report the Minister was signalling changes to the legislation which will require Councils to disclose information that was previously kept confidential. Confidentiality has been a central tenet of the Medical Council's Health and Performance programs since their inception (1992 and 2000 respectively), so any erosion of that confidentiality through legislative change will herald a new era in the professional regulation of practitioners in NSW.

Aside from any government response to local regulatory matters, review of the *Health Practitioner Regulation National Law* is on the horizon both in NSW and nationally:

1) The National Registration and Accreditation Scheme is undergoing the three year independent review that was agreed after the commencement of the scheme. That review is being chaired by Mr Kim Snowball, and the Medical Council will be invited to make a submission to the review. Of interest to NSW is the future direction of regulatory processes under the NRAS scheme in other States and Territories, noting the commencement of the Queensland Health Ombudsman and Queensland's transition to a co-regulatory jurisdiction from 1 July 2014. Also of interest is any development that may impact on the critical and productive relationship between the National Board and the NSW Council.

2) In NSW, the *Health Practitioner Regulation (Adoption of National law) Act 2009* will be reviewed in 2015. This contains the "nuts and bolts" of regulating health practitioners in NSW. Its review will provide an opportunity to make submissions on the various mechanisms available to regulate practitioners, including mechanisms that grapple with the tensions between transparency and confidentiality (or publication and privacy), as well as an opportunity to improve the operation of some legislative provisions.

The Medical Council and HPCA staff are looking at commissioning research and developing other quality assurance processes to evaluate the effectiveness of the Medical Council's complaints handling functions and regulatory activities, and to identify areas for improvement and/or increased resources. A review of staffing requirements is also being considered. In the meantime, the staff who support the Medical Council are deserving of praise for their unflagging contributions towards supporting the Medical Council and hearing members in meeting the Medical Council's core responsibilities.

In December 2013 Mr Ameer Tadros resigned as Executive Officer, Medical Council / HPCA Assistant Director, Medical to take up the role of Director HPCA. The Medical Council is grateful for his contribution during its initial years, and we look forward to continuing to work with him in his new role. Ms Miranda St Hill has been acting as Executive Officer since Mr Tadros' departure and the Medical Council will be appointing a new Executive Officer in the near future. Dr Stuart Dorney is the Council's Medical Director, a role he commenced in an acting capacity in August 2013 and permanently since January 2014.

This reporting year, saw the Medical Tribunal come to a close, with the commencement of the NSW Civil and Administrative Tribunal (NCAT) on 1 January 2014. The health practitioner list of the Occupational Division of NCAT now deals with the cases formerly heard by the Medical Tribunal. Further details of the changes are contained in this report, but I would like to take this opportunity to acknowledge the dedication of the many Deputy Chairpersons who served on the Medical Tribunal and to particularly thank the now retired Chief Judge of the District Court, Reg Blanch, for serving as Chairperson of the Medical Tribunal for many years. Some decisions of the former Medical Tribunal have had lasting and important impact on the regulation of medical practitioners in NSW and Australia wide, and will continue to be referred to for years to come.

During the year Professor Belinda Bennett and Mr Anthony Carpentieri resigned from their positions on the Medical Council and Dr Bruce Doust's term expired. These members made long term and valuable contributions during their terms of office as Council members.

The year ahead will be my last year as President and member of the Medical Council and the previous Board, as my maximum terms will be reached in June 2015. Fortunately this Council's appointments are staggered sufficiently to ensure continuity of regulatory experience will continue in years to come. The Council also has enough financial stability to allow me to look forward to steering the Medical Council through the challenges of the next year.

P G Procopis
President

> year in **summary**

The following table gives an overview and a three-year comparison of the Medical Council's activities in its three major areas of activity: professional conduct, performance and health. The table includes information from the past three years relating to the Medical Council's role in monitoring compliance with conditions on practitioners' registration following a performance, conduct or health outcome. The table also provides information as to the number of registered medical practitioners whose principal place of practice is NSW.[1]

Table 1: Year in summary

	2011/12	2012/13	2013/14
Professional conduct			
Complaints assessed	1,508	1,696	1,697
Professional Standards Committees finalised	17	10	16
Tribunal complaints finalised[2]	22	27	16
Tribunal appeals and review applications finalised[3]	4	5	0
Counselling interviews finalised	19	36	29
Section 150 proceedings finalised (including section 150A and section 150C proceedings)	53	45[4]	55[4]
Health			
Medical practitioners in Health Program	122	118	110
Entrants to Program	29	21	20
Impaired Registrants Panels conducted	64	48	81
Board / Medical Council Review Interviews conducted	234	226	212
Performance			
Performance Interviews conducted	69	77	85
Medical Practitioners in Performance Assessment Program [5]	70	97	99
Entrants to Performance Assessment Program	25	40	37
Performance Assessments conducted	22	10	25
Re-Assessments conducted	3	15	11
Performance Review Panels conducted	12	12	17
Exits from Performance Assessment Program	22	13	34
Monitoring [6]			
New cases – Health	37	25	22
New cases – Performance	8	3	9
New cases – Conduct	31	31	33
Total cases completed	81	57	59
Total active cases	227	239	244
Registration[1]			
Medical practitioners in NSW	28,972	30,333	31,269
Medical students	5,800	5,853	6,438
Total number of medical practitioners in Australia	91,648	95,690	99,379

[1] Data concerning registration numbers for medical practitioners who have a principal place of practice as NSW or students training in NSW has been provided by the Australian Health Practitioner Regulation Agency.
[2] Figure for 2013/14 includes complaints finalised by the NSW Civil and Administrative Tribunal and former Medical Tribunal. Complaints from previous years were finalised by the Medical Tribunal.
[3] Figure for 2013/14 includes appeals and review applications finalised by the NSW Civil and Administrative Tribunal and former Medical Tribunal. Appeals and reviews from previous years were finalised by the Medical Tribunal.
[4] Data for 2012/13 and 2013/14 include matters where practitioners consented to the imposition of conditions or suspension under section 41P.
[5] There were 37 practitioners who entered the Performance Assessment Program, with a total of 99 practitioners who either: required a Performance Assessment, were subject to a Performance Assessment, or had conditions imposed by a Performance Review Panel and were being monitored by the Medical Council.
[6] May include practitioners who move to NSW during reporting year, who have interim s150 conditions imposed, as well as practitioners from the Council's programs.

> structure of the **medical council** and the health professional councils authority

Membership of the Medical Council of NSW

The Medical Council consists of 19 part-time members appointed by the Governor of NSW for a term of up to three years.

From 1 January 2014, legislative amendments resulted in changes to the composition and appointment to the Medical Council. Most notably, the Australian and New Zealand College of Anaesthetists and the Australasian College for Emergency Medicine were included in the eight specialist medical colleges that directly nominate a member to the Medical Council.

The Minister for Health also nominates one medical practitioner who is a member of one or more of five specialist medical colleges: the Australasian College of Dermatologists, the Australian College of Rural and Remote Medicine, the Royal Australian and New Zealand College of Ophthalmologists, the Royal Australian and New Zealand College of Radiologists and the Royal College of Pathologists of Australasia.

Membership of the Medical Council is prescribed in Part 2 of Schedule 1A of the *Health Practitioner Regulation (New South Wales) Regulation 2010*. The positions of the President and Deputy President are prescribed at Part 2 of Schedule 5C of the *Health Practitioner Regulation National Law (NSW).*

As of 30 June 2014 there were 17 members of the Medical Council, with a selection process underway for the appointment of a Legal Member and a Community Member nominated by the Minister. Membership of the Medical Council includes five female members and six members with a culturally diverse background.

Members of the Medical Council, their qualifications, term of appointment and nominating body for the period 1 July 2013 to 30 June 2014 are listed below. During this period, six ordinary meetings and one extraordinary meeting were held. Attendances at these meetings are recorded in square brackets.

Professor Peter George Procopis AM, President, MBBS (Sydney), FRACP, Royal Australasian College of Physicians nominee (current term: 1.7.2012 – 30.6.2015) [5]

Dr Gregory John Kesby, Deputy President, MBBS (UNSW), BSc Hons (UNSW), PhD (Cambridge), FRANZCOG, DDU, CMFM, Royal Australian and New Zealand College of Obstetricians and Gynaecologists nominee (current term: 1.7.2012 – 30.6.2015) [7]

Dr Stephen Adelstein, MB BCh (Wits), PhD (Sydney), FRACP, FRCPA, Royal College of Pathologists of Australasia nominee (term: 1.7.2012 - 31.12.2013), Ministerial nominee (current term: 18.6.2014 – 1.6.2017) [3]

Professor Belinda Bennett, B Ec. LLB (Macquarie), LLM SJD (Wisconsin), GAICD, Legal Member nominated by the Minister (term: 1.7.2012 – 30.6.2015) resigned 17.2.2014 [2]

Dr Roger Gregory David Boyd, MBBS (Sydney), MBA (Geneva), MHP (UNSW), FRACMA, AFCHSM, Royal Australasian College of Medical Administrators nominee (current term: 18.6.2014 – 1.6.2017, previous term: 1.7.2012 - 31.12.2013) [4]

Mr Antony Carpentieri, LLB (UTS), Ministerial nominee (term: 1.7.2012 – 30.6.2015) resigned 28.2.2014 [2]

Mr Michael Christodoulou AM, Community Relations Commission nominee (current term: 1.7.2012 – 30.6.2015) [7]

Dr Bruce David Doust, BSc(Med), MBBS (Sydney), LLB (Macquarie), FRANZCR, Royal Australian and New Zealand College of Radiologists nominee (term: 1.7.2012 to 31.12.2013) [3]

Professor Anthony Andrew Eyers, MBBS (Sydney), FRACS, FRCS, Master of Bioethics (Monash), Royal Australasian College of Surgeons nominee (current term: 1.7.2012 – 30.6.2015) [6]

Professor Cheryl Anne Jones, MBBS Hons 1 (UTas), FRACP, PhD (Sydney), Universities nominee (current term: 1.7.2012 – 30.6.2015) [4]

Ms Rosemary Eva Kusuma, BSW (Sydney), Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [5]

Dr Alix Genevieve Magney, BA Sociology (Hons), PhD Sociology (UNSW), Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [7]

Mr Jason Masters, BEc. (Flinders), GAICD, CFIAA, CRMA, CGEIT, CFE, JP, Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [5]

Associate Professor Rodney James McMahon, MBBS (Sydney), Flt Lt (ret), DRCOG, DRANZCOG, IDD (Hons) ADD MMED FAIM, FRACGP, Royal Australian College of General Practitioners nominee (current term: 1.7.2012 – 30.6.2015) [5]

Dr Robyn Stretton Napier, MBBS (Sydney), Australian Medical Association nominee (current term: 1.7.2012 – 30.6.2015) [7]

Dr Julian Parmegiani, MBBS (Hons) (UNSW), FRANZCP, GAICD, Royal Australian & New Zealand College of Psychiatrists nominee (current term: 1.7.2012 – 30.6.2015) [7]

Ms Lorraine Poulos, RN (SVH), Grad Cert HSM (ECU), Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [4]

Dr John Frank Charles Sammut, MBBS (Hons) (Sydney), FACEM, Australasian College for Emergency Medicine nominee (current term: 18.6.2014 – 1.6.2017) [N/A]

Clinical Associate Professor Richard George Walsh, MBBS (Sydney), FANZCA, Ministerial nominee and from 1.1.14 Australian and New Zealand College of Anaesthetists nominee (current term: 1.7.2012 – 30.6.2015) [6]

Dr Choong-Siew Yong, MBBS (Sydney), FRANZCP, Australian Medical Association nominee (current term: 1.7.2012 – 30.6.2015) [2]

Medical Council members generally serve on two or more Committees, including the Conduct Committee, Health Committee, Performance Committee, Executive Committee and Corporate Governance Committee and may also serve on steering committees and working parties for various projects. The Committees are established pursuant to section 41F of the *Health Practitioner Regulation National Law (NSW)* to assist the Medical Council in the exercise of its functions. Committee members need not be members of the Medical Council. (See **Table 2** for details of the composition of the Committees.)

The Medical Council acknowledges the invaluable contribution of the following members of the profession and the public who serve as members of Tribunals, Professional Standards Committees, Impaired Registrants Panels, Performance Review Panels, urgent inquiries, interview panels, Committees, and in a variety of other capacities, including as auditors and health and performance assessors:

Dr G Abouyanni
Dr P Anderson
Dr C Barnes
Dr H Bittar
Dr A Brooks
Mr A Carpentieri
Ms A Collier
Dr C Commens
Dr M Cox
Dr J Davidson
Dr V de Carvalho
Dr B Doust
Dr N Evans
Dr R Fisher
Dr M-A Friend
Dr M Giuffrida
Dr P R Gordon
A/Prof G Herkes
Ms J Houen
Dr R Ilchef
Mr R Kelly
Dr K Khor
Dr L King
Dr E Kok
Prof H Lapsley
Dr R Lyneham
Dr K McCarthy
Dr A Meares
Dr J Ng
Dr P O'Connell
Dr A Pethebridge
Dr A Reid
Dr D Richards
Dr W Ross
Dr D Semmonds
Dr J Spies
Dr J Sullivan
Dr I Symington
Dr S-H Toh
Dr P Truskett
Dr A Walker
Dr B Westmore
Dr J M Wright

Dr I Alexander
Dr K Arnold
Prof D Barnes
Dr P Bland
Dr L Brown
Dr R Chapman-Konarska
Dr H Chriss
Dr L Cotterell
Dr J Curotta
Dr M Davies
Dr M Diamond
Dr K Edwards
A/Prof M Fearnside
Dr J Fogarty
Dr S Gani
Dr A Glass
Ms A Gray
Dr M Higgins
Dr S Howle
Dr M Jarrett
Dr E Kertesz
Ms H Kiel
Dr R King
Dr K Koster
Dr V Lele
Dr J Mair
Dr M McGlynn
Dr S Messner
Dr K Nunn
Dr N O'Connor
Dr R Pillemer
Dr W Reid
Ms D Robinson
Dr I Rotenko
Mr R Smith
Dr I Stewart
Dr K Sundquist
Dr G Szonyi
Dr E Tompsett
Dr C Varol
Dr M Walker
Dr C Wijeratne
Dr M Wroth

Dr H An
Dr B Bailey
Dr C Berglund
Dr J Branch
Dr G Burton
Dr D Chisholm
Dr C Clarke
Dr S Cowap
A/Prof M da Cruz
Dr R Davies
Dr G Dore
Ms G Ettinger
Dr P Fishburn
Mr P French
Dr P Gibson
Dr M Gleeson
Dr D Heffernan
Dr A Holdgate
Dr K Ilbery
Ms M Kelly
Dr M Khadra
Dr J King
Dr H Knox
Dr P Langeluddecke
Dr K Liyanagama
Dr S Mares
Dr A Meachin
Dr C Newberry
Dr E O'Brien
Dr C Perry
A/Prof R Rae
Dr S Rewais
Dr J Rodney
Dr A Samuels
Dr R Spark
Dr D Storey
Dr V Sutton
Dr W Y V Tam
Dr V Tran
Dr A Virgona
Dr L Watterson
Prof K Wilhelm
Dr G Yeo

Executive Officer

Ms Miranda St Hill is the Acting Executive Officer of the Medical Council of NSW. The role of Executive Officer is prescribed under section 41Q of the *Health Practitioner Regulation National Law (NSW).*

Senior Officers

Ameer Tadros BA/LLB (ANU) MALP (Sydney) GAICD
Director
Health Professional Councils Authority

Miranda St Hill BA LLB (Monash)
Acting Assistant Director, Medical
Health Professional Councils Authority,
Acting Executive Officer, Medical Council of NSW

David Rhodes B Soc Stud, Grad Cert in Health Management
Assistant Director, Allied Health, Nursing and Midwifery
Health Professional Councils Authority

Iain Martin B Ec (Syd), Dip Law (LPAB) Assistant Director, Legal
Health Professional Councils Authority

Tim Burke BBus FCA, FCPA & FGIA
Assistant Director, Finance and Shared Services
Health Professional Councils Authority

Dr Stuart Dorney MBBS, FRACP
Medical Director
Health Professional Councils Authority

Domarina Azad LLB (UWS) MA (UWS)
Acting Legal Director, Medical
Health Professional Councils Authority

Table 2: Medical Council of NSW Committees 2013/14

CONDUCT	HEALTH	PERFORMANCE	EXECUTIVE	CORPORATE GOVERNANCE
Chair **G Kesby**	**Chair** **C-S Yong**	**Chair** **R McMahon**	**Chair** **P Procopis**	**Chair** **P Procopis**
S Adelstein	R Boyd	B Bennett[1]	B Bennett[1]	S Adelstein
B Bennett[1]	A Carpentieri[2]	B Doust[3]	G Kesby	B Bennett[1]
A Carpentieri[2]	M Christodoulou	A Eyers	R McMahon	R Boyd
A Eyers	B Doust[3]	C Jones	C-S Yong	M Christodoulou
C Jones	R Kusuma	G Kesby		R Kusuma
A Magney	R Napier	A Magney		J Masters
J Masters	J Parmegiani	R Napier		
R McMahon	L Poulos	J Parmegiani		
P Procopis	P Procopis	L Poulos		
M Walker[4]		P Procopis		
R Walsh		J Sammut[5]		
C-S Yong		E Tompsett[6]		
		R Walsh		

[1] Prof B Bennett, former Chair of the Corporate Governance Committee, resigned from Council on 17.2.2014
[2] Mr A Carpentieri resigned from Council on 28.2.2014 and continued as a non-Council Committee member until 30.6.2014
[3] Dr B Doust continued as a non-Council Committee member after term as Council member expired on 31.12.2013
[4] Dr M Walker is a non-Council Committee member
[5] Dr J Sammut, former non-Council Committee member, was appointed a Council member on 18.6.2014
[6] Dr E Tompsett is a non-Council Committee member

Remuneration

The members of the Medical Council of NSW are remunerated as follows:

- President $43,266 per annum
- Deputy President/Committee Chair $27,038 per annum
- Members $12,978 per annum

Establishment of the NSW Civil and Administrative Tribunal

The NSW Civil and Administrative Tribunal (NCAT) was established on 1 January 2014, under section 7 of the *Civil and Administrative Tribunal Act 2013*. It consolidated the work of 22 NSW tribunals, including the Medical Tribunal, into a single tribunal. Hearings before NCAT are public and the parties can be legally represented.

Proceedings that would formerly have been heard in the Medical Tribunal, are now heard in the Occupational Division of NCAT. Under Schedule 1 to the *Civil and Administrative Tribunal Act*, proceedings that were commenced in the Medical Tribunal prior to 1 January 2014 were heard and determined by NCAT after that date.

A Tribunal comprises four members. The proceedings are chaired by an NCAT member who is a senior judicial officer. The Medical Council appoints the non-judicial members to sit on all NCAT hearings, appeals and review hearings, and staff of the HPCA monitor compliance with any orders and conditions that are imposed by a Tribunal. Whilst complaints before the Tribunal are prosecuted by the HCCC, the Medical Council is a party (respondent) to review hearings and certain appeals which are lodged in the Tribunal. Tribunal hearings are open to the public and are primarily held in dedicated hearing rooms at the HPCA, located at 477 Pitt St, Sydney.

Health Professional Councils Authority

The HPCA provides shared executive and corporate services to the 14 NSW health professional Councils to support their regulatory activities.

On behalf of the Councils, the HPCA liaises with:

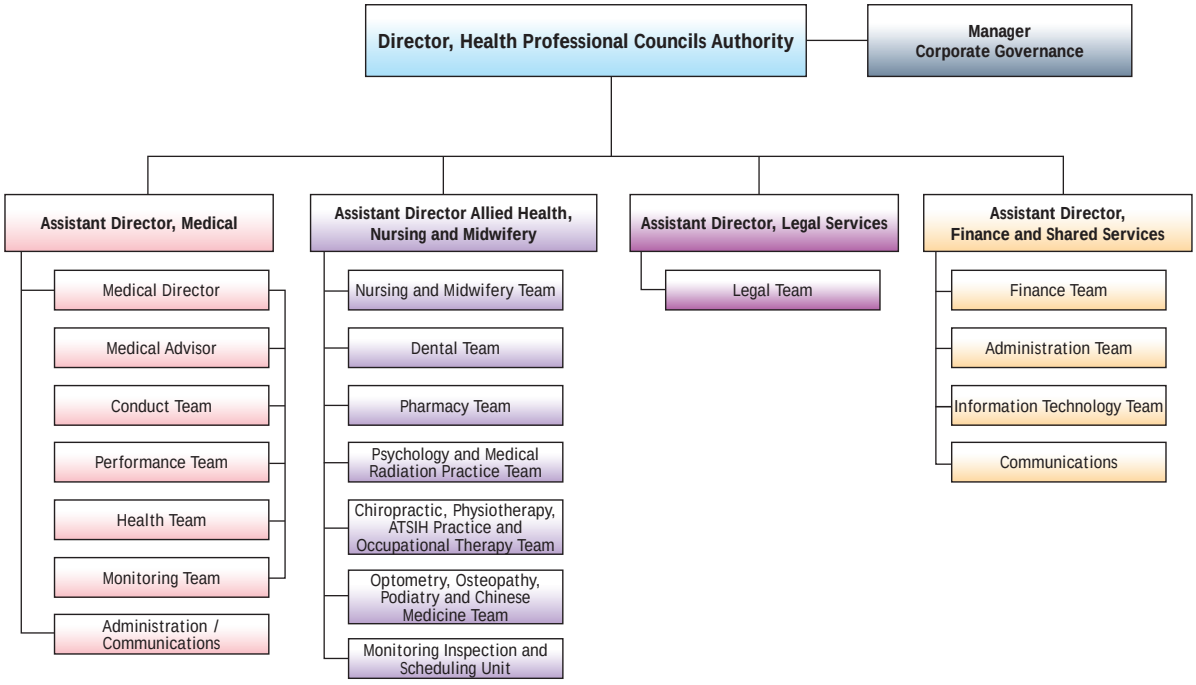
- The Australian Health Practitioner Regulation Agency (AHPRA) regarding financial, registration and reporting matters;
- The HCCC on complaints management issues; and
- The Ministry of Health on human resources and providing advice and responses to the Minister for Health and the Secretary on regulatory matters and member appointments.

This coordinated approach provides efficiencies through shared services that would be costly for each Council to implement on its own. It also allows the Medical Council to direct its attention to protection of the public by concentrating on its core regulatory functions.

The Medical Council and the HPCA have signed a three year Service Level Agreement (SLA) effective from 1 July 2012. The SLA outlines the services the HPCA provides and key performance indicators against which performance is assessed annually. It provides certainty and a shared understanding for the Medical Council and the HPCA on the range and quality of services provided.

The HPCA Advisory Committee was established in October 2013 to advise on strategy and improvements to services the HPCA provides to Councils and to support communication with the Ministry of Health and the Secretary on matters relating to Council regulatory practices and emerging issues. The Committee is chaired by the Ministry's Director of Legal and Regulatory Services and includes selected Council Presidents and the HPCA Director. The Medical Council President is a member of the Committee. A priority for the Committee will be a response to the NRAS review and a review of the Law in 2015.

Chart 1: Health Professional Councils Authority organisation chart (June 2014)



> regulatory **activities**

- **National registration**
- **Professional conduct**
- **Health**
- **Performance**
- **Monitoring**

> national **registration**

Health practitioners, including medical practitioners, are registered under the National Registration and Accreditation Scheme (NRAS), which was introduced in 2010. Through the National Scheme, responsibility for registering and regulating health practitioners and accrediting education programs transferred from State and Territory authorities to National Boards.

The National Boards are supported by AHPRA, which has an office in each State and Territory, including in NSW.

Further information about the Medical Board of Australia can be obtained from its website: www.medicalboard.gov.au.

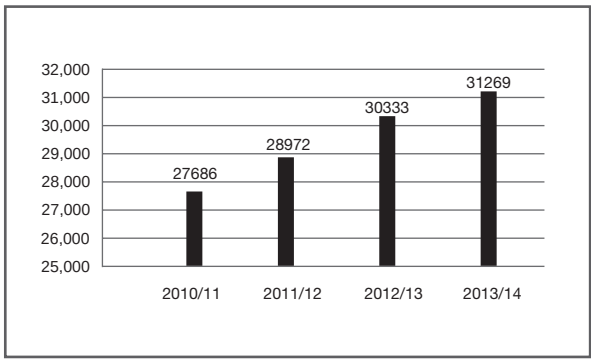
NSW did not adopt the regulatory component of the National Scheme which involves the management of complaints and notifications about health practitioners. Instead, the co-regulatory environment that existed in NSW prior to the commencement of the National Scheme was maintained. As a result, the NSW health professional Councils and the HCCC are responsible for assessing and managing complaints about the professional performance, conduct and health of practitioners, including medical practitioners, and about the health and conduct of medical students in NSW.

Registrations in NSW

At 30 June 2014, there were 31,269 medical practitioners whose principal place of practice was in NSW. This represents 31.46% of the total number of 99,379 medical practitioners registered under the National Scheme across Australia. There are 6,438 students registered to undertake approved programs of study in NSW. This represents 33.4% of the total number of 19,301 medical students registered under the National Scheme across Australia. Data for the current reporting year has been provided by AHPRA.

Chart 2 below provides information about the number of registered medical practitioners in NSW from 2010/11 to 2013/14. Since the commencement of the National Scheme, the number of medical practitioners registered to practise in NSW has increased by 13% over the four years.

Chart 2: Registered medical practitioners in NSW



> professional **conduct**

2013-2014 **snapshot**

- → 1,798 complaints against medical practitioners were received by the Medical Council and the HCCC in 2013/14, of which 1,697 were assessed during the period.
- → Of the 1,697 assessed complaints, 945 (56%) were discontinued, 298 (18%) were referred to the Medical Council and 34 (2%) were referred for investigation by the HCCC.
- → Prior to the commencement of the NSW Civil and Administrative Tribunal (NCAT) on 1 January 2014, the Medical Tribunal made determinations on complaint matters against seven practitioners.
- → Between 1 January 2014 and June 30 2014, NCAT made determinations on complaint matters against nine practitioners.
- → Sixteen Professional Standards Committee (PSC) decisions were handed down.
- → The Medical Council considered exercising its urgent interim action powers under section 150 on 55 occasions. In addition, three practitioners surrendered their registration either prior to the proceedings being held or prior to the proceedings being finalised.

Introduction

The Medical Council and the HCCC accept written complaints from any source about medical practitioners. Complaints received by AHPRA about medical practitioners, where the conduct occurred in NSW, are forwarded to the Medical Council and the HCCC for assessment and management. Information about complaints received is exchanged between the Medical Council and the HCCC as soon as practicable. This allows the Medical Council to review each complaint received and ensures that complaints which appear to warrant urgent interim action to protect the public can be dealt with by the Medical Council promptly under section 150 of the *Health Practitioner Regulation National Law (NSW).*

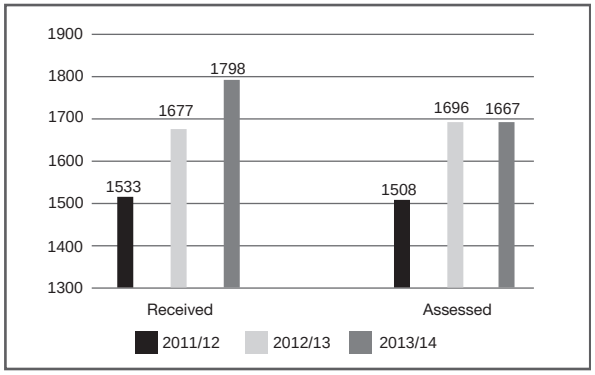
Legislation requires the HCCC to consult with the Medical Council on the assessment of each complaint. This consultation occurs weekly. The HCCC is required to process the complaint from receipt to assessment within 60 days.

Complaints and notifications

Complaints received

In 2013/14, the Medical Council and the HCCC received 1,798 complaints, up from 1,677 in the previous year (a 6.7% increase). This increase is consistent with increasing numbers of complaints received and assessed over recent years (see **Chart 3**).

Chart 3: Complaints received and assessed from 2011/12 to 2013/14



During this reporting year, complaints concerning clinical competence continued to dominate as the main area of complaint and have remained relatively stable, as have complaints about communication. Complaints concerning conduct issues have reduced by 5%, however complaints about practice administration have increased by 5%.

Table 3 shows the types of complaints assessed over the past three reporting periods.

Table 3: Type of complaint (%) 2011/12 to 2013/14

	2011/12 n=1,508	2012/13 n=1,696	2013/2014 n=1,697
Clinical competence	57	60	60
Communication	10	14	18
Conduct	27	20	11
Practice administration	6	6	11

Complaints assessed

The Medical Council and the HCCC together assessed 1,697 complaints (compared to 1,696 in the previous year). Ninety-five complaints received during this reporting period are to be assessed during 2014/15.

At the weekly consultation meeting between the HCCC and the Medical Council complaints may be discontinued if they fall outside the Medical Council's or HCCC's jurisdiction, if they do not relate to health care (for example, complaints about fees), or if they fail to raise sufficiently serious concerns. In some instances, no further action is taken because the parties have resolved the matter prior to the consultation meeting, either by themselves or with the assistance of the HCCC, and in other cases the complaint is withdrawn by the complainant prior to the consultation meeting.

Complaints that the Medical Council considers demonstrate or appear to demonstrate reckless, unethical, wilful or criminal behaviour in either clinical or non-clinical domains will usually be referred for investigation to the HCCC's Investigation team. In other circumstances, public protection can be achieved through the application of non-disciplinary and educative responses. Options include referring complaints to the Medical Council for consideration through its Conduct, Health or Performance Programs, or to the HCCC's Resolution Service for conciliation or assisted resolution. Information concerning the Medical Council's Conduct, Health and Performance programs is contained in this Annual Report.

Table 4 illustrates the trends in complaint assessments over the past three reporting years.

Table 4: Outcomes of complaint assessments (%) 2011/12 to 2013/14

	2011/12 n=1,508	2012/13 n=1,696	2013/14 n=1,697
Investigation	6	5	2
Refer to the Medical Council	18	22	17
Refer to another person or body	2	2	5
Resolution*	9	10	13
Discontinue	65	61	63

**Resolution includes referral of a complaint to the HCCC's Resolution Service for conciliation or assisted resolution.*

There has been a decrease in the number of complaints referred to the Medical Council following complaint assessment: 297 complaints were referred to the Medical Council, compared with 373 the previous year – a 21% decrease.

This is counterbalanced by the number of complaints referred for conciliation or assisted resolution which has increased (224 matters, as compared with 161 in 2012/13 and 136 in 2011/12).

Mandatory notifications

Notifications received

Division 2 of the *Health Practitioner Regulation National Law (NSW)* sets out the requirements for reporting notifiable conduct to AHPRA. Where the conduct has occurred in NSW, AHPRA forwards the mandatory notification to the Medical Council and the HCCC.

Notifiable conduct is defined in section 140 of the *Health Practitioner Regulation National Law (NSW).* It requires registered health practitioners, education providers and employers of a registered medical practitioner to make a report if they have formed a reasonable belief that another registered medical practitioner has either:

- Practised the profession while intoxicated by alcohol or drugs;
- Engaged in sexual misconduct in connection with the practice of the medical practitioner's profession;
- Placed the public at risk of substantial harm in the medical practitioner's practice of the profession because the medical practitioner has an impairment; or
- Placed the public at risk of harm because the medical practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.
- Prior to the commencement of the National Scheme, only medical practitioners were subject to mandatory reporting requirements.

In 2013/14, the Medical Council received 76 mandatory notifications, down from 87 in the previous reporting year. **Table 5** illustrates the trend in mandatory notifications lodged over the past three reporting years.

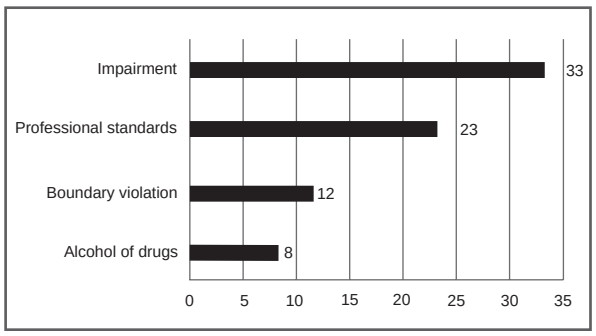
Table 5: Number of mandatory notifications received 2011/12 to 2013/14

	2011/12	2012/13	2013/14
Number of mandatory notifications received	72	87	76

The 76 notifications received have been categorised into four grounds of notifiable conduct which are illustrated in **Chart 4** below. As can be seen from the chart, impairment comprises the largest category of notifiable conduct, with professional standards the second largest. These two categories represent almost 74% of the total number of matters which have triggered an obligation to report notifiable conduct.

Mandatory notifications about impairment relate to matters concerning psychiatric illness or cognitive impairment. Mandatory notifications about professional standards relate to clinical matters such as diagnosis, treatment, prescribing and communication.

Chart 4: Mandatory notifications received in 2013/14



Mandatory Notifications assessed

The Medical Council and the HCCC assessed 76 mandatory notifications during this reporting period, eleven fewer than in 2012/13. **Table 6** illustrates the assessment outcomes of these mandatory notifications. It shows a significant proportion (58%) of mandatory notifications were referred to the Medical Council's Health, Performance or Conduct programs. Ten mandatory notifications (13%) were referred to the HCCC for investigation.

Table 6: Outcome of mandatory notifications assessed 2013/14

	2013/14 n =76
Investigation	10 (13%)
Refer to the Medical Council	44 (58%)
Refer to another person/body	8 (11%)
Resolution	1 (1%)
Discontinue	11 (14%)
Unassessed	2 (3%)
TOTAL	**76**

Of the mandatory notifications referred to the Medical Council, 27 (61%) were referred to the Health Program. This is the same number as in the previous reporting year. Five mandatory notifications (11%) were referred to the Performance Program. The majority of these matters related to treatment, diagnosis or prescribing.

Investigations

Complaints are referred for investigation when, at the time of assessment, the information before the Medical Council or the HCCC appears to raise significant issues of public health or safety, or if substantiated, would provide grounds for disciplinary action against the medical practitioner, or if the complaint involves gross negligence on the part of the medical practitioner. In 2013/14, 34 complaints were referred to the HCCC for investigation, which is down from 82 complaints referred in the previous reporting year.

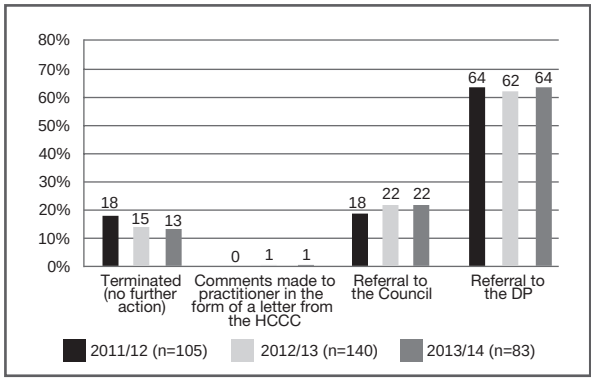
Investigation outcomes

The HCCC is required to consult with the Medical Council before deciding what action to take following the completion of investigations. However, the final decision concerning the ultimate outcome rests with the HCCC. During this reporting year, 83 investigations were finalised, a decrease from 140 investigations in the previous reporting year.

Section 39(1) of the *Health Care Complaints Act 1993* identifies the outcomes available to the HCCC at the completion of its investigation. This includes referral of a matter to the Medical Council; referral to the HCCC's Director of Proceedings (DP); comments being made to the practitioner in the form of a letter from the HCCC; or termination of the matter and no further action being taken.

Chart 5 provides a three-year comparison of outcomes of investigations.

Chart 5: Investigation outcomes: 2011/12 to 2013/14 by outcome category



Matters referred to the Medical Council

The courses of action available to the Medical Council following referral of a practitioner at the conclusion of a HCCC investigation include disciplinary counselling and management of the practitioner through the Medical Council's Health or Performance programs.

As **Table 7** illustrates, of the 18 investigated matters referred to the Medical Council in 2013/14:

- Ten investigations resulted in practitioners undergoing disciplinary counselling;
- Six investigations resulted in the practitioner being referred to the Performance Program;
- One investigation resulted in a practitioner being counselled by comments in a letter; and
- One investigation resulted in the Medical Council referring the matter to AHPRA (as the medical practitioner had surrendered his/her registration).

Table 7: Outcomes of HCCC-investigated matters referred to Medical Council 2013/14

	Number of investigations
Disciplinary counselling	10
Performance Program	6
Counselling by comments/letter	1
Refer to AHPRA	1
TOTAL	**18**

Matters referred to the Director of Proceedings

Upon referral of an investigation the DP considers whether or not the complaint should be prosecuted before a disciplinary body. The DP is required to consult with the Medical Council prior to making such a determination, although the final determination rests with the DP.

Section 90B of the *Health Care Complaints Act 1993* sets out the functions of the DP and section 90C identifies the relevant criteria the DP must take into account when making a determination as to whether or not to prosecute a complaint before a disciplinary body. The criteria used include the protection of the health and safety of the public; the seriousness of the alleged conduct; and the likelihood of proving the alleged conduct.

In 2013/14, the DP made the following determinations, as set out in **Table 8**.

Table 8: DP determinations 2013/14

	Number of investigations	Number of practitioners
Not to prosecute a complaint	10	7
Referred a complaint to a Professional Standards Committee	8	8
Referred to a Medical Tribunal	31	22
TOTAL	**49**	**37**

In the reporting period, the DP determined not to prosecute ten complaints before a disciplinary body because there was insufficient evidence. This involved seven practitioners and no further action was taken with respect to these investigations. In some instances more than one complaint was prosecuted before a Tribunal.

Notifying AHPRA

The Medical Council liaises with AHPRA to ensure an alert is placed on its database in matters where the HCCC or the DP determines to take no further action because the medical practitioner has surrendered his/her registration or when a medical practitioner is not registered as his/her registration had already been cancelled by a Tribunal. This ensures that in the event that the medical practitioner seeks registration in the future, the outcome of the investigation is considered when determining the suitability of the medical practitioner to hold registration.

Complaints remaining under investigation

Open investigations

At 30 June 2014, the HCCC reported that 98 practitioners were currently under investigation (up from 62 practitioners in the previous reporting year).

Open matters with the DP

At the conclusion of the reporting year, 36 matters involving 29 practitioners were with the DP awaiting consideration of possible disciplinary action (down from 40 matters in the previous reporting year).

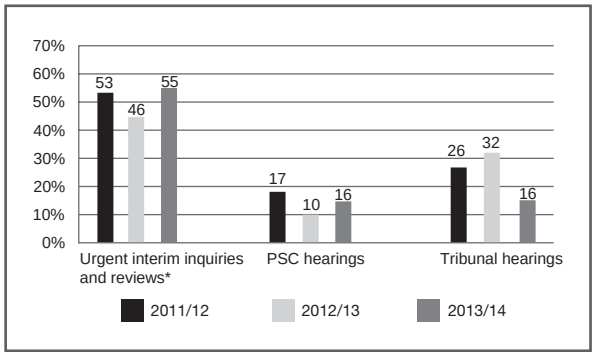
Disciplinary proceedings

The *Health Practitioner Regulation National Law (NSW)* establishes a number of disciplinary procedures and bodies of inquiry to deal with complaints that a medical practitioner may have engaged in unsatisfactory professional conduct or professional misconduct. These include:

- disciplinary counselling
- the use of the Medical Council's powers to take urgent interim action to protect the public (section 150 proceedings)
- Professional Standards Committee hearings
- Tribunal hearings.

Chart 6 provides a comparison of the total number of section 150 proceedings and reviews, PSC hearings, and Tribunal hearings (complaints, appeals and review matters) that have been finalised over the past three reporting years.

Chart 6: Section 150 proceedings and reviews, PSC and Tribunal hearings finalised 2011/12 to 2013/14



** The total for 2012/13 and 2013/14 includes practitioners who have consented to conditions or suspensions under section 41P of the Health Practitioner Regulation National Law (NSW) in lieu of urgent interim inquiries.*

Counselling interviews

Section 145B of the *Health Practitioner Regulation National Law (NSW)* provides that the Medical Council may direct a medical practitioner to attend counselling. A medical practitioner may be referred for counselling or interview in the following circumstances:

- At the completion of an investigation by the HCCC;
- Following a determination by the DP not to prosecute a complaint; or
- Following completion of the assessment of a complaint under section 25B of the *Health Care Complaints Act 1993*. (In relation to this type of referral, the Medical Council may determine that counselling is warranted and resolve to invite the medical practitioner to attend the Medical Council for an interview to discuss any concerns that have come to the Medical Council's attention.)

A referral to counselling usually occurs because a practitioner's apparent departure from acceptable standards is not considered significant enough to warrant referral to the DP or prosecution before a disciplinary body, but is still significant enough to raise concerns that require counselling. Counselling provides an opportunity for the practitioner to reflect upon the issues raised within the context of his/her practice and to critically examine suggestions for improvements to his/her practice.

Table 9 illustrates the number of practitioners referred and the number of practitioners who were counselled/interviewed by the Medical Council. There were 43 practitioners referred to counselling/conduct interview, which is a slight increase from 41 referred during 2012/13. The Medical Council maintains the view that it is important to take action in response to conduct which may not necessarily require investigation or prosecution but which still represents a departure from accepted standards.

Table 9: Medical practitioners referred and counselled/interviewed in 2013/14

	Practitioners referred	Practitioners counselled/ interviewed
Counselling	26	16
Conduct Interview	17	13
TOTAL	**43**	**29**

Section 150 proceedings – urgent interim action to protect the public

The Medical Council must exercise its powers under section 150 of the *Health Practitioner Regulation National Law (NSW)* when it is satisfied that such an action is appropriate for the protection of the health or safety of any person or persons or it is otherwise in the public interest. As a result of such action, a medical practitioner's registration can be suspended or conditions can be imposed on their registration. Any action is only an interim public protective measure. Following any Medical Council action under section 150, a matter must be referred to the HCCC for investigation or, alternatively, subject to consultation between the Medical Council and the HCCC, the matter may be referred to an Impaired Registrants Panel (if the practitioner is impaired) or a Performance Assessment (if a condition is imposed requiring it).

Section 150 proceedings represent a significant proportion of the workload of the HPCA professional conduct and legal staff who support the activities of the Medical Council. This is due to the urgent nature of the proceedings together with the large volume of proceedings held. Section 150 proceedings are usually held within two to four weeks of a matter being identified as raising sufficient concern to warrant proceedings being held.

The number of urgent interim proceedings held is dependent on the nature and type of concern which comes to the Medical Council's attention from a variety of sources. Triggers for convening section 150 proceedings include:

- A practitioner being charged with serious criminal offences (particularly arising within the practice of medicine and including sexual offences);
- A practitioner suffering from a serious impairment and demonstrating little or no insight into the extent of his/her problem and the potential or actual risk posed to the public;
- A practitioner practising medicine recklessly, such as prescribing drugs in a manner which is dangerous and likely to cause harm; or
- A practitioner breaching conditions imposed on his/her registration

Section 150 – breakdown of proceedings

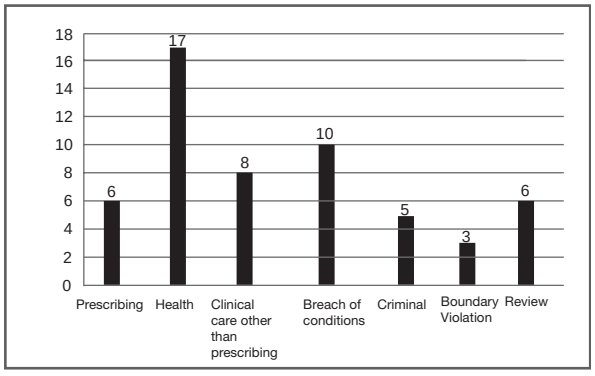
In 2013/14, the Medical Council considered whether to exercise its urgent interim action powers to protect the public on 55 occasions. The results were:

- conditions imposed following a hearing - 25;
- a suspension ordered following a hearing - 13;
- conditions imposed with consent (under s41P of the Law) - 4;
- a suspension agreed (by consent under s41P of the Law) - 3;
- a review hearing was held under s150A of the Law - 6;
- no action under s150 - 4;

The Medical Council decided to initiate urgent interim action proceedings in an additional five matters, however these did not proceed. In three of these instances the practitioner surrendered their registration prior to proceedings, and in the remaining two instances the decision was rescinded on receipt of further information.

Chart 7 illustrates the categories of matters that initiated section 150 proceedings during the reporting period.

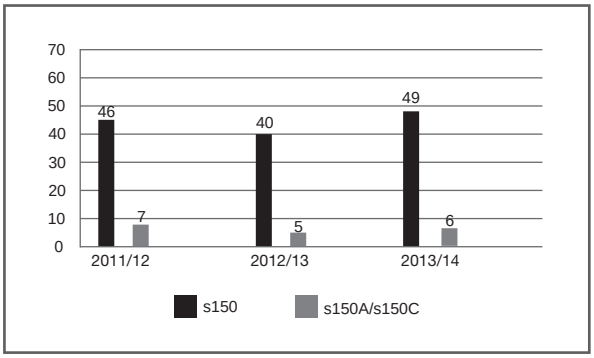
Chart 7: Categories of triggers for section 150 proceedings finalised in 2013/14



The Medical Council concluded 55 section 150 proceedings this year. This was an increase on the 53 occasions in 2011/12 and 45 occasions in 2012/13.

Chart 8 provides a comparison of the number of matters with those of the previous two years.

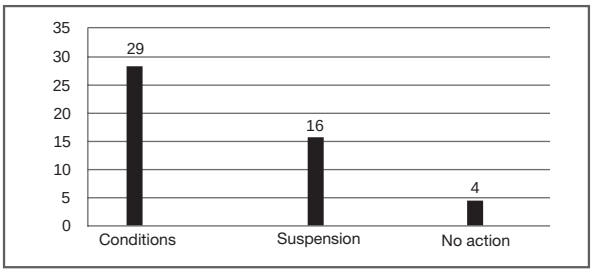
Chart 8: Numbers of occasions the Council considered urgent action to protect the public and number of reviews



Data includes matters where practitioners consented to the imposition of conditions or suspension under section 41P)

As a result of 49 section 150 proceedings, the registration of 16 practitioners was suspended and 29 practitioners had conditions imposed on their registration (as illustrated in **Chart 9**). Four proceedings resulted in no action being taken by the Medical Council.

Chart 9: Outcomes of section 150 proceedings 2013/14



Consent to conditions or suspension under section 41P

Under section 41P of the *Health Practitioner Regulation National Law (NSW),* the Medical Council can, with the consent of the practitioner or student, exercise its section 150 powers to suspend or impose conditions in lieu of convening related proceedings. In this reporting period four practitioners consented to the imposition of conditions on their registration and three practitioners consented to the suspension of their registration in lieu of holding section 150 proceedings. These outcomes are included in the figures in **Chart 9** above.

Section 150A and 150C reviews

In addition to the 49 section 150 proceedings held during the reporting year, six section 150A or section 150C reviews were also conducted. These applications relate to the review of orders previously imposed by the Medical Council under section 150. The number of reviews this year has not changed significantly when compared with five review hearings in 2012/13 and seven review hearings during 2011/12.

Two of these reviews resulted in a change to conditions, one resulted in conditions being lifted, two resulted in suspension being lifted and conditions being imposed and one resulted in no change to the medical practitioner's suspension.

Professional Standards Committee hearings

A Professional Standards Committee hearing (PSC) is established under section 169 of the *Health Practitioner Regulation National Law (NSW)* and comprises four members. The Chairperson is an Australian lawyer who is appointed by the Medical Council. The Medical Council also appoints the other Committee members who include two registered medical practitioners and a person who is not registered in the same profession from a panel of persons nominated by the Minister for Health.

A legal officer and administrative support staff assist the PSC, and monitor compliance with any orders and conditions that are imposed by the PSC.

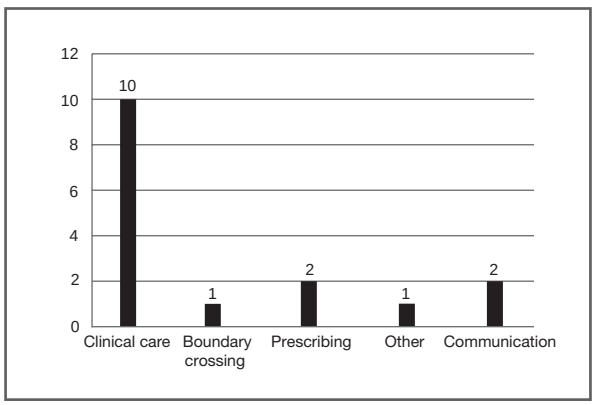
PSC inquiries are open to the public and are held in the Old Medical Council Building (Building 54A) at the former Gladesville Hospital, Gladesville. Details of upcoming PSC inquiries are published on the Medical Council's website. In almost all PSC matters, the parties are legally represented by a solicitor and more often than not by a barrister.

PSC inquiries

In the 2013/14 reporting year, 16 PSC inquiries were finalised in relation to complaints prosecuted by the HCCC, compared with 10 in 2012/13 and 17 in 2011/12. An additional 13 matters were referred to PSCs but were yet to be finalised at the completion of the reporting period.

The categories of complaints which were considered by PSCs that were finalised during the 2013/14 year varied, with clinical care being the most prevalent. **Chart 10** illustrates the categories of complaints determined by PSCs during this reporting period.

Chart 10: Categories of complaints determined by PSCs in 2013/14

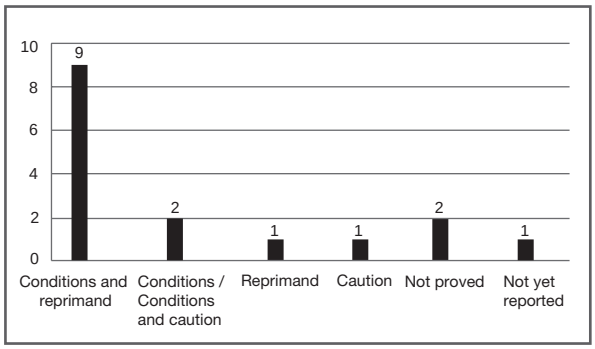


PSC outcomes

PSCs found the medical practitioner guilty of unsatisfactory professional conduct in 13 of the 16 inquiries that were finalised. Two practitioners were found not guilty of unsatisfactory professional conduct and one decision remains unreported pending finalisation of a related matter.

Chart 11 illustrates the orders made by PSCs

Chart 11: PSC outcomes in 2013/14



The following is a list of PSC decisions concerning medical practitioners for the reporting period, which are published in full on the Medical Council's website (subject to any relevant non-publication directions).

Table 10: PSC decisions 2013/14

Decision date	Practitioner	Outcome
23 July 2013	John Theodore Miller	Reprimand and Conditions
29 July 2013	Joachim Fluhrer	Reprimand and Conditions
31 July 2013	Firoz Uddin Ahmad	Reprimand and Conditions
5 August 2013	Decision not published	Not proven
7 August 2013	Samy Alfy Nassief	Reprimand and Conditions
17 October 2013	Wenxiong He	Conditions
13 November 2013	Peter Bruce Loder	Reprimand and Conditions
6 December 2013	Thomas Tham Duy Luong	Decision on Findings
19 March 2014	Thomas Tham Duy Luong	Reprimand and Conditions
30 January 2014	Decision not published	Not proven
17 February 2014	Decision not yet published*	Not yet reported
28 February 2014	Colin Campbell Marshall Moore	Reprimand
23 April 2014	Licia Beatriz Maiocchi	Reprimand and Conditions
5 May 2014	Farhad Rahimpanah	Caution and Conditions
15 May 2014	Roger Andrew McMaster-Fay	Reprimand and Conditions
27 May 2014	Mohamed El Sayed Abdeen	Caution
28 May 2014	Raouf Eshak Farag	Reprimand and Conditions

** The hearing has concluded and the decision handed down. Publication of the decision has been delayed pending the finalisation of a related PSC hearing.*

NSW Civil and Administrative Tribunal

The NSW Civil and Administrative Tribunal (NCAT) deals with serious complaints that may lead to suspension or cancellation of registration, appeals against Medical Council decisions regarding disciplinary matters and appeals against decisions of the National Board in relation to registration matters.

The Medical Tribunal ceased on 31 December 2013 with the commencement of the NCAT on 1 January 2014. The NCAT exercises jurisdiction for all matters previously dealt with by the 14 distinct health profession Tribunals. Health practitioner matters are now dealt with in the Health Practitioner Division List in the Occupational Division of NCAT. The Medical Council nominates two registered practitioners and a lay person to NCAT for appointment to a Tribunal.

Medical Tribunal

The former NSW Medical Tribunal was established under section 165 of the *Health Practitioner Regulation National Law (NSW)* and comprised four members, with the Chairperson or Deputy Chairperson a Judge of the Supreme Court, Justice of the Industrial Relations Commission or Judge of the District Court of NSW. Similarly, the Medical Council appointed non-judicial members to sit on all Medical Tribunal hearings, appeals and review hearings.

Table 11 illustrates matters concluded by the Medical Tribunal and NCAT over the past three reporting years.

Table 11: Concluded Medical Tribunal and NCAT hearings 2011/12 to 2013/14

	Complaint matters	Appeal matters	Applications for review/ restoration applications
2011/12	22 (3 withdrawn)	2	2 (2 withdrawn/terminated)
2012/13	27 (2 withdrawn)	1 (2 withdrawn)	4 (3 withdrawn/terminated)
2013/14	16 (2 withdrawn)	0 (3 withdrawn/terminated)	0 (3 withdrawn/terminated)

NCAT and Medical Tribunal complaint hearings

Since 1 January 2014 there were ten matters heard in the NCAT, of which nine complaint matters were finalised in the NCAT.

The ten complaints were initially filed in the Medical Tribunal. Thirteen complaint matters referred to the former Tribunal have been set down for hearing in the next reporting year. Eight complaint matters have been referred to the NCAT in the reporting year and have been set down for hearing in the next reporting year.

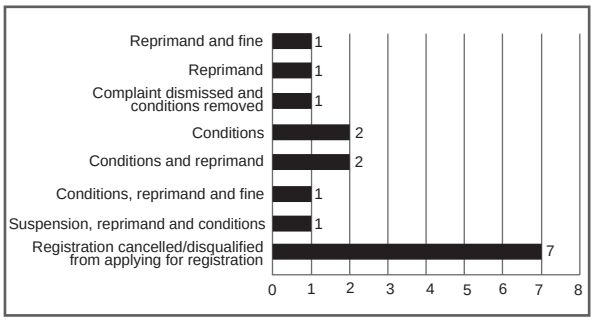
From 1 July 2013 to 1 January 2014, seven complaint matters were finalised in the Medical Tribunal. Two further complaints were withdrawn.

NCAT and Medical Tribunal complaint hearing outcome

Of the nine complaints against practitioners finalised in the period from 1 January 2014 to 30 June 2014, the NCAT found the practitioner guilty of unsatisfactory professional conduct and/or professional misconduct in nine cases. The former Tribunal found six of seven practitioners guilty of unsatisfactory professional conduct and/or professional misconduct.

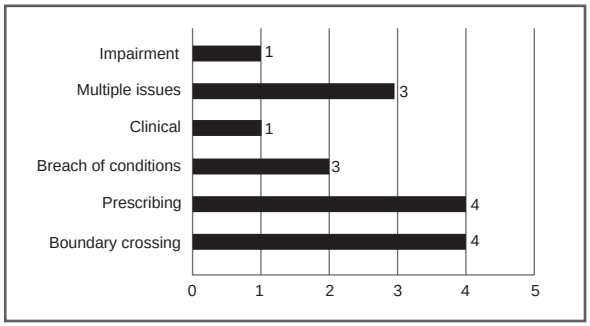
In these cases findings were made in relation to the complaints either being proven in full or in part. Protective orders were made in respect of each of the 15 practitioners with the details illustrated in **Chart 12.** Seven practitioners had their registration cancelled and/or were disqualified from re-registering for a specified period or until specific criteria were met. In two of these cases, the order for cancellation of registration comes into effect in the next reporting year. One practitioner was reprimanded and suspended with conditions imposed on their registration, while two practitioners were issued with a reprimand in addition to the imposition of conditions or orders.

Chart 12: NCAT and Medical Tribunal determinations (complaint matters) 2013/14



Boundary crossing and prescribing issues were the most common categories identified in the complaints finalised by the NCAT and the Medical Tribunal in the reporting period. **Chart 13** illustrates the nature of complaints matters determined by the NCAT and the Medical Tribunal.

Chart 13: Issues raised in the complaints determined by NCAT and the Medical Tribunal 2013/14



Medical Tribunal decisions up to 31 December 2013 are listed in **Table 12** and published on the Medical Council's website (subject to any relevant non-publication directions). In matters where no judgment was handed down, the orders have been published. NCAT decisions from 1 January 2014 are published by the NCAT on NSW Caselaw. The Medical Council's website also provides a link to the decisions.

A practitioner's current registration status, including the details of any published conditions, is available from AHPRA's website at www.ahpra.gov.au. A search of the AHPRA website can also be made for the details of medical practitioners whose registration has been cancelled by the NCAT or the Medical Tribunal.

Table 12: Medical Tribunal decisions in relation to complaints 2013/14

Judgment Date	Practitioner	Tribunal Decision
2 August 2013	Annette Dao Quynh Do	Conditions- must comply before apply for re-registration
9 August 2013	Cathryn Carmel Platt	Suspended for 3 months, reprimand and conditions
28 August 2013	Malcolm Ridley Hughes	Reprimand
20 September 2013	Robert Bernard Hampshire	Reprimand and fine
19 November 2013	Don Nguyen	Complaint dismissed and conditions lifted
2 December 2013	Suresh Surendranath Nair	Registration cancelled, may not apply for review for 6 years
17 December 2013	Michael John McKay	Disqualified from applying for re-registration for 3 years
20 December 2013	Zeitoun Athour	Decision on findings*
3 February 2014	Fabian Baez	Decision on findings*
14 March 2014	Zeitoun Athour	Reprimand, conditions and fine
28 March 2014	Fabian Baez	Disqualified from applying for re-registration for 5 years
7 April 2014	Gordon Christopher Howe	Conditions – must comply before apply for re-registration
8 April 2014	Albina Teresa Della Bruna	Reprimand and conditions
2 May 2014	Shaheen Qasim	Registration cancelled, may not apply for review for 4 years
6 May 2014	David John Bennett	Registration cancelled, may not apply for review for 5 years
13 May 2014	Mohammed Adnan Naiyer	Decision on findings*
21 May 2014	Colin John Jamieson	Reprimand and conditions
6 June 2014	Mohammed Adnan Naiyer	Registration cancelled, may not apply for review for 18 months
16 June 2014	Richard Norman Townsend	Registration cancelled, may not apply for review for 1 year

** The Tribunal has conducted its hearing in 2 stages (Findings, and then Orders). This is the judgment in relation to Stage 1.*

NCAT and Medical Tribunal appeals

Five appeals were referred to the NCAT and the Medical Tribunal in the reporting year and five were withdrawn. Four of the appeals were against the decision of the Medical Board of Australia. The remaining practitioner sought an appeal of the Medical Council's decision.

NCAT and Medical Tribunal applications for review

There were seven applications for review referred to the NCAT or the Medical Tribunal in the reporting year and three were withdrawn. As at 30 June 2014 there are four reviews, yet to be finalised. Three of these are applications for a review of an order to cancel registration and one application is for a review of conditions. The Medical Council appears as the respondent in these applications.

Review of NCAT and Medical Tribunal orders

Under section 163A of the *Health Practitioner Regulation National Law (NSW),* a practitioner may apply to the Medical Council for a review of an order that conditions be imposed on the practitioner's registration. In 2013/14, six practitioners applied for a review of a Tribunal order imposing conditions on their registration and one was withdrawn. Of the two applications that were determined in the reporting year, one practitioner had their conditions altered and one practitioner's conditions remained the same. One practitioner sought review of conditions imposed by a PSC and had their conditions lifted.

> health

2013-2014 **snapshot**

- → 117 notifications were made to the Health Program, compared with 90 in 2012/13 and 99 in 2011/12.
- → 18% of notifications were made by colleagues, 10% were self-notified, 13% were referred from AHPRA and 20% were made by treating practitioners, or as a result of a hospital admission. 39% of notifications came from other sources.
- → 81 Impaired Registrants Panels were conducted and considered issues related to psychiatric illness (46%), drug addiction (10%), alcohol addiction (12%) and cognitive problems (16%).
- → There were 110 participants in the Health Program and 12 practitioners exited the Program.

Overview

A medical practitioner's health is one area that may impact on his or her capacity to practise medicine safely and effectively. Among its range of programs and services aimed at ensuring all medical practitioners in NSW are fit to practise medicine, the Medical Council has a long established Health Program that enables it to deal with impaired medical practitioners and medical students in a constructive and non-disciplinary manner.

The Health Program aims to protect the public while at the same time allowing participants with health problems to remain in active practice or training, if it is safe to do so. The Health Program is designed to be non-disciplinary and non-adversarial and is conducted under the *Health Practitioner Regulation National Law (NSW).*

Impairment has a specific, statutory definition. A medical practitioner is impaired if they have a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects, or is likely to detrimentally affect, their capacity to practise medicine, or for a student, the student's capacity to undertake clinical training. Illness does not necessarily equate to impairment. If an impaired practitioner is insightful and practises within their residual capacity, they are not necessarily impaired for the Medical Council's purposes.

The Health Program manages medical practitioners suffering from psychiatric illness, problems with alcohol abuse or the self-administration of addictive drugs, cognitive impairment and occasionally, physical illness.

Obligations to notify

The Medical Council through its Health Program receives self-notifications from practitioners and third party notifications from parties including colleagues, employers, treating practitioners, and from AHPRA.

The *Health Practitioner Regulation National Law (NSW)* requires registered health practitioners, education providers and employers of a registered medical practitioner to report to AHPRA certain types of misconduct committed by another registered medical practitioner. Notifiable conduct includes practitioners who are reasonably believed to have been practising while intoxicated through the consumption of drugs or alcohol, or to have placed the public at risk of substantial harm due to an impairment. For further information on mandatory notifications activity, see the 'Professional Conduct' section of this Annual Report.

In all other circumstances, although there is no legal obligation for practitioners to notify AHPRA or the Medical Council about practitioners with health problems, there is a strong professional and ethical obligation to do so.

How the Program operates

When a notification is received which raises a legitimate concern about possible impairment, the medical practitioner will be assessed by a Medical Council-appointed practitioner (CAP) to determine the nature of the impairment. The CAP's role is to make an independent assessment about the nature and extent of the impairment and whether participation in the Health Program is appropriate. The medical practitioner will meet with two members of the Medical Council's Impaired Registrants Panel (IRP) and agree on the action necessary to protect the public. The most common outcome is conditions on the medical practitioner's registration, although on occasions, it may be necessary for the medical practitioner to be suspended for a period of time.

Conditions on registration are tailored to address the practitioner's particular circumstances and type of impairment. Under the provisions of the *Health Practitioner Regulation National Law (NSW),* AHPRA is required to notify the practitioner's employer of the conditions imposed on the practitioner's registration. Conditions are also published on the National Register of Practitioners, which is available on the AHPRA website.

The Medical Council's Health Committee monitors these conditions, which may include urine drug testing, regular reviews and assessments. Medical practitioners are expected to comply with their conditions of registration so as to assure the Medical Council that they pose no risk to the public. As the medical practitioner demonstrates progress in rehabilitation and recovery, the conditions on their registration are gradually eased. While return to unconditional practice is a goal of the program, some medical practitioners, for example those with recurring psychiatric illness, may remain on the program indefinitely, albeit with low level, occasional review by the Medical Council.

The Health Committee also utilises the Chronic Relapsing Illness Authority form (CRIA), which allows treating practitioners to advise the Medical Council if there is any concern about the practitioner's health or if the practitioner is non-compliant with treatment, or terminates treatment against advice. This has been useful in replacing the need for some practitioners to remain on the Health Program despite being stable. A CRIA is also used in some cases as an alternative to entry to the Health Program. As at 30 June 2014 there were approximately 74 practitioners subject to a CRIA.

The Health Committee requires Health Program participants to attend an exit interview prior to leaving the Program. The interview serves to focus attention on the practitioner's insight, learning and relapse prevention strategies. It also provides the Medical Council with useful feedback about the administration of the Program.

Program activity

Notifications

In the year ending 30 June 2014, the Medical Council received 117 health notifications about practitioners, including 12 medical students. **Table 15** details the source of these notifications and a comparison over the past two reporting years. This year has seen a decrease in health complaints/notifications made to the Medical Council by AHPRA. Notification may occur when a practitioner makes a declaration that he/she is impaired at the time of the initial application for registration or renewal of registration – a process managed by AHPRA. In most of these cases, the practitioner is already in the Health Program and is subject to conditions and monitoring by the Medical Council.

There have been more notifications received from employers and treating practitioners when compared with last year, although the numbers are more consistent with the numbers received in 2011/12. Notifications categorised as received from "Other" were made by other regulatory agencies, such as the HCCC, Pharmaceutical Services of the Ministry of Health, overseas regulatory authorities, or other NSW health professional Councils. Sixteen notifications were made by the Medical Council following section 150 proceedings

Table 15: Source of notifications 2011/12 to 2013/14

Notifications by source	2011/12 n=99	2012/13 n=90	2013/14 n=117
Colleagues (including employers)	30	12	21
Self-notifications	19	5	12
Treating practitioner/ hospital admission	20	10	23
AHPRA	10	35	15
University	0	1	4
Medical Council committee	4	1	4
Other	16	26	22
Referrals from s150	Not Reported	Not Reported	16
TOTAL	**99**	**90**	**117**

Impaired Registrants Panels

There were 81 Impaired Registrants Panels (IRPs) held during the reporting year in relation to 66 practitioners. 70 IRP reports were endorsed by the Health Committee. Three IRPs were convened under section 152K of the *Health Practitioner Regulation National Law (NSW),* which are held following a request by a practitioner to ease or remove conditions or lift a suspension. Twenty practitioners entered the program during the reporting year.

Of the 81 IRPs held, 57% recommended that the practitioner agree to new or changed conditions being placed on his or her registration, 14% of IRPs resulted in no further action being taken, 14% were adjourned, and in 15% of cases, some other type of action was taken. There are a range of reasons for an IRP being adjourned, including to obtain further information or to allow the practitioner to seek further treatment or support, particularly if they are significantly unwell at the time of the initial IRP.

The details of the nature of impairments considered by an IRP in this and the previous two reporting periods are at **Table 16**. Psychiatric illness continues to be the largest type of impairment considered by IRPs. There has been a 10% increase in the number of IRPs where the nature of the impairment is cognitive. This reflects the increased awareness that unsatisfactory professional performance or conduct may be caused by an underlying health problem.

Table 16: Nature of impairment considered by IRPs

	2011/12*	2012/13*	2013/14**
Psychiatric illness	37	22	37
Alcohol	13	8	10
Drug	10	12	8
Physical	0	2	2
Cognitive	4	4	13
Multiple issues	n/a	n/a	11
TOTAL	**64**	**48**	**81**

* *Figures indicate number of IRP Reports endorsed by the Health Committee*

** *Figures indicates number of IRPs held (This is consistent with other Health Professional Councils)*

Review and exit

One of the ways that the Medical Council monitors an impaired practitioner is through regular review interviews. Following an IRP, conditions will require the practitioner to be reviewed by a Medical Council-appointed practitioner (CAP). The CAP will provide the Medical Council with a report on the impaired practitioner's progress and make any recommendations about varying or easing conditions of registration. The frequency of such reviews varies depending on the practitioner's health, progress and level of compliance with conditions. The Medical Council conducted 212 review interviews in 2013/14, 14 fewer than the previous reporting period.

During 2013/14, 12 practitioners exited the Health Program returning to general registration without conditions. The Medical Council was satisfied that these practitioners had actively sought to manage their impairment, were willing and able to take responsibility for their own health and were safe to practise without conditions.

As can be seen from **Table 17**, in 2013/14 the overall activity of the Health Program has mostly been consistent with previous years, with the number of participants in the Health Program and number of Review Interviews remaining high and a similar number of Exit Interviews held compared with the previous year. However, there has been an increase in the number of IRPs held.

Table 17: Health Program activity 2011/12 to 2013/14

Hearings	2011/12	2012/13	2013/14
IRP reports endorsed	64	48	70
Review interviews	234	226	212
Exit interviews	20	13	12
Participants in Program as at 30 June	122	118	110

In addition to Health Program participants being monitored, there are practitioners who are also subject to conditions on their registration relating to their health but who are not participants in the Program. This is because the conditions were imposed through another process other than the Health Program IRP, such as a Tribunal Hearing or urgent section 150 proceedings. At the time of reporting there were 18 practitioners in this category being monitored by the Medical Council.

Case studies

As with all case studies contained in this Annual Report, the name, age and their area of practice of all practitioners have been de-identified. Specific details concerning practitioner notification and impairments may have been altered.

Case study – Notification with outcome of no further action

Dr W is a 70-year-old practitioner about whom a notification was received alleging they had a cognitive impairment. Dr W underwent a Council-appointed practitioner (CAP) assessment by a psychiatrist, who reported that there was no evidence of a mood, anxiety or personality disorder and no obvious cognitive disorder. Dr W underwent neuropsychometric testing that indicated that there was no evidence of a progressive neurodegenerative condition. The matter proceeded to an Impaired Registrants Panel (IRP) which concluded that there was a dysfunctional, interpersonal relationship with the notifying practitioner. The Panel found no evidence of impairment. Dr W had a well thought out retirement plan. The Panel encouraged Dr W to continue with their current, manageable workload with low patient numbers and proceed with their retirement plan. No further action was taken by the Medical Council following consideration of the IRP report.

Case study – Notification with outcome of signing a Chronic Relapsing Illness Authorisation (CRIA)

Dr X is a 64-year-old practitioner about whom a notification was received from their treating psychiatrist. Dr X had experienced a seizure at work that was later found to be solely due to a change in medication for bipolar affective disorder. The matter was referred to the Medical Council and Dr X underwent a CAP assessment by a psychiatrist. The CAP agreed with the diagnosis of bipolar affective disorder and opined that there was a potential for this to impact on Dr X's clinical functioning and professional abilities. The matter proceeded to an IRP, which the Panel commented on Dr X's high level of insight, compliance with treatment, and support from treating practitioners and work colleagues. The Panel did not recommend any conditions on Dr X's registration but recommended Dr X sign a CRIA to allow the treating practitioner to notify the Medical Council if Dr X is non-compliant with treatment, terminates treatment against advice or if there is any concern about Dr X's mental state.

Case study – Health program participant with relapsing illness

Dr Y is a 49-year-old practitioner who joined the Health program in 2002 after the Medical Council received a self-notification regarding excessive alcohol consumption. Following that notification Dr Y had two separate, but extended periods on the Health program with conditions on their registration regarding alcohol, monitoring and treatment. Dr Y exited the Health program for the second time in 2013 and signed a CRIA to allow the Medical Council to be notified should their health deteriorate. Later that year a notification was received from Dr Y's employer regarding an extended period of sick leave. The matter proceeded to an IRP where Dr Y advised they had self-initiated the period of leave when their mental health deteriorated in response to a number of personal stressors. Dr Y had sought assistance from their treating practitioners and support group at that time. Dr Y had relapsed to alcohol consumption on one occasion. Dr Y re-entered the Health program with conditions on their registration including that Dr Y remain abstinent from alcohol, have regular blood test monitoring, and regular contact with treating practitioners. Currently Dr Y's health is stable and Dr Y remains compliant with conditions.

Case study – Health program participant exiting

Dr Z is a 46-year-old practitioner who first came to the attention of the Medical Council following a notification from the then Pharmaceutical Services Branch that Dr Z's Schedule 8 prescribing authority had been withdrawn. Dr Z had been self-administering pethidine from their doctor's bag, as well as presenting prescriptions in the names of patients. Dr Z joined the Health program in 2005 and a number of conditions were placed on Dr Z's registration including that Dr Z be monitored with regular urine drug tests, and that Dr Z have regular contact with their treating practitioners. In 2008 Dr Z's registration was suspended due to failure to comply with conditions. Dr Z sought assistance from their treating practitioners and support groups during the suspension and made a positive recovery. Dr Z's registration was restored in 2009 and Dr Z remained on the health program with the conditions monitored and adjusted over several years. Dr Z remained compliant with their conditions and Dr Z exited the health program in 2013.

Conclusion

The Medical Council's Health Program provides a clear and well-defined process for initial assessment and ongoing management of medical practitioners with impairment. The Medical Council's program focusses on regulation with independent assessment, which is distinct from treating relationships. The Health Program relies on the combination of independent opinion and regular in-person review interviews with the impaired practitioner. This provides a sound basis on which to judge whether a practitioner's health is, or may be, having an impact on his/her professional performance or whether a practitioner should be referred for disciplinary measures because of non-compliance with conditions.

> performance

2013-2014 **snapshot**

- → Following assessment, the HCCC referred 165 complaints to the Medical Council as performance matters.
- → 85 Performance Interviews were conducted (a 10% increase on the previous reporting year).
- → 25 Performance Assessments were conducted and 11 re-assessments were conducted – a total of 36 (a 44% increase on the previous reporting year for the total assessments conducted).
- → 17 Performance Review Panels were conducted (a 42% increase on the previous reporting year).
- → There were 37 practitioners who entered the Performance Assessment Program, with a total of 99 practitioners who either: required a Performance Assessment; were subject to a Performance Assessment or had conditions imposed by a Performance Review Panel and were being monitored by the Medical Council.

Overview

The Performance Program is a pivotal part of the Medical Council's activities to ensure the health and safety of the public is protected and medical practitioners are fit to practise. Introduced in October 2000, it represents the culmination of intensive research, consultation and development. The program is designed to complement the Conduct and Health streams by providing an alternative pathway for dealing with practitioners who are neither impaired nor guilty of professional misconduct, but about whom the Medical Council has concerns about the standard of their clinical performance. The program is designed to provide an avenue for education and retraining where inadequacies are identified, while at all times ensuring that the public is adequately protected. It is designed to address patterns of practice rather than one-off incidents unless the single incident is demonstrative of a broader problem.

The professional performance of a registered medical practitioner is considered to be unsatisfactory if it is below the standard reasonably expected of a practitioner of an equivalent level of training or experience. In addition, the Medical Board of Australia's, *Good Medical Practice: A Code of Conduct for Doctors* in Australia sets out relevant expectations for registered medical practitioners. The causes of poor performance are many and varied. Professional isolation and inattention to continuing professional development are common contributing factors. On occasions, medical practitioners present with adequate knowledge, but an inability to apply that knowledge in their day-to-day practice. This may be due to external 'distractors' such as illness and financial stress which may affect a practitioner's performance in the short or longer term.

The Medical Council's Performance Committee has a number of tools available to determine whether a medical practitioner's professional performance is satisfactory, including the Performance Interview (PINT), Performance Assessment (PA) and Performance Review Panel (PRP). Once performance has been found to be unsatisfactory, there is a range of means available to support improvement, including education and observation of another medical practitioner's practice, as well as public protection measures, such as supervision and limits on practice. These measures may be imposed on the medical practitioner by way of conditions placed on his/her registration. Compliance with registration conditions is monitored by the Medical Council's Monitoring Program.

Program activity

Thirty-seven practitioners entered the Performance Assessment Program in the reporting year and 99 participants were in the Program at 30 June 2014.

Complaints

The Medical Council and the HCCC jointly assess all complaints received about the practice of medicine in NSW. Following this joint assessment, a matter related to a practitioner's professional performance may be referred to the Medical Council for further consideration within the Medical Council's Performance Program, which is non-disciplinary and works within a framework of early intervention, and if required, remediation.

The HCCC referred 165 complaints to the Medical Council as performance matters during the current reporting year, a decrease from 264 in the previous reporting year.

Outcomes of complaints

The Medical Council considers a range of actions in response to performance matters that come to its attention, including that:

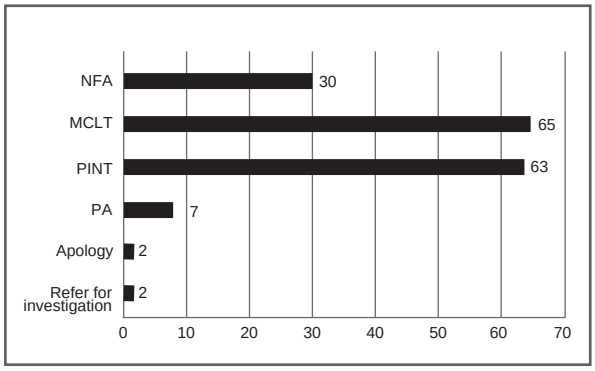
- No further action be taken as the medical practitioner's response to the issues raised by the complaint is considered satisfactory and there are no outstanding issues;
- A letter be sent from the Medical Council to the medical practitioner drawing attention to significant performance issues and giving advice on how deficient areas of practice could be improved;
- The medical practitioner should attend a Performance Interview where the issues raised by the complaint can be further explored; or
- The medical practitioner should undergo a detailed Performance Assessment (PA).

Other outcomes include an apology to the complainant, referral to the Medical Council's Conduct or Health programs, referral to the HCCC for investigation, or referral elsewhere (for example, resolution or conciliation between the practitioner and complainant).

In 2013/14, the Medical Council's Performance Committee determined outcomes in relation to 169 performance complaints. If appropriate, the Medical Council may take action in response to unsatisfactory

performance that may not require investigation or prosecution, but which still represents a departure from accepted standards.
The complaint outcomes following initial consideration of the complaint and the practitioner's response are summarised in **Chart 14**. The most common outcomes following initial consideration of the complaint and the practitioner's response are a Medical Council letter (MCLT), a Performance Interview (PINT), or no further action (NFA).

Chart 14: Initial outcomes of complaints considered by the Performance Committee in 2013/2014



Performance Interviews

Where a complaint raises concern about a medical practitioner's professional performance but does not immediately reach the threshold for a Performance Assessment (PA), the Performance Committee may hold a Performance Interview (PINT). This is an informal interview, during which issues raised by the complaint and the medical practitioner's response, as well as any broader issues regarding the practitioner's practice, are explored. In the majority of cases, matters raised by the complaint can be addressed at a PINT, with appropriate advice and counselling given to the medical practitioner, with no further action taken by the Medical Council. Other outcomes available to the Medical Council following a PINT are referral to a PA, referral to a disciplinary pathway, or referral to a Council-appointed practitioner (CAP) assessment which may include neuropsychometric testing or psychiatrist assessment.

PINTs held

During 2013/14, 85 PINTs were conducted as a result of 96 complaints (a PINT may be triggered by more than one complaint). The increase in the total number of PINTs conducted from 77 in the previous reporting year reflects the Performance Committee's continuing view that a PINT is an effective means of obtaining further information when a complaint raises concerns about a practitioner's professional performance.

PINT outcomes

The Performance Committee determined outcomes for 98 PINTs in 2013/14. This was an increase from 73 in the previous reporting year, and reflects the increase in PINTs conducted from 2012/13 to 2013/14. The outcomes are summarised in **Table 18**.

Table 18: PINT outcomes

	2012/13	2013/14
No further action	48	68
Referral to medical assessment	2	1
Referral to medical assessment and PA	-	3
PA	22	19
Referral to disciplinary pathway	1	1
Referral to health pathway	0	1
Medical Council letter with advice	0	1
Did not proceed	0	4
TOTAL	**73**	**98**

Case study - PINT

Dr X is a 57–year-old medical practitioner about whom a complaint was received by the HCCC alleging inadequate follow up of an abnormal X-ray report indicating the complainant may have had cancer. Dr X's response to the complaint indicated that Dr X had never received the X-ray report. The matter was referred to the Medical Council and Dr X was invited to attend a PINT. Despite not receiving the report, the interviewers, together with Dr X, identified the other contributing factors for the complaint. These included Dr X's change from regular practice with regards to following-up with patients, communication errors with the radiology practice, and failure to respond promptly to a letter of complaint from the patient. Dr X was counselled to ensure appropriate follow-up of test results takes place, that there is clear communication with patients and documentation of management plans in the medical records, and complaints from patients are promptly responded to. Dr X was also encouraged to discuss the case with the radiology practice involved to consider system changes to ensure unexpected abnormal results are phoned through by the radiologist. Dr X was receptive to these suggestions. No further action was taken by the Medical Council following consideration of the PINT report.

Performance Assessment (PA)

A Performance Assessment (PA) is one of the mechanisms available to the Medical Council in response to concern about a medical practitioner's professional performance. The practitioner's complaint history is taken into consideration. In a small number of cases, the decision to hold a PA is based on the triggering complaint alone (in 2013/14 this occurred in relation to five medical practitioners, based on six complaints). One other complaint had an outcome of a PA but a PA was already to be held. In the majority of cases the medical practitioner attends a PINT (this was the case for 22 medical practitioners) or is involved in another Medical Council process before being referred to the Performance Committee for consideration of a PA.

PAs are usually conducted in the medical practitioner's environment by two or three practitioners familiar with the medical practitioner's area of practice. The assessment is broad-based and is not limited to the particulars of the matter that triggered the assessment. Multiple assessment tools are used, including the observation of consultations and procedures, a review of records and a clinical practice interview.

Once the PA report is received, a number of options are available to the Performance Committee. In cases where the performance assessors do not identify performance deficiencies, no further action is taken in relation to the medical practitioner. In cases where minor concerns are raised, the assessors may counsel the medical practitioner and provide advice and recommendations during the assessment. More formal counselling can occur when there are more significant performance issues that still need to be brought to the practitioner's attention, but do not require remediation or limitations in practice. A Performance Review Panel (PRP) is conducted if remediation or limitations in practice appear to be required, or if there are issues of public protection.

Referrals to PA

In 2013/2014, the Performance Committee considered 43 practitioners and decided that a PA should be conducted for 37 practitioners. **Table 19** provides a breakdown of the practice areas of the medical practitioners referred for consideration of a PA. As in previous reporting years, general practitioners make up the majority (60%) of medical practitioners, reflecting their proportionate number in the medical workforce.

Table 19: Practice area of medical practitioners referred for consideration of a PA in 2013/14

	2013/2014
Anaesthetist	1
Cosmetic procedures	1
Dermatologist	1
General Practitioner	26
Hospital Non-Specialist	2
Obstetrician & Gynaecologist	2
Ophthalmologist	1
Physician	3
Psychiatrist	1
Surgeon	5
TOTAL	**43**

PAs conducted

There were 25 PAs conducted and 11 re-assessments.

The Performance Committee considered 21 PA reports from PAs conducted in this and the previous reporting year. The outcomes of the PA reports appear in **Table 20**. The Performance Committee also considered 11 matters where a decision was previously made to hold a PA and it did not go ahead because of the following reasons:

- It was rescinded or the PA could not be held;
- The practitioner changed their registration to non-practising or failed to renew their registration and was therefore no longer registered; or
- The practitioner moved to another State so their Principal Place of Practice (PPP) was no longer in NSW and a notification of the matter was made to the Medical Board of Australia/AHPRA.

In relation to the 15 re-assessment reports considered, the outcome was no further action for four practitioners, counselling for one practitioner and a PRP for eight practitioners. Two practitioners agreed to a further re-assessment so no PRP was required.

Table 20: PA outcomes in 2013/14

	2013/14
No further action	7
Performance Review Panel	11
Counselling	3
TOTAL	**21**

Case study – PA

Dr Y is a 76-year-old medical practitioner about whom a complaint was received by the HCCC alleging that their consulting rooms were untidy and dirty. The complainant also alleged Dr Y communicated in a manner that was rude and abusive. After the Medical Council had considered the complaint and Dr Y's response, it was resolved that Dr Y undergo a PA that was conducted at Dr Y's consulting rooms. The assessors concluded that while Dr Y demonstrated reasonable knowledge, concern was raised with regard to Dr Y's patient management skills. Dr Y's medical records were not at the standard expected and the practice facilities were lacking, particularly a lack of equipment available to meet an emergency. The assessors concluded that Dr Y's professional performance was unsatisfactory in the areas of clinical judgment, patient management skills, medical records and office facilities. The PA report was considered by the Performance Committee and the matter was referred to a PRP to review Dr Y's professional performance.

Medical Assessment

On occasion the Performance Committee will require a medical practitioner to be assessed by a Council-appointed practitioner. This occurs when the complaint, or additional information obtained by the Medical Council, indicates that the medical practitioner may have an impairment.

In 2013/14, the Performance Committee decided to refer four medical practitioners to attend neuropsychometric testing by a clinical neuropsychologist due to concerns about cognitive impairment and this occurred prior to their Performance Assessment. One medical practitioner was referred to an assessment by a Council-appointed psychiatrist.

These referrals reinforce the Medical Council's view that many factors influence and affect a medical practitioner's performance and a practitioner's health may be one factor which may cause unsatisfactory performance.

Performance Review Panel

A Performance Review Panel (PRP) is held if, as a result of a PA or a re-assessment, the Performance Committee considers that the medical practitioner's professional performance is unsatisfactory and should be referred to a PRP. The Panel, which consists of three members, one not being a registered medical practitioner, considers the areas believed by the assessors at the PA or re-assessment to be unsatisfactory, as well as submissions made by the medical practitioner. Where a PRP makes a finding of unsatisfactory professional performance, it may impose conditions on a medical practitioner's registration. Such conditions may relate to remediation, for example completion of appropriate education courses, or public protection, such as limitation on the scope of practice – or both. The Panel may also make a direction for a performance re-assessment.

PRPs held

During the reporting year, 17 PRPs were held and one did not proceed. The outcomes are summarised in **Table 21**. Two outcomes were from PRPs held in the previous reporting year.

Table 21: PRP outcomes in 2013/14

	2013/14
No further action	2
Re-assessment only	4
Conditions and re-assessment	7
Decision pending	6
Did not proceed	1
TOTAL	**20**

Conditions that are imposed by a PRP may be removed after the medical practitioner has satisfactorily completed any remediation or after the medical practitioner has been subject to a performance re-assessment at which the practitioner demonstrates satisfactory performance.

Thirty-four practitioners exited the Performance Assessment Program during the reporting year.

Case study – PRP

Dr Z is a 35-year-old medical practitioner about whom a complaint was received regarding an investigation into multiple complaints received about Dr Z's practice at the hospital at which Dr Z worked. The investigation had identified a number of clinical concerns including the appropriateness and timeliness of Dr Z's medical assessment and management of patients, delay in escalating treatment or transferring care of unwell patients, and failure to understand on-call requirements. As a result of the investigation Dr Z's position had been terminated and Dr Z was thereafter working in private practice. The matter was referred to the Medical Council and it was resolved that a PA be conducted. The assessors concluded that Dr Z's professional performance was unsatisfactory in the areas of basic clinical skills, clinical judgment, prescribing skills, practical / technical skills, and interaction / communication with patients. Following consideration of the PA report it was resolved that a PRP be convened. At the PRP Dr Z impressed the Panel with the improvement in their clinical practice since the PA. Dr Z had reflected upon the deficiencies identified in the PA report and had changed their practice dramatically, including completing a significant proportion of their current training program. The Panel found Dr Z's professional performance satisfactory and no orders or directions were required. No further action was taken by the Medical Council following consideration of the PRP report.

Conclusion

The Medical Council's Performance Program has seen a substantial increase in activity in the reporting year with an increase in the number of hearings being conducted. The Program continues to respond to concerns about medical practitioners' professional performance with an emphasis on education and remediation to ensure public protection.

> monitoring

2013–2014 **snapshot**

- → 303 medical practitioners were subject to conditions monitored by the Medical Council.
- → 64 practitioners were referred to the Council's Monitoring Program.
- → 59 practitioners no longer required monitoring.
- → At 30 June 2014, 244 practitioners were subject to conditions monitored by the Medical Council.

Overview

The Monitoring Program is responsible for monitoring compliance with orders and conditions imposed on a medical practitioner's registration, following a Health, Performance, or Conduct outcome, including any urgent interim action.

Orders and conditions are imposed on a medical practitioner's registration, if it is necessary, to protect the public. This can be achieved by:

- Placing limitations on a medical practitioner's practice of medicine. For example, restricting the type of procedure(s) a medical practitioner may perform or limiting the number of patient consultations per day;
- Setting in place conditions aimed at remediating the medical practitioner. For example, requiring a practitioner to undertake specific courses or participate in supervision; and/or
- Ensuring practitioners attend for treatment in order to manage an impairment so they can practise safely. This may include engaging in treatment or participating in alcohol or drug testing.

The Medical Council differentiates conditions imposed on medical practitioners' registration into practice conditions and health-related conditions. The Program monitors compliance with all practice conditions. These conditions are published on the Register of Practitioners, which is available through the AHPRA website. Published conditions may relate to a practitioner's work arrangements, such as where and in what capacity a practitioner may work, for how many hours per day or week, and whether supervision is required and, if so, at what level.

Health conditions are not usually published on the register. These conditions regulate a medical practitioner's treatment and will be adjunct conditions relating to activities that occur outside of the practitioner's workplace. They may include monitoring activities, such as urine drug screening, alcohol testing or hair testing and requirements to engage in treatment. These conditions also specify the review cycle undertaken by the Medical Council, including the frequency of review by the Council-appointed practitioner and interview by the Medical Council. Monitoring of compliance with health conditions is the combined responsibility of the Health and Monitoring Programs, with the latter being responsible for conditions relating to drug and alcohol testing. The Health Program monitors the remainder of health conditions.

Monitoring process

Following the imposition of conditions on a medical practitioner's registration, a monitoring program officer makes initial contact with the medical practitioner and advises of all compliance requirements, including whether adherence to a particular Medical Council Policy or Protocol is required. An action schedule covering all conditions is then established and regularly updated.

Depending on the case, information regarding compliance may be obtained from the medical practitioner themselves, external organisations such as Medicare or Pharmaceutical Services and/or independent third parties such as Council-appointed practitioners, supervisors, auditors or testing laboratories.

Medical Council Committees are responsible for decisions regarding applications and submissions to vary or lift condition(s), any approvals required by the medical practitioner's conditions and/or any actions required following a breach of a condition. HPCA staff prepare a brief which includes relevant information to inform the Committees and also action outcomes following a Committee resolution.

All changes to a medical practitioner's conditions are communicated by HPCA staff to AHPRA so that the public register can be amended accordingly.

The level, complexity and duration of monitoring activity varies considerably over the range of conditions being monitored by the Program. Some conditions may require no more than a periodic letter to request confirmation of the medical practitioner's circumstances. Other cases require more frequent contact and scrutiny, such as an analysis of data from Medicare to determine compliance with a specific condition, for example a restriction prohibiting the prescription of schedule 8 drugs, or reviewing drug or alcohol testing results.

The Program has developed a Conditions Bank as a resource which outlines standard conditions. These conditions are consistent with the Medical Council's Policies and Protocols and are readily able to be monitored. Staff are also available to provide assistance on a case-by-case basis should these standard conditions require amendment to reflect a practitioner's particular circumstances.

Monitoring activity

The activity of the Program in the reporting year is summarised in **Table 22**. As at 30 June 2014, there were 244 practitioners being monitored, an increase of five practitioners since 30 June 2013.

Table 22: Monitoring activity in 2013/14

Primary source of conditions	Total number of practitioners monitored at 30 June 2013	Number of new* practitioners monitored 2013/14	Number of practitioners no longer monitored 2013/14	Total number of practitioners monitored at 30 June 2014
Health Program	107	22	28	96
Performance Program	21	9	5	24
Conduct Program	111	33	26	124
TOTAL	**239**	**64**	**59**	**244**

*A new practitioner is defined as a practitioner who was not subject to conditions at the time the conditions were imposed. If a practitioner was already subject to conditions on their registration and further conditions were imposed, this is not deemed to be a new practitioner.

Table 23 lists the reasons monitoring was no longer required during the reporting period.

Table 23: Reasons for closure of monitoring cases 2013/14

Reason for closure	Number of practitioners 2012/13	Number of practitioners 2013/14
Conditions lifted	23	26
Registration surrendered/Failure to renew registration	17	12
Principal Place of Practice changed (other than NSW)	6	6
Registration suspended	4	7
Registration cancelled by a Tribunal	3	0
Practitioner deceased	3	2
Moved to non-practising registration	1	6
TOTAL	**57**	**59**

The State or Territory office responsible for monitoring a medical practitioner's conditions is determined by the practitioner's principal place of practice.

Of those medical practitioners no longer requiring monitoring as their conditions were lifted in 2013/14, the median length of time the practitioner was subject to conditions was approximately two years. When looking at these practitioners according to their program the median length of time is 18 months for practitioners in the Conduct Program, three years for practitioners in the Health program, and three years and eight months for practitioners in the Performance Program.

Six practitioners who were subject to interim action conditions imposed on their registration no longer required monitoring in the reporting period as their registration lapsed (surrendered/failed to renew) or they moved to non-practising registration.

Table 24 lists the number of practitioners subject to a particular condition or order as at 30 June 2014. (A practitioner may be subject to one or more of the conditions/orders listed.)

Table 24: Practitioners subject to conditions, by type, as at 30 June 2014

Condition/Order	Number of practitioners 2012/13	Number of practitioners 2013/14
Urine Drug Testing (UDT)	26	27
Ethyl Glucuronide (EtG) Testing	15	14
Carbohydrate-Deficient Transferrin (CDT) testing	14	13
Chaperone	6	9
Education course	14	19
Mentor	21	22
Supervision	74	77
Audit	23	25

Audits

Seventeen audits were conducted in 2013/14. Audits are conducted by registered medical practitioners who practice in the same or similar field to the practitioner subject to the audit condition. The most common form of audit condition is a medical records audit. This type of audit is imposed to monitor whether a practitioner's:

- Standard of creating and maintaining records complies with the appropriate regulations or standards; and/or
- Compliance with other conditions imposed on their registration, for example an audit may be used to monitor a condition requiring a practitioner to seek a second opinion before undertaking a specific procedure.

Sixteen audit reports were finalised in 2013/14.

Table 25 lists the outcomes of the audits conducted in this period.

Table 25: Audit outcomes

Outcome	Number of audits finalised 2012/13	Number of audits finalised 2013/14
Further audit required	14	8
Audit satisfactory (condition requiring audit lifted)	7	7
Other action (such as urgent interim action, refer a complaint to HCCC)	2	1
TOTAL	**23**	**16**

Critical compliance

A Tribunal or a Professional Standards Committee may direct that a specific order or condition is a 'critical compliance condition' of a medical practitioner's registration. A breach of a critical compliance condition or order results in the immediate suspension of a practitioner's registration. Eight practitioners (up from seven practitioners in 2012/13) were subject to at least one critical compliance order or condition during the reporting period. There were no breaches identified of any critical compliance conditions or orders in this period.

Policies and protocols

The Medical Council is in the process of finalising the *Conditions Handbook* which captures the Medical Council's knowledge of conditions into a single resource, to assist decision makers in drafting conditions that are both workable and effective, and ultimately achieve their intended purpose.

The Handbook will provide an "Explanatory Paper" which guides decision makers through the practical considerations relevant when drafting conditions and a "Template Conditions Bank" which provides a set of template conditions, which have been formulated to suit most circumstances. The Template Conditions Bank has revised and updated the former NSW Medical Board's Conditions Bank, published in 2009.

The *Conditions Handbook* is scheduled to be published as an online resource in the next reporting year.

Breach of conditions

Outcomes following the identification of breach of conditions by the Program in the reporting period include:

Urgent action

Five practitioners had urgent interim action taken in 2013/14 for failing to comply with conditions requiring strict compliance with either the Council's Urine Drug Testing or Urine Ethyl Glucuronide (EtG) Testing Protocols. Both protocols outline the collection, supervision and testing requirements of each sample.

Referral to a Tribunal

Two practitioners were referred to the NSW Civil and Administrative Tribunal (NCAT) in 2013/14 for failing to comply with conditions requiring they undertake education course(s) within a specified timeframe. One practitioner's registration was cancelled by the NCAT. The second practitioner is yet to appear before the NCAT.

Case study – Breach of conditions

Dr X first came to the attention of the then NSW Medical Board (the Board) in 2007 following a self-notification to the Board about the practitioner's self-administration of an addictive drug. Dr X was assessed by a Board-nominated psychiatrist and referred to an Impaired Registrants Panel where Dr X agreed to conditions being imposed on their registration (including regular urine drug testing). Urgent interim action was taken by the Board in 2007 and 2008 following positive urine drug test results with the medical practitioner being suspended for 12 weeks in 2008/09. A complaint was then referred to the HCCC. Following the lifting of Dr X's suspension, Dr X was fully compliant with the conditions and was moved to random urine drug testing in November 2009. A complaint was prosecuted in the Medical Tribunal, which found Dr X guilty of professional misconduct and unsatisfactory professional conduct in relation to self-administration and imposed conditions (including random drug testing) on Dr X's registration. Following three years of negative urine drug test results the condition requiring random drug testing was lifted. Dr X remained compliant with all the remaining conditions and 11 months later all remaining conditions were lifted.

Conclusion

In 2013/14 the Medical Council continued to see a steady increase in the number of medical practitioners subject to monitoring conditions, with 244 medical practitioners actively monitored in 2013/14, compared with 239 in 2012/13 and 227 in 2011/12 – a 7% increase over three years.

As the number of medical practitioners subject to monitoring conditions increases, it is important that decision makers continue to have the necessary tools and resources to ensure that the conditions they impose are appropriate for the protection of the public, applicable to the circumstances of each case, and can operate in a practical sense. The new *Conditions Handbook*, to be finalised in the next reporting year, will harness the Medical Council's working knowledge of how conditions operate effectively into a single resource, to assist decision makers with the drafting of conditions. The aim of the *Conditions Handbook* is to ensure that appropriate conditions are imposed to achieve desired outcomes, which can be effectively monitored, and provide adequate protection for the public.

> management and administration

Strategic Planning

In April 2014 Council Presidents and senior HPCA staff participated in a facilitated planning session to agree on a shared strategic vision and priorities for the next three years. A broad Strategic Framework was outlined and further work is underway to develop a strategic plan. The first priorities focus on communication and stakeholder engagement, in particular to improve Council websites and electronic communication, including newsletters and to develop a research plan. These plans will be developed during 2014/15.

Research

The Medical Council continues to participate in and contribute to an Australian Research Council (ARC) research project in partnership with the University of Sydney, the Pharmacy, Psychology, Dental and Nursing and Midwifery Councils, the HCCC and AHPRA. The project involves a number of studies to enable comparative review of the notifications and complaint systems in NSW compared with other States, inform best practice and investigate complainants' expectations and experiences under the two systems. The project outcomes will be progressively reported in 2014 and 2015.
This year complaints data from July 2012 to June 2014 has been collected from each of the participating professions across Australia and is being analysed. Staff and members of tribunals, committees and panels participated in a survey to determine their priorities in handling complaints and decision-making, and will be reported later in 2014. A survey of complainants commenced and a range of complaints are being selected for a series of case studies.

Human resources

Employees

The HPCA staff who support the Medical Council are employed under Part 4 of the *Government Sector Employment Act 2013*.

At 30 June 2014 the HPCA employed 97 full-time equivalent (FTE) staff and three temporary FTE staff, of whom 31 FTE staff and one temporary FTE staff member provided secretariat support directly to the Medical Council.

Learning and development

Learning and development opportunities are available to staff to ensure that they have the necessary skills and knowledge to support the Medical Council's core business and the HPCA's organisational priorities.

In the reporting year, staff supporting the Medical Council attended training sessions on:

- Writing Clear Correspondence
- Word and Outlook Transition to Version 2010
- Managing unreasonable complainant conduct
- GIPA
- Taking Good Minutes
- Records Management Fundamentals
- *Government Sector Employment Act 2013* requirements.

Managers and staff also attended training on the Performance Management Framework. The *Government Sector Employment Act 2013* requires all agencies across NSW to implement a Performance Management Framework and for all employees to have a performance agreement in place. At 30 June 2014, performance agreements are being developed and staff and managers are working on their individual priorities and identifying training needs.

The first HPCA all staff forum was held in July 2013, which brought staff together to hear about the organisation's priorities, strategic and operational issues, and to provide an opportunity for discussion about matters of interest. It also enabled staff from across teams and work groups to meet and share ideas. The forum included discussion on the common issues raised through the *YourSay* staff survey that was conducted through the Ministry of Health.

The second forum was held in February 2014 and included staff-led discussion to develop team building and communication activities. The forums have been well received by staff and will be held twice yearly. Each forum includes a presentation and discussion on an aspect in the HPCA's Code of Conduct.

Induction sessions for members of Councils, committees and panels were held in September 2013 and October 2013. These annual events aim to introduce new members to their legislative and regulatory responsibilities and were very well received. A number of long-standing members also participated and reported that the workshops provided a valuable opportunity to refresh their knowledge and share their experiences.

A series of seminars on the health professionals Councils' core programs was also initiated. The Conduct Program seminar, held in June 2014, was attended by over 70 members from all Councils, committees and panels, as well as practitioners who provide assessments, counselling and other services to the Councils. Sessions focused on the management of complaints about practitioners' conduct, including progression to a tribunal. The conduct and content of the seminar received overwhelmingly positive feedback.

Seminars on the Performance Program and the Health Program are being planned for 2014/2015. The Handbook for members of Councils, committees and panels was also revised and is available on the HPCA website.

Public Interest Disclosures

The Medical Council is subject to the provisions of the *Public Interest Disclosures Act 1994* and the reporting requirements of the *Public Interest Disclosures Regulation 2011*. Staff and Medical Council members comply with the policy and information is available on the requirements and processes for making and managing disclosures. The Medical Council provides six monthly reports to the NSW Ombudsman and Ministry of Health.

There were no public interest disclosures (PIDs) made by staff or Medical Council members during the reporting year:

	Made by public officials performing their day to day functions	Under a statutory or other legal obligation	All other PIDs
Number of public officials who made PIDs	0	0	0
Number of PIDs received	0	0	0
Of PIDs received, number primarily about:			
Corrupt conduct	0	0	0
Maladministration	0	0	0
Serious and substantial waste	0	0	0
Government information contravention	0	0	0
Number of PIDs finalised	0	0	0

Multicultural policies and services program

The Medical Council applies the NSW Government's *Principles of Multiculturalism* and ensures that information and services are available to meet the diverse language needs of the people of NSW.

The Medical Council and the HPCA websites provide advice on how to access translating and interpreting services in 19 languages for people making an inquiry or a complaint. A number of HPCA staff are also able to provide assistance in translating and interpreting in a range of languages.

Responsibility for the registration and accreditation of overseas trained medical practitioners rests with the National Medical Board. The Medical Council supports the National Medical Board's commitment to providing opportunities for overseas trained health practitioners to be registered and practise in Australia.

The following strategies are in place across the HPCA to address the *Principles of Multiculturalism*:

- Promoting a culturally diverse workforce, membership of Committees and participation in the Councils' regulatory activities; and
- Maintaining an ongoing commitment to the *Principles of Multiculturalism* and the requirements of relevant legislation and Government policy.

The HPCA is organising cultural awareness and diversity training for staff and members. Staff are also encouraged to complete the Health Education and Training Institute's online cultural training modules.

Disability services

The Medical Council supports the NSW Government's *Disability Policy Framework* and the Principles outlined in Schedule 1 of the *Disability Services Act 1993*.

The HPCA maintains a range of strategies to implement these requirements including:

- Workplace assessment and adjustments to support staff and members with a disability;
- Assistance from external providers to prepare and coordinate return to work plans for staff with work related injuries and/or temporary disabilities;
- Provision of ergonomic furniture and equipment for all staff, including those requiring workplace adjustment;
- Access to disabled washrooms; and
- A TTY service and a hearing loop in hearing rooms for the hearing impaired.

Workplace diversity

The HPCA recognises the value of workforce diversity and encourages and aims to attract and retain people with diverse skills, experience and background. Appointments to the Councils, committees and panels are also made on the understanding that diversity of knowledge, experience and background supports the Medical Council's regulatory activities.

The workforce diversity statistics provided by the Public Service Commission are in **Appendix 5**.

Occupational health and safety

The HPCA's Work Health and Safety Committee oversights workplace environments to ensure compliance with legislation and government policy. In the reporting year, Committee members participated in training in the legislative requirements and new members received appropriate induction. Fire wardens also undertook refresher training and the outcomes of an evacuation drill were reviewed.

Waste management (WRAPP)

The HPCA manages implementation of the NSW Government's WRAPP on behalf of the Medical Council. During the reporting year the HPCA maintained efforts to reduce waste, recycle paper products, consumables and equipment, and to purchase resources with recycled content, with the following results:

- Purchased all A4 copy paper with 50% recycled content;
- Recycled 95% of total paper waste;
- Recycled 100% of paper/cardboard packaging by separating and directing packaging material to the building's centralised recycling systems;
- Provided paper recycling containers at each workstation to divert paper from waste bins and landfill; and
- Sent 100% of toner cartridges for recycling.

The following waste avoidance strategies are in place across the HPCA:

- Scrap recycled paper diverted for use as message pads and note taking;
- Increased use of email for internal communication and with Council members. The introduction of the Boardbooks technology for the distribution and management of Council meeting papers has significantly reduced the use of paper. It will be progressively extended to other meetings to further reduce dependence on printed papers;
- Stakeholders referred to Council websites for access to publications and other information as an alternative to providing hard copy documents;
- Use of double-sided printing as much as possible; and
- Inclusion of "please consider the environment before printing" note on email communication.

Insurance and risk management activity

Insurance

The Medical Council's insurance activities are conducted by the HPCA through the NSW Ministry of Health's insurance cover with the NSW Treasury Managed Fund, and include:

- Legal liability – public liability, professional indemnity, product liability;
- A Comprehensive Motor Vehicle Insurance Policy;
- A Personal Accident Policy for volunteer workers;
- Property coverage; and
- Workers compensation.

Audit and risk management

NSW Treasury has granted the Medical Council an exemption from the *Internal Audit and Risk Management Policy for the NSW Public Sector* (TPP09-05) on the grounds that it is a small agency for which the administrative and cost burden of full compliance would be prohibitive. Nevertheless the Medical Council has appropriate internal audit and risk management practices in place in-line with the core requirements of TPP09-05.

In 2013/14 the HPCA Audit and Risk Committee continued to review and monitor its Risk Register, discussed and monitored internal audits and reviews, and received high level summaries on the Medical Council's financial reports.

The HPCA implemented the recommendations of the Audit Office of NSW 2012/2013 Management Letter, and improved the finance working papers in preparation for the 2014 audit. A repeat recommendation that the HPCA has a memorandum of understanding (MOU) with the Ministry of Health for the services the Ministry provides has been completed with the MOU being signed in May 2014.

Internal Audit

IAB (formerly the Internal Audit Bureau of NSW) is commissioned to undertake the internal audits nominated in the HPCA's Internal Audit Plan. In 2013/14 an audit of monitoring of practitioners with orders and/or conditions on their registration was completed and the recommendations are being implemented. Standard operating procedures for dealing with monitoring cases have been documented and will be published following consultation with staff.

Implementation of the recommendations of the audit of the HPCA's Workforce Management Framework was also completed. Position descriptions have been updated and the performance management framework is being implemented in accordance with the *Government Sector Employment Act 2013*.

An internal audit of complaint handling was undertaken in June 2014 and the report and recommendations will be considered in the next reporting year.

Information Management and Systems

The Medical Council underwent an upgrade to IT hardware and software, to provide greater consistency and compatibility across the HPCA. Following a tender process, which concluded in April 2013, Private Universe was selected as the successful tenderer to facilitate the hardware and software upgrade, as well as provide ongoing technical support. Private Universe also provides IT support to the HPCA offices at Pitt Street, Sydney.

The new hardware, which included new desktop computers, monitors and laptops, and a software upgrade from Microsoft Office 2003 to Microsoft Office 2010, was rolled out in February 2014. Significantly, the upgrade introduced a new virtualised environment, which allows staff located at the HPCA offices at Gladesville and HPCA offices at Pitt Street to work on the same operating network, and also to work remotely. This was achieved via a new high speed connection, which connects the HPCA offices at Gladesville with the HPCA offices at Pitt Street.

To support staff through the transition, training was provided on Microsoft Office 2010.

An Information and Communications Technology (ICT) strategic plan is also being developed across the HPCA that formally identifies the ICT infrastructure, capability and priorities for the next three years. An ICT Steering Committee was established in the reporting year and includes a Ministry of Health IT professional to inform the Committee on developments within the health sector and provide expert advice on proposed ICT projects.

Further system modifications were made to the HPCA's case management system (MaCS) in the reporting year to improve usability and reporting. The MaCS User Group guides priorities and contributes to user testing. Staff received ongoing training and support as changes were implemented and the accuracy and reliability of reporting is improved.

During the reporting year, the TRIM records management system was further embedded in practice. Training has been a focus and priorities were developed to promote the use of TRIM to meet State Records compliance requirements. As at 30 June 2014, planning is underway to upgrade and integrate TRIM to one platform across the Gladesville and Pitt St sites, with a request for quote issued and a successful provider selected.

The HPCA's TRIM User Group was also established to finalise the file and document naming conventions for regulatory activities that will be applied consistently across all Councils. The User Group members also provide back-up support and training within their work groups.

Information security

The Medical Council has adopted the NSW Government *Digital Information Security Policy*. As the Councils' shared services provider the HPCA has submitted an attestation statement to the Department of Finance and Services which outlines the timeframes for compliance with the core requirements of the Policy.

The Medical Council is also required to present an attestation statement in the Annual Report, which is at **Appendix 4**.

Promotion of Medical Council's activities / Overseas travel

No HPCA staff or Medical Council members undertook overseas travel during the reporting year.

The Medical Council maintains a website which is updated on a regular basis (www.mcnsw.org.au) and is the principal medium for disseminating information to practitioners and students. In the reporting period the Medical Council also launched a bi-annual e-newsletter to provide information and updates on the work of the Medical Council. The e-newsletter was distributed to registered medical practitioners across the State and is available on the Medical Council's website. During the reporting period the Medical Council's Medical Director also held a series of presentations to university students to educate them on the role of the Medical Council.

Use of consultants and other external costs

Table 27 shows the Medical Council's contribution to consultancies commissioned by the health professional Councils in 2013/14:

Table 27: Engagements costing less than $50,000

Service Provided	Number	Cost inc. GST $
Council business processes	2	3,162
Financial management	2	5,570
Governance	2	3,853
TOTAL	**6**	**12,586**

Annual Report costs

The Medical Council did not produce printed copies of this Annual Report in accordance with the NSW Premier's *Memorandum Production costs of Annual Reports* (M2012-11). As at 30 June 2014, the total cost of layout and design was quoted at $944.06 (GST inclusive).

The Annual Report is published on the Medical Council's website.

Business process improvement

A Process Improvement Plan is being implemented across the HPCA that brings together the recommendations of the Business Process Reviews completed in 2012 and 2013. It also includes the priorities in the records management plan and the workforce management plan. A priority in 2014/2015 is to develop a regulatory handbook for use by staff that will bring together the complaints management business process maps and other key business processes, resources and information guides. This will promote consistency in the way complaints are managed from receipt to resolution by all Councils.

A project to publish an electronic *Conditions Handbook* is underway to promote consistent decision making and monitoring. The handbook includes generic information about the regulatory adjudication bodies and considerations when drafting conditions; information unique to individual professions that decision-makers need to take into account when imposing conditions, and a set of resources. The first tranche of conditions is nearing completion and covers procedural conditions, limiting practice conditions and prescribing and drug conditions.

In 2013/14 a series of process indicators were developed as a mechanism for Councils to report on qualitative aspects for their work and to supplement the current quantitative measures in place. The indicators will also identify areas where there is a need to focus on strategies for improvement and support consistent and regular reporting across Councils.

A major initiative this reporting year was implementation in February 2014 of a technology solution for the preparation and distribution of Medical Council and Committee meeting papers. Diligent Boardbooks software was selected through a comprehensive tender and evaluation process.

Staff upload the agenda papers to a secure Internet portal from which Medical Council members can download them to iPads prior to their meeting. The Boardbooks application allows members to read and annotate the papers on their iPad during the meeting when the agenda is discussed. The system eliminates the need to print large agenda packs for all Members for each meeting, which saves on mailing and courier costs, enhances security by restricting access to confidential information and provides Members with a lightweight and effective means of viewing Medical Council material. The new system has been very positively received by Medical Council Members.

Consumer response

The Medical Council acknowledges that the trust and confidence of the public are essential to its role and welcomes all forms of feedback. Complaints regarding the administrative processes of the Medical Council, its activities, staff, or service delivery, can be made by members of the public to the Medical Council itself or to external organisations such as the NSW Ombudsman.

In the reporting year, the Medical Council received a small number of complaints about its processes from the public and members of the medical profession. These complaints primarily related to dissatisfaction with the outcome of the complaints or investigations concerning medical practitioners. Complaints were referred to the appropriate area for investigation and resolution, and if necessary, procedures were reviewed and amended.

One complaint against a current staff member was made to another organisation. The Ombudsman contacted the Medical Council to make preliminary enquiries in relation to two matters. As at 30 June 2014 no subsequent investigation has ensued.

Activity under the Government Information (Public Access) Act 2009

The Medical Council is committed to the principles of the *Government Information (Public Access) Act 2009* (GIPA Act) and makes available, free of charge on its website, a large range of publications, documents and information that form part of the Medical Council's open access information and pro-actively released information. Details are contained in the Agency Information Guide on the Medical Council's website.

Open access and pro-active release

In accordance with the obligations in section 7(3) of the GIPA Act, the Medical Council continually publishes information on the Medical Council website such as publicly available decisions, handbooks and newsletters. Links are also included on the Medical Council website, where appropriate, to direct the public to other relevant publications. The Medical Council has a mechanism to ensure that the publication of key documents is considered at the time of endorsement. All newly created and revised key documents are assessed to determine whether they should be published on the Medical Council's website in accordance with the requirements of the GIPA Act.

Review of pro-active release program

The Medical Council reviewed its program for the release of government information to identify the type of information that can be made publicly available.

The Medical Council releases all new and revised policies and other information publicly on its website. In addition, the Medical Council reviewed the program and the policy register including monitoring the completion and approval of relevant information.

New and revised policies and documents released on the Medical Council website are:

- Medical Council Annual Report 2013;
- Medical Council of NSW e-newsletters (2);
- Medical Council Strategic Plan for 2013/14 to 2015/16;
- Medical Tribunal and Professional Standards Committee Decisions;
- A link to Legal Practice Notes published by the HPCA;
- Links to individual NCAT decisions published on Caselaw;
- A link to the Medical Board of Australia's updated Guidelines for advertising regulated health services;
- Information on the NSW Civil and Administrative Tribunal; and
- Updated information on Council Members and staff.

Number of access applications received

During the reporting period, the Medical Council received nine formal access applications for information from eight different applicants, compared to 14 (11 different applicants) in the preceding year. No invalid applications were received which subsequently became valid applications. Determinations were made for nine applications, including three applications received in the previous reporting year and three applications remained under consideration at the end of the reporting period. Eight of the nine applications received were determined either within the statutory timeframe or with an extended timeframe agreed to by the applicant.

Number of refused applications for Schedule 1 information - Clause 7(c)

Of the nine applications determined in the period, the Medical Council released documents to seven of the applicants. In four of these seven applications, the application was refused in part because the information requested was information referred to in Schedule 1 of the GIPA Act. One decision was made to refuse to deal with an application under s 60(1)(a) of the GIPA Act as the applicant had previously been provided with the information requested.

The overriding secrecy laws in regards to the *Health Care Complaints Act 1993 (NSW)* was the most applied conclusive presumption of overriding public interest against disclosure under Schedule 1 of the GIPA Act. The categories of individual rights, judicial processes and natural justice were the most applied public interest considerations against disclosure that the Medical Council relied on under s 14 of the GIPA Act.

During this period, seven access applicants sought a review of the Medical Council's decision: three applications for internal review by the Medical Council, two by the Information Commissioner and two by the Administrative Decisions Tribunal (the ADT) / NSW Civil and Administrative Tribunal (NCAT). The three internal review applications were determined in the period and four external review applications remain under review. In each of the three reviews completed, the Medical Council's decision was confirmed. The Medical Council's 2013/14 GIPA statistics are reported in **Appendix 2** of this Annual Report.

Privacy management

The Medical Council is subject to the provisions of the *Privacy and Personal Information Protection Act 1998* (PIPA) and the *Health Records and Information Privacy Act 2002*.

The Medical Council received five applications for internal review regarding privacy matters in the reporting period. All five applications were made by the same applicant.

Decisions were made in respect of four of the five applications for internal review in the period and the fifth remained outstanding at the end of the period. The same applicant has lodged three applications for external review with the ADT / NSW Civil and Administrative Tribunal (NCAT). These, together with two applications for external review lodged in the previous reporting year, are listed for hearing by the NCAT in the second half of 2014.

The Medical Council received two requests (by two separate applicants) for an alteration of records under s15 of PIPA. One application was refused. The other is the subject of an application for internal review (included in the five matters referred to above) and remained outstanding at the end of the reporting period.

The Medical Council has also adopted the Ministry of Health *Privacy Management Policy*, pending development of a specific privacy management plan.

Financial management

The HPCA provides financial management services to the Medical Council including the payment of accounts, budget preparation and monitoring and coordination of regular financial reporting to the Medical Council.

In signing the Service Level Agreement, the Medical Council endorsed revised cost allocation methodologies for the distribution of shared costs across all Councils. The methodologies are largely based on Council activity and provide a formula to apportion shared services staff, facilities and other resources. The methodologies were reviewed in 2013/2014 to ensure they are equitable and the best means of cost allocation. The review concluded that the existing formulae are equitable and the most effective means of calculating Councils' individual contributions to shared costs. Minor adjustments were made to the methodologies following consultation with all Councils.

Format

The accounts of the Medical Council's administrative operations, including the Education and Research activities, together with the Independent Auditor's Report are set out in the Financial Statements contained in this Annual Report.

Performance

The Medical Council's accounts performance as reported in the Financial Statements is as follows:

Table 28: Accounts performance 2013/14:

	$
Operating expenditure	8,563,067
Revenue	11,897,882
Net profit/(loss)	3,324,015
Net cash reserves (cash and cash equivalents minus current liabilities)*	4,163,782
* Included in the net cash reserves is Education and Research bank account balance of	0

Investment performance

The Medical Council's banking arrangements transferred to Westpac Banking Corporation in accordance with the agreement between NSW Treasury and Westpac Banking Corporation for the provision of transactional banking.

The guaranteed credit interest rate is calculated on daily balances as per the Reserve Bank of Australia cash rate plus an agreed fixed margin for five years.

Payments performance

See **Appendix 6**.

Budget

Table 30 shows the Medical Council's Budget for the period 1 July 2014 to 30 June 2015.

Table 30: 2014/15 Budget:

	$
Revenue	12,347,205
Operating expenditure	9,833,905
Net profit/(loss)	2,513,300

MEDICAL COUNCIL OF NEW SOUTH WALES

YEAR ENDED 30 JUNE 2014

STATEMENT BY MEMBERS OF THE COUNCIL

Pursuant to s 41C(1B) *Public Finance and Audit Act 1983* , and in accordance with the resolution of the members of the Medical Council of New South Wales, we declare on behalf of the Council that in our opinion:

1. The accompanying financial statements exhibit a true and fair view of the financial position of the Medical Council of New South Wales as at 30 June 2014 and financial performance for the year then ended.

2. The financial statements have been prepared in accordance with the provisions of Australian Accounting Standards, Accounting Interpretations, the *Public Finance and Audit Act 1983, the Public Finance and Audit Regulation 2010* , and the Treasurer's Directions.

Further, we are not aware of any circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

Peter Procopis
President

Date: 20 October 2014

Greg Kesby
Deputy President

Date: 20 October 2014

INDEPENDENT AUDITOR'S REPORT

Medical Council of New South Wales

To Members of the New South Wales Parliament

I have audited the accompanying financial statements of the Medical Council of New South Wales (the Council), which comprise the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of changes in equity and statement of cash flows, for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information.

Opinion

In my opinion, the financial statements:

- give a true and fair view of the financial position of the Council as at 30 June 2014, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards
- are in accordance with section 41B of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2010.

My opinion should be read in conjunction with the rest of this report.

The Council's Responsibility for the Financial Statements

The members of the Council are responsible for the preparation of the financial statements that give a true and fair view in accordance with Australian Accounting Standards and the PF&A Act, and for such internal control as the members of the Council determine is necessary to enable the preparation of financial statements that give a true and fair view and that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I conducted my audit in accordance with Australian Auditing Standards. Those Standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Council's preparation of the financial statements that give a true and fair view in order to design audit procedures appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Council's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the members of the Council, as well as evaluating the overall presentation of the financial statements.

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I believe the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

My opinion does *not* provide assurance:

- about the future viability of the Council
- that it has carried out its activities effectively, efficiently and economically
- about the effectiveness of its internal control
- about the security and controls over the electronic publication of the audited financial statements on any website where they may be presented
- about other information which may have been hyperlinked to/from the financial statements.

Independence

In conducting my audit, I have complied with the independence requirements of the Australian Auditing Standards and other relevant ethical pronouncements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General
- mandating the Auditor-General as auditor of public sector agencies, but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their roles by the possibility of losing clients or income.

C J Giumelli
Director, Financial Audit Services

20 October 2014
SYDNEY

> Statement of Comprehensive Income

FOR THE YEAR ENDED 30 JUNE 2014

	Notes	2014	2013
		$	$
Expenses Excluding Losses			
Operating expenses			
Personnel services	2(a)	(3,081,355)	(2,768,509)
Other operating expenses	2(b)	(3,586,595)	(3,331,786)
Depreciation and amortisation	2(c)	(396,094)	(490,363)
Other expenses	2(d)	(1,499,023)	(1,160,226)
Total Expenses Excluding Losses		**(8,563,067)**	**(7,750,884)**
Revenue			
Registration fees		11,443,137	9,868,189
Interest revenue	4(a)	278,777	162,184
Other revenue	4(b)	175,968	111,064
Total Revenue		**11,897,882**	**10,141,437**
Gain/(Loss) on disposal/additions	5	(10,800)	3,589
Net Result		**3,324,015**	**2,394,142**
Other Comprehensive Income		-	-
Total Comprehensive Income		**3,324,015**	**2,394,142**

The accompanying notes form part of these financial statements.

> Statement of Financial Position

AS AT 30 JUNE 2014

	Notes	2014	2013
		$	$
ASSETS			
Current Assets			
Cash and cash equivalents	6	9,097,957	5,116,721
Receivables	7	210,339	163,892
Total Current Assets		**9,308,296**	**5,280,613**
Non-Current Assets			
Plant and equipment	8		
Leasehold improvements		1,536,612	1,645,867
Motor vehicles		13,671	16,202
Furniture and fittings		8,087	11,191
Other		199,936	120,202
Total Plant and equipment		1,758,306	1,793,462
Intangible assets	9	91,457	317,568
Total Non-Current Assets		**1,849,763**	**2,111,030**
Total Assets		**11,158,059**	**7,391,643**
LIABILITIES			
Current Liabilities			
Payables	10	1,814,825	1,481,087
Fees in advance	11	3,119,350	3,002,217
Total Current Liabilities		**4,934,175**	**4,483,304**
Non-Current Liabilities			
Fees in advance	11	-	8,470
Total Non-Current Liabilities		**-**	**8,470**
Total Liabilities		**4,934,175**	**4,491,774**
Net Assets		**6,223,884**	**2,899,869**
EQUITY			
Accumulated funds		6,223,884	2,899,869
Total Equity		**6,223,884**	**2,899,869**

The accompanying notes form part of these financial statements.

> Statement of Changes in Equity

FOR THE YEAR ENDED 30 JUNE 2014

	Notes	Accumulated Funds
		$
Balance at 1 July 2013		2,899,869
Net Result for the Year		3,324,015
Other comprehensive income		-
Balance at 30 June 2014		**6,223,884**
Balance at 1 July 2012		505,727
Net Result for the Year		2,394,142
Other comprehensive income		-
Balance at 30 June 2013		**2,899,869**

The accompanying notes form part of these financial statements.

> Statement of Cash Flows

FOR THE YEAR ENDED 30 JUNE 2014

	Notes	2014	2013
		$	$
Cash Flows from Operating Activities			
Payments			
Personnel services		(3,011,409)	(2,913,151)
Other		(4,943,437)	(4,060,175)
Total Payments		**(7,954,846)**	**(6,973,326)**
Receipts			
Receipts from registration fees		11,610,372	10,856,634
Interest received		292,117	152,485
Other		179,217	112,142
Total Receipts		**12,081,706**	**11,121,261**
Net Cash Flows from Operating Activities	**15**	**4,126,860**	**4,147,935**
Cash Flows from Investing Activities			
Proceeds from sale of plant and equipment		-	-
Purchases of plant and equipment and intangible assets		(145,624)	(129,283)
Net Cash Flows from Investing Activities		**(145,624)**	**(129,283)**
Net Increase/(Decrease) in Cash		3,981,236	4,018,652
Opening cash and cash equivalents		5,116,721	1,098,069
Closing Cash and Cash Equivalents	**6**	**9,097,957**	**5,116,721**

The accompanying notes form part of these financial statements.

> notes to **the financial statements**

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

a. Reporting Entity

The Medical Council of New South Wales (the Council) as a not-for-profit reporting entity with no cash generating units, performs the duties and functions contained in the *Health Practitioner Regulation National Law (NSW) No 86a* (the Law).

These financial statements for the year ended 30 June 2014 have been authorised for issue by the Council on 20 October 2014.

b. Basis of Preparation

The Council has adopted the going concern basis in the preparation of the financial statements.

The Council's financial statements are general purpose financial statements and have been prepared in accordance with:

- applicable Australian Accounting Standards (which include Australian Accounting Interpretations), and
- the requirements of the *Public Finance and Audit Act 1983* and Regulation.

The financial statements have been prepared on the basis of historical cost.

Judgements, key assumptions and estimations management has made are disclosed in the relevant notes to the financial statements.

All amounts are rounded to the nearest dollar and are expressed in Australian currency.

c. Statement of Compliance

The financial statements and notes comply with Australian Accounting Standards, which include Australian Accounting Interpretations.

d. Significant Accounting Judgments, Estimates and Assumptions

There has been no significant change from the agreed cost sharing arangements for the pooled costs between Health Professional Councils introduced effective 1 July 2012.

These indirect costs are shown as part of the Council's statement of comprehensive income under the following expense line items:

1. Personnel services
2. Contracted labour
3. Depreciation and amortisation
4. Rent & building expenses

e. Insurance

The Council's insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self-insurance for Government entities. The expense (premium) is determined by the Fund Manager based on past claim experience.

f. Accounting for the Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of GST, except that:

- the amount of GST incurred by the Council as a purchaser that is not recoverable from the Australian Taxation Office is recognised as part of the cost of acquisition of an asset or as part of an item of expense, and
- receivables and payables are stated with the amount of GST included.

Cash flows are included in the statement of cash flows on a gross basis. However, the GST components of cash flows arising from investing and financing activities which are recoverable from, or payable to, the Australian Taxation Office are classified as operating cash flows.

g. Income Recognition

Income is measured at the fair value of the consideration or contribution received or receivable.

The National Registration and Accreditation Scheme for all health professionals commenced on 1 July 2010. NSW opted out of the complaint handling component of the National scheme and the health professional Councils were established in NSW effective from 1 July 2010 to manage the complaints function in a co-regulatory arrangement with the NSW Health Care Complaints Commission (HCCC).

Under s 26A of the Law, the complaints element of the registration fees payable during 2014 by NSW health practitioners was decided by the Council established for that profession subject to approval by the Minister for Health.

The Council, under the Law, receives fees on a monthly basis from the Australian Health Practitioner Regulation Agency (AHPRA) being the agreed NSW complaints element for the 2014 registration fee.

Fees are progressively recognised as income by the Council as the annual registration period elapses. Fees in advance represent unearned income at balance date.

h. Personnel Services

In accordance with an agreed Memorandum of Understanding, the Ministry of Health (MOH) being the employer charges the Council for personnel services relating to the provision of all employees. Staff costs are shown in the Statement of Comprehensive Income as personnel services in the financial statements of the Council. Amounts owing for personnel services in the Statement of Financial Position represent amounts payable to the MOH in respect of personnel services.

i. Interest Revenue

Interest revenue is recognised using the effective interest method as set out in AASB 139 *Financial Instruments: Recognition and Measurement.*

j. Assets

i. Acquisition of Assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the Council. Cost is the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of its acquisition or construction or, where applicable, the amount attributed to that asset when initially recognised in accordance with the requirements of other Australian Accounting Standards.

Assets acquired at no cost, or for nominal consideration, are initially recognised at their historical cost at the date of acquisition.

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Where payment for an item is deferred beyond normal credit terms, its cost is the cash price equivalent, i.e. the deferred payment amount is effectively discounted at an asset-specific rate.

ii. Capitalisation Thresholds

The Health Professional Councils Authority (HPCA) acquires all assets on behalf of the Council. Shared use assets that cost over $5,000 at the time of purchase by the HPCA are capitalised. These capitalised shared use assets are then allocated to the Council using an appropriate allocation method. The minimum capitalisation threshold limits applied to the Council for the asset are $1,822 (2012/2013 - $1,678).

iii. Impairment of Plant and Equipment

As a not-for-profit entity with no cash generating units, AASB 136 *Impairment of Assets* effectively is not applicable. AASB 136 modifies the recoverable amount test to the higher of fair value less costs to sell and depreciated replacement cost. This means that, where an asset is already measured at fair value, impairment can only arise if selling costs are material. Selling costs for the entity are regarded as immaterial.

iv. Depreciation of Plant, Equipment and Leasehold Improvements

Depreciation and amortisation is provided for on a straight-line basis for all depreciable assets so as to write off the amounts of each asset as it is consumed over its useful life to the Council.

Depreciation and amortisation methods, useful lives and residual values are reviewed at each reporting date and adjusted if appropriate.

Depreciation rates used are as follows:

Plant and equipment 20% - 25%
Furniture and fittings 16% - 20%
Motor vehicles 25% - 29%
Leasehold improvements 1.49% - 10.15%

v. Fair Value of Plant and Equipment

There has been no revaluation on any of the Council's plant and equipment as they are non-specialised assets. Non-specialised assets with short useful lives are measured at depreciated historical cost as a surrogate for fair value.

vi. Maintenance

Day-to-day servicing costs or maintenance are charged as expenses as incurred, except where they relate to the replacement of a component of an asset, in which case the costs are capitalised and depreciated.

vii. Intangible Assets

The Council recognises intangible assets only if it is probable that future economic benefits will flow to the entity and the cost of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition.

All research costs are expensed. Development costs are only capitalised when certain criteria are met.

The useful lives of intangible assets are assessed to be finite.

Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for the entity's intangible assets, the assets are carried at cost less any accumulated amortisation.

Intangible assets are tested for impairment where an indicator of impairment exists. If the recoverable amount is less than its carrying amount, the carrying amount is reduced to recoverable amount and the reduction is recognised as an impairment loss.

The Council's intangible assets are amortised using the straight line method over a period of four years. In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity with no cash generating units, the Council is effectively exempted from impairment testing.

viii. Loans and Receivables

Loans and receivables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial. An allowance for impairment of receivables is established when there is objective evidence that the Council will not be able to collect all amounts due. The amount of the allowance is the difference between the assets carrying amount and the present value of the estimated future cash flows, discounted at the effective interest rate. Bad debts are written off with approval of the Council as incurred.

k. Liabilities

i. Trade and Other Payables

These amounts represent liabilities for goods and services provided to the Council and other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-term payables with no stated interest rates are measured at the original invoice amount where the effect of discounting is immaterial.

ii. Personnel Services – Ministry of Health

In accordance with an agreed Memorandum of Understanding, personnel services are acquired from the MOH. As such the MOH accounting policy is below.

Liabilities for salaries and wages (including non-monetary benefits), recreation leave and paid sick leave that are due to be settled within 12 months after the end of the period in which the employees render the service are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

In accordance with NSWTC 14/04 'Accounting for Long Service Leave and Annual Leave', the Council's annual leave has been assessed as a short-term liability as these short-term benefits are expected to be settled wholly before 12 months after the end of the annual reporting period in which the employee renders the related services (AASB 119, para 8).

Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of payroll tax, workers' compensation insurance premiums and fringe benefits tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

All employees receive the Superannuation Guarantee Levy contribution. All superannuation benefits are provided on an accumulation basis – there are no defined benefits. Contributions are made by the entity to an employee superannuation fund and are charged as an expense when incurred.

l. Equity

Accumulated Funds

The category 'Accumulated Funds' includes all current and prior period funds.

m. Comparative information

Except when an Australian Accounting Standard permits or requires otherwise, comparative information is disclosed in respect of the previous period for all amounts reported in the financial statements.

n. Cash and cash equivalents

Cash and cash equivalent assets in the statement of financial position would normally comprise cash on hand, cash at bank and short-term deposits and include deposits in the NSW Treasury Corporation's Hour-Glass cash facility, other Treasury Corporation deposits (less than 90 days) and other at-call deposits that are not quoted in the active market.

Bank overdrafts are included within liabilities.

o. Adoption of New and Revised Accounting Standards

A number of new standards were applied from 1 July 2013, including AASB 13 *Fair Value Measurement* and AASB 119 *Employee Benefits*. The application of these new standards did not have a significant impact on the financial statements.

A number of new standards, amendments to standards and interpretations are effective for annual periods beginning after 1 July 2014, and have not been applied in preparing these financial statements. None of these are expected to have a significant effect on the financial statements of the Council.

NSW Treasury issued NSWTC14/03 circular which states none of the new or revised Standards of Interpretations are to be adopted early.

The standards that are relevant to the Council are as follows:

a) AASB 9, AASB 2010-7 and AASB Financial Instruments 2012-6 regarding financial instruments (2015/2016)
b) AASB 10 Consolidated Financial Statements with NFP guidance
c) AASB 12 Disclosure of interests in other entities.

2. EXPENSES EXCLUDING LOSSES

a. Personnel Services Expenses

Personnel services expenses are acquired from the MOH and comprise the following:

	2014	2013
	$	$
Salaries and wages (including recreation leave)	2,630,464	2,362,006
Superannuation	253,461	238,041
Payroll taxes	170,605	158,777
Workers compensation insurance	26,825	9,685
	3,081,355	**2,768,509**

b. Other Operating Expenses

	2014	2013
	$	$
Auditor's remuneration	22,500	21,430
Rent and building expenses	190,792	111,348
Medical Tribunal expenses	404,167	675,000
Council fees	276,916	303,458
Sitting fees	1,702,082	1,338,897
NSW Civil & Administrative Tribunal fixed costs	153,500	-
Contracted labour	836,638	881,653
	3,586,595	**3,331,786**

c. Depreciation and Amortisation Expense

	2014	2013
	$	$
Depreciation		
Motor vehicles	3,999	7,901
Furniture and fittings	3,053	4,356
Other	17,692	31,690
	24,744	**43,947**
Amortisation		
Leasehold improvements	109,255	103,030
Intangible assets	262,095	343,386
	371,350	**446,416**
Total Depreciation and Amortisation	**396,094**	**490,363**

d. Other Expenses

	2014	2013
	$	$
Subsistence and transport	69,427	84,921
Funding contributions	91,000	42,653
Fees for service	965,723	670,785
Postage and communication	88,033	81,773
Printing and stationery	120,474	116,484
Equipment and furniture	742	2,550
General administration expenses	163,624	161,060
	1,499,023	**1,160,226**

3. EXPENDITURE MANAGED ON BEHALF OF THE COUNCIL THROUGH THE NSW MINISTRY OF HEALTH

The HPCA, which is an Executive agency of the NSW Ministry of Health (MOH) provides executive and administrative support funcitons to Council's.

In accordance with an agreed MOU salaries and associated oncosts are paid by the MOH. The MOH continues to pay for the staff and associated oncosts. These costs are reimbursed by the Council to the MOH.

4. (a) INTEREST REVENUE

	2014	2013
	$	$
Interest revenue from financial assets not at fair value through profit or loss	278,678	160,493
TCorp Hour Glass investment facility	99	1,691
	278,777	**162,184**

During the year, in accordance with the agreement between NSW Treasury and Westpac Banking Corporation on 1 April 2013 for the provision of Transactional Banking, the HPCA on behalf of the Council, transitioned all current banking arrangements to Westpac Banking Corporation.

The guaranteed credit interest rate is calculated on daily balances as per the RBA cash rate plus an agreed fixed margin for five years.

	2014	2013
	%	%
Average Interest Rate	2.31	3.092

(b) OTHER REVENUE

	2014	2013
	$	$
Legal fee recoveries	137,471	72,677
Other revenue	38,497	38,386
	175,968	**111,063**

5. GAIN/(LOSS) ON DISPOSAL/ ADDITIONS

	2014	2013
	$	$
Plant and equipment		
Net book value disposed/acquired during the year	(6,310)	3,640
Proceeds from sale/acquisition costs	-	-
	(6,310)	3,640
Intangible assets		
Net book value disposed/acquired during the year	(4,490)	(51)
Proceeds from sale/acquisition costs	-	-
	(4,490)	(51)
Total Gain/(Loss) on Disposal/Additions	**(10,800)**	**3,589**

Included in the above Gain/(Loss) on disposal are adjustments arising from the Council's prior year decision to adopt a significant accounting policy, an agreed cost sharing arrangement for the distribution of pooled costs between health professional Councils and to dispose or acquire of a portion of its share of the opening carying values of the pooled assets. Refer Note 1 (d).

6. CASH AND CASH EQUIVALENTS

	2014	2013
	$	$
Cash at bank and on hand	1,011	247,142
TCorp Hour Glass investment facility	-	5,347
Cash at bank - held by HPCA*	9,096,946	4,864,232
	9,097,957	**5,116,721**

* This is cash held by the HPCA, an executive agency of the MOH, on behalf of the Council for its operating activities.

7. RECEIVABLES

	2014	2013
	$	$
Prepayments	49,998	21,865
Other receivables	90,227	(543)
Interest receivable	48	13,387
Trade receivables	73,841	131,110
Less: Allowance for impairment	(3,775)	(1,927)
	210,339	**163,892**

Movement in the allowance for impairment

	2014	2013
	$	$
Balance at beginning of year	1,927	3,548
Amounts recovered during the year	-	(1,716)
Increase/(decrease) in allowance recognised in profit or loss	1,848	95
Balance at end of year	**3,775**	**1,927**

Trade receivables have been considered for impairment.

The trade receivables include monies that AHPRA has collected from registrants as at 30 June 2014 and has remitted the monies to HPCA in July 2014.

Analysis of Trade Debtors Overdue	**$**		
2014	**Total**	**Past due but not impaired**	**Considered impaired**
< 3 months overdue	-	-	-
3-6 months overdue	924	924	-
> 6 months overdue	5,623	1,848	3775
2013			
< 3 months overdue	5,806	-	-
3-6 months overdue	2,772	-	-
> 6 months overdue	2,851	924	1,927

Notes

1. Each column in the table represents the 'gross receivables'.

2. The ageing analysis excludes statutory receivables that are not past due and not impaired.

8. PLANT AND EQUIPMENT

Plant and equipment is owned individually by the Council and the Council also has an interest in plant and equipment used by all health professional Councils. The amounts recognised in the financial statements have been calculated based on the benefits expected to be derived by the Council.

	Work in Progress Software / Hardware	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Other	Total
	$	$	$	$	$	$
At 1 July 2013						
Gross carrying amount	109,764	3,615,799	27,769	354,065	491,143	4,598,540
Accumulated depreciation and impairment	-	(1,969,932)	(11,567)	(342,874)	(480,705)	(2,805,078)
Net Carrying Amount	109,764	**1,645,867**	**16,202**	**11,191**	**10,438**	**1,793,462**
At 30 June 2014						
Gross carrying amount	-	3,615,799	28,622	354,065	706,060	4,704,546
Accumulated depreciation and impairment	-	(2,079,187)	(14,951)	(345,978)	(506,124)	(2,946,240)
Net Carrying Amount	**-**	**1,536,612**	**13,671**	**8,087**	**199,936**	**1,758,306**

Reconciliation

A reconciliation of the carrying amount of each class of plant and equipment at the beginning and end of the current reporting period is set out below:

	Work in Progress Software / Hardware	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Other	Total
	$	$	$	$	$	$
Year Ended 30 June 2014						
Net carrying amount at start of year	109,764	1,645,867	16,202	11,191	10,438	1,793,462
Additions	-	-	-	-	214,917	214,917
Disposals	-	-	-	-	-	-
Transfers	(109,764)	-	-	-	-	(109,764)
Other [1]	-	-	1,468	(51)	(7,727)	(6,310)
Depreciation	-	(109,255)	(3,999)	(3,053)	(17,692)	(133,999)
Net Carrying Amount at End of Year	**0**	**1,536,612**	**13,671**	**8,087**	**199,936**	**1,758,306**

	Work in Progress Software / Hardware	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Other	Total
	$	$	$	$	$	$
At 1 July 2012						
Gross carrying amount	-	3,615,799	23,170	341,632	491,143	4,471,744
Accumulated depreciation and impairment	-	(1,866,902)	(2,706)	(338,518)	(449,015)	(2,657,141)
Net Carrying Amount	-	**1,748,897**	**20,464**	**3,114**	**42,128**	**1,814,603**
At 30 June 2013						
Gross carrying amount	109,764	3,615,799	27,769	354,065	491,143	4,598,540
Accumulated depreciation and impairment	-	(1,969,932)	(11,567)	(342,874)	(480,705)	(2,805,078)
Net Carrying Amount	109,764	**1,645,867**	**16,202**	**11,191**	**10,438**	**1,793,462**

Reconciliation

A reconciliation of the carrying amount of each class of plant and equipment at the beginning and end of the prior reporting period is set out below:

	Work in Progress Software / Hardware	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Other	Total
	$	$	$	$	$	$
Year Ended 30 June 2013						
Net carrying amount at start of year	-	1,748,897	20,464	3,114	42,128	1,814,603
Additions	109,764	-	-	12,433	-	122,197
Disposals	-	-	-	-	-	-
Other	-	-	3,639	-	-	3,639
Depreciation	-	(103,030)	(7,901)	(4,356)	(31,690)	(146,977)
Net Carrying Amount at End of Year	109,764	**1,645,867**	**16,202**	**11,191**	**10,438**	**1,793,462**

1. Other includes:

a. Adjustments required to opening balances due to the agreed Cost Allocation Methodology as at 1 July 2013 & 1 July 2012.

9. INTANGIBLE ASSETS

Plant and equipment is owned individually by the Council and the Council also has an interest in plant and equipment used by all health professional Councils. The amounts recognised in the financial statements have been calculated based on the benefits expected to be derived by the Council.

	Software Work in Progress	Software	Total
	$	$	$
At 1 July 2013			
Cost (gross carrying amount)	10,495	1,882,005	1,892,500
Accumulated amortisation and impairment	-	(1,574,932)	(1,574,932)
Net Carrying Amount	**10,495**	**307,073**	**317,568**
At 30 June 2014			
Cost (gross carrying amount)	42,957	1,892,625	1,935,582
Accumulated amortisation and impairment	-	**(1,844,125)**	(1,844,125)
Net Carrying Amount	**42,957**	**48,500**	**91,457**

	Software Work in Progress	Software	Total
	$	$	$
Year Ended 30 June 2014			
Net carrying amount at start of year	10,495	307,073	317,568
Additions	32,462	8,012	40,474
Disposals	-	-	-
Other[1]	-	(4,490)	(4,490)
Amortisation	-	(262,095)	(262,095)
Net Carrying Amount at End of Year	**42,957**	**48,500**	**91,457**

	Software Work in Progress	Software	Total
	$	$	$
At 1 July 2012			
Cost (gross carrying amount)	3,409	1,879,419	1,882,828
Accumulated amortisation and impairment	-	(1,228,910)	(1,228,910)
Net Carrying Amount	**3,409**	**650,509**	**653,918**
At 30 June 2013			
Cost (gross carrying amount)	10,495	1,882,005	1,892,500
Accumulated amortisation and impairment	-	(1,574,932)	(1,574,932)
Net Carrying Amount	**10,495**	**307,073**	**317,568**

	Software Work in Progress	Software	Total
	$	$	$
Year Ended 30 June 2013			
Net carrying amount at start of year	3,409	650,509	653,918
Additions	7,086	-	7,086
Disposals	-	-	-
Other	-	(50)	(50)
Amortisation	-	(343,386)	(343,386)
Net Carrying Amount at End of Year	**10,495**	**307,073**	**317,568**

1. Other includes:

a. Adjustments required to opening balances due to the agreed Cost Allocation Methodology as at 1 July 2013 & 1 July 2012.

10. PAYABLES

	2014	2013
	$	$
Personnel services - Ministry of Health	336,248	293,127
Trade and other payables	1,478,577	1,187,960
	1,814,825	**1,481,087**

11. FEES IN ADVANCE

	2014	2013
Current	$	$
Registration fees in advance	3,119,350	3,002,217
	3,119,350	**3,002,217**

Non-Current	$	$
Registration fees in advance	-	8,470
	-	**8,470**

Registration fees in advance is the unearned revenue from NSW Regulatory Fees received on behalf of the Council by the HPCA from the AHPRA.

12. COMMITMENTS FOR EXPENDITURE

a. Capital Commitments

There is no aggregate capital expenditure contracted for at balance date and not provided for.

Aggregate capital expenditure contracted (2014) was for the computers and software at Building 45 Gladesville Hospital Gladesville.

	2014	2013
	$	$
Not later than one year	-	57,424
Later than one year and not later than five years	-	-
Total (including GST)	**-**	**57,424**

b. Operating Lease Commitments

Future non-cancellable operating lease rentals not provided for and payable:

	2014	2013
	$	$
Not later than one year	79,820	61,784
Later than one year and not later than five years	329,028	283,110
Later than five years	610,499	578,556
Total (including GST)	1,019,347	923,450

13. RELATED PARTY TRANSACTIONS

The Council has only one related party, being the HPCA, an executive agency of the MOH.

The Council's accounts are managed by the MOH. Executive and administrative support functions are provided by the HPCA. All accounting transactions are carried out by the HPCA on behalf of the Council.

14. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

The Health Professional Councils Authority received advice from the Ministry of Health and the Ministry's independent tax advisors to the effect that payments made to Council and Hearing members attract a pay as you go (PAYG) wihtholding tax obligation and superannuation guarantee levy payments. As a result of that advice, the Health Professional Councils Authority had undertaken an audit of the financial records.

The impact of the superannuation back pay adjustments and administration fees has been included in the annual accounts as well as an estimate of the nominal interest as at 30 June 2014. However, the nominal interest component cannot be finally determined until the voluntary disclosure of the superannuation guarantee charge statements by the Health Professional Councils Authority on behalf of the Council are submitted and agreed to by the Australian Taxation Office for all the affected Council and Hearing members.

The variation between the accrued estimated nominal interest and the final agreed amount are considered to be immaterial.

There are no material contingent assets as at 30 June 2014.

15. RECONCILIATION OF NET RESULT TO CASH FLOWS FROM OPERATING ACTIVITIES

	2014	2013
	$	$
Net result	3,324,015	2,394,142
Depreciation and amortisation	396,094	490,363
Allowance for impairment	-	1,621
Increase/(Decrease) in receivables	(46,446)	(24,297)
Increase/(Decrease) in fees in advance	108,662	1,056,491
Increase/(Decrease) in payables	333,735	233,204
Net gain/(loss) on sale of plant and equipment	10,800	(3,589)
Net cash used on operating activities	**4,126,860**	**4,147,935**

16. FINANCIAL INSTRUMENTS

The Council's main risks arising from financial instruments are outlined below, together with the Council's objectives, policies and processes for measuring and managing risk. Further quantitative and qualitative disclosures are included throughout the financial statements.

The Council has overall responsibility for the establishment and oversight of risk management and reviews and agrees on policies for managing each of these risks.

a. Financial Instrument Categories

Financial Assets Class	Note	Category	Carrying Amount 2014	Carrying Amount 2013
			$	$
Cash and Cash Equivalents	6	N/A	9,097,957	5,116,721
Receivables [1]	7	Loans and receivables (measured at amortised cost)	70,114	142,027

Financial Liabilities Class	Note	Category	Carrying Amount 2014	Carrying Amount 2013
			$	$
Payables [2]	10	Financial liabilities (measured at amortised cost)	1,814,825	1,481,087

Notes:
1. Excludes statutory receivables and prepayments (i.e. not within scope of AASB 7).
2. Excludes statutory payables and unearned revenue (i.e. not within scope of AASB 7).
3. There are no financial instruments accounted for at fair value.

b. Credit Risk

Credit risk arises when there is the possibility of the Council's debtors defaulting on their contractual obligations, resulting in a financial loss to the Council. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from the financial assets of the Council, including cash, receivables, and authority deposits. No collateral is held by the Council. The Council has not granted any financial guarantees.

Cash

Cash comprises cash on hand and bank balances held by the Council and the HPCA on behalf of the Council. Interest is earned on the daily bank balances.

Receivables - Trade Debtors

All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. Debts which are known to be uncollectible are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect all amounts due. This evidence includes past experience, and current and expected changes in economic conditions and debtor credit ratings. No interest is earned on trade debtors. The Council is not materially exposed to concentrations of credit risk to a single trade debtor or group of debtors.

c. Liquidity Risk

Liquidity risk is the risk that the Council will be unable to meet its payment obligations when they fall due. The HPCA on behalf of the Council continuously manages risk through monitoring future cash flows and maturities planning to ensure adequate holding of high quality liquid assets.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set out in Treasurer's Direction 219.01. If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received. Treasurer's Direction 219.01 allows the Minister to award interest for late payment.

All payables are current and will not attract interest payments.

d. Market Risk

The Council does not have exposure to market risk on financial instruments.

e. Interest Rate Risk

The Council has minimal exposure to interest rate risk from its holdings in interest bearing financial assets. The Council does not account for any fixed rate financial instruments at fair value through profit or loss or as available-for-sale. A reasonably possible change of +/- 1% is used, consistent with current trends in interest rates. The basis will be reviewed annually and amended where there is a structural change in the level of interest rate volatility.

17. EVENTS AFTER THE REPORTING PERIOD

There are no events after the reporting period to be included in the financial statements as of 30 June 2014.

End of Audited Financial Statements

> appendices

Appendix 1: Legislative changes

Health Practitioner Regulation National Law

The NSW Parliament passed the *Civil and Administrative Legislation (Repeal and Amendment) Act 2013*. The *Civil and Administrative Legislation (Repeal and Amendment) Act* commenced on 1 January 2014 and is one part of the suite of legislation that established the Civil and Administrative Tribunal of New South Wales (NCAT).

The *Civil and Administrative Legislation (Repeal and Amendment) Act* amended the *Health Practitioner Regulation National Law (NSW)* (the Law) to abolish each of the 14 separate health practitioner Tribunals and to incorporate their functions within the Health Practitioner Division List of the Occupational Division of NCAT. NCAT is now the responsible Tribunal as defined in section 5 of the Law.

Extensive consequential amendments were required to Part 8 of the Law along with minor consequential amendments to Part 5A of the Law and to the *Health Practitioner Regulation (New South Wales) Regulation 2010.*

Appendix 2: GIPA statistics 2013/14

The Medical Council is required to report its activity annually in accordance with s125 of the GIPA Act and clause 7 of the Regulations. The statistical reports that follow correspond to Schedule 2 of the *Government Information (Public Access) Amendment Regulation 2010*.

Table 31: Number of GIPA applications – type of applicant and outcome

	Access granted in full	Access granted in part	Access refused in full	Information not held	Information already available	Refuse to deal with application	Refuse to confirm/ deny whether information is held	Application withdrawn
Media								
Members of Parliament								
Private sector business								
Not for profit organisations or community groups								
Members of the public (application by legal representative)		3				1		
Members of the public (other)	1	3	1		1	2		

* More than one decision can be made in respect of a particular access application. If so, a recording must be made in relation to each such decision. This also applies to Table 32.

Table 32: Number of GIPA applications – type of application and outcome

	Access granted in full	Access granted in part	Access refused in full	Information not held	Information already available	Refuse to deal with application	Refuse to confirm/ deny whether information is held	Application withdrawn
Personal information applications*	1	6	1		1	3		
Access applications (other than personal information applications)								
Access applications that are partly personal information applications and partly other								

* A personal information application is an access application for personal information (as defined in clause 4 of Schedule 4 to the Act) about the applicant (the applicant being an individual).

Table 33: Invalid applications

Invalid applications	
Reason for invalidity	**No of applications**
Application does not comply with formal requirements (s 41 of the Act)	0
Application is for excluded information of the agency (s 43 of the Act)	5
Application contravenes restraint order (s 110 of the Act)	0
Total number of invalid applications received	5
Invalid applications that subsequently became valid applications	0

Table 34: Presumption of overriding public interest

Conclusive presumption of overriding public interest against disclosure: matters listed in schedule 1 to Act	
	Number of times consideration used*
Overriding secrecy laws	4
Cabinet information	
Executive Council information	
Contempt	
Legal professional privilege	3
Excluded information	
Documents affecting law enforcement and public safety	
Transport safety	
Adoption	
Care and protection of children	
Ministerial code of conduct	
Aboriginal and environmental heritage	

* More than one public interest consideration may apply in relation to a particular access application and, if so, each such consideration is to be recorded (but only once per application). This also applies in relation to Table 35

Table 35: Other public interest considerations against disclosure

Other public interest considerations against disclosure: matters listed in table to s 14 of Act	Number of occasions when application not successful
Responsible and effective government	1
Law enforcement and security	
Individual rights, judicial processes and natural justice	4
Business interests of agencies and other persons	3
Environment, culture, economy and general matters	
Secrecy provisions	2
Exempt documents under interstate Freedom of Information legislation	

Table 36: Timeliness

Timeliness	Number of applications
Decided within the statutory timeframe (20 days plus any extensions)	5
Decided after 35 days (by agreement with applicant)	2
Not decided within time (deemed refusal)	2
Total	9

Table 37: Applications reviewed – by type of review and outcome

Number of applications reviewed under Part 5 of the Act (by type of review and outcome)	Decision varied	Decision upheld	Total
Internal review		3	3
Review by Information Commissioner*			
Internal review following recommendation under s 93 of Act			
Review by ADT or NCAT			
Total			3

* The Information Commissioner does not have the authority to vary decisions, but can make recommendations to the original decision-maker. The data in this case indicates that a recommendation to vary or uphold the original decision has been made by the Information Commissioner.

Table 38: Applications for review – by type of applicant

Applications for review under Part 5 of the Act (by type of applicant)	Number of applications for review
Applications by access applicants	2
Applications by persons to whom information the subject of access application relates (see s 54 of the Act)	1

Appendix 3: Legal matters in other jurisdictions

Maiocchi v Medical Council of NSW & Ors

In 2012 the plaintiff commenced action in the Federal Court against the Medical Council and others alleging unlawful discrimination and victimisation under the *Racial Discrimination Act 1975 (Cth).* In October 2013 the application was summarily dismissed with costs awarded to the defendants (including the Medical Council), and in March 2014 the plaintiff's application for leave to appeal was also dismissed with costs.

Bar-Mordecai M v Attorney General & Medical Council – Supreme Court no. 2013/270999

The Supreme Court has previously declared the plaintiff to be a vexatious litigant meaning that he must seek the leave of the Court to institute proceedings. This application was for leave to bring proceedings in the NSW Civil and Administrative Tribunal to have an earlier cancellation order made by the former Medical Tribunal reviewed.

The Court's judgment is reserved.

Appendix 4: Digital Information Security Attestation Statement for the 2013/2014 Financial Year

I, Professor Peter Procopis, President of the Medical Council of New South Wales, am of the opinion that the Medical Council had an Information Security Management System in place during the financial year being reported on which is materially consistent with the Core Requirements set out in the *Digital Information Security Policy for the NSW Public Sector* with the following exceptions:

Core requirement 1 –Information Security Management System

Policy PD2013_033, Electronic Information Security Policy - NSW Health applies to the Medical Council. Agreement has been received that at its next update the Policy will be amended in view of the changes in NSW since 1 July 2010 following the enactment of the *Health Practitioner Regulation National Law (NSW)* and the commencement of the *National Registration and Accreditation Scheme*.

The Health Professional Councils Authority's ICT Strategic Plan, to be finalised in 2014/2015, will implement the Ministry of Health Policy Directive PD2013_033 for the Medical Council.

Core requirement 2 – Compliance with Minimum Controls
Full adoption of DFS C2013-5 Information Classification and Labelling Guidelines will be completed in 2014/2015.

An information security review is planned for 2015/2016 as a prelude to seeking ISO 27001 Certification.

Core requirement 3 – Compliance by Shared Service Provider
The Health Professional Councils Authority provided its *Digital Information Security Annual Attestation* for the 2013/2014 Financial Year to the ICT Board on 30 June 2014.

Core requirement 4 – Certified Compliance with AS/NZS ISO/IEC 27001
Compliance for ISO 27001 Certification is to be sought in 2015/2016.

Appendix 5: Workplace diversity statistics

Trends in the Representation of Workforce Diversity Groups

Workforce Diversity Group	Benchmark/Target	2012	2013	2014
Women	50%	N/A	N/A	85.1%
Aboriginal People and Torres Strait Islanders	2.60%	N/A	N/A	0.0%
People whose First Language Spoken as a Child was not English	19.00%	N/A	N/A	2.3%
People with a Disability	N/A	N/A	N/A	0.0%
People with a Disability Requiring Work-Related Adjustment	1.50%	N/A	Prof	0.0%

Trends in the Distribution of Workforce Diversity Groups

Workforce Diversity Group	Benchmark/Target	2012	2013	2014
Women	100	N/A	N/A	N/A
Aboriginal People and Torres Strait Islanders	100	N/A	N/A	N/A
People whose First Language Spoken as a Child was not English	100	N/A	N/A	N/A
People with a Disability	100	N/A	N/A	N/A
People with a Disability Requiring Work-Related Adjustment	100	N/A	Prof	Prof

Note 1: A Distribution Index of 100 indicates that the centre of the distribution of the Workforce Diversity group across salary levels is equivalent to that of other staff. Values less than 100 mean that the Workforce Diversity group tends to be more concentrated at lower salary levels than is the case for other staff. The more pronounced this tendency is, the lower the index will be. In some cases the index may be more than 100, indicating that the Workforce Diversity group is less concentrated at lower salary levels.

Note 2: The Distribution Index is not calculated where Workforce Diversity group or non-Workforce Diversity group numbers are less than 20.

Appendix 6: Payments Performance

The Medical Council's accounts are managed by the Health Administration Corporation. The consolidated accounts payable performance report for all 14 Councils is as shown below:

Table 29: Payments performance 2013/14

Quarter	Current (within due date)	Less than 30 days overdue	Between 30 to 60 days overdue	Between 60 to 90 days overdue	More than 90 days overdue
	$	**$**	**$**	**$**	**$**
All suppliers					
September	1,832,116	6,704	-	-	-
December	1,137,594	2,880	-	-	-
March	1,327,468	4,705	2,316	2,494	-
June	1,585,322	11,586	68	2,658	-
Small business suppliers					
September	636,714	5,204	-	-	-
December	178,388	2,400	-	-	-
March	399,398	2,720	2,316	2,494	-
June	291,675	9,455	68	2,376	-

Measure	**Sept**	**Dec**	**Mar**	**June**
All suppliers				
Number of accounts due for payment	203	121	210	133
Number of accounts paid on time	195	117	205	121
% of accounts paid on time (based on number of accounts)	96.1	96.7	97.6	91
$ amount of accounts due for payment	1,838,819	1,140,474	1,336,982	1,599,633
$ amount of accounts paid on time	1,832,116	1,137,594	1,327,468	1,585,322
% of accounts paid on time (based on $)	99.6	99.7	99.3	99.1
Number of payments for interest on overdue accounts	0	0	0	0
Interest paid on overdue accounts	0	0	0	0
				-
Measure	**Sept**	**Dec**	**Mar**	**June**
Small business suppliers				
Number of accounts due for payment	173	101	181	101
Number of accounts paid on time	167	97	177	92
% of accounts paid on time (based on number of accounts)	97	96	98	91
$ amount of accounts due for payment	641,918	180,788	406,927	303,574
$ amount of accounts paid on time	636,714	178,388	399,398	291,675
% of accounts paid on time (based on $)	99	99	98	96
Number of payments for interest on overdue accounts	0	0	0	0
Interest paid on overdue accounts	0	0	0	0

Glossary of terms

Adjudication Body	A term used in the Health Practitioner Regulation National Law ((NSW) to describe the decision making bodies, including: Tribunals, Courts, Professional Standards Committees, Councils, and Performance Review Panels
Caution	A formal outcome of disciplinary proceedings that is intended to act as a deterrent to a practitioner not to repeat specified conduct
Complainant	A person whose correspondence to any of the following is dealt with as a complaint under the *Health Practitioner Regulation National Law (NSW)*, and the *Health Care Complaints Act*: • Health Professional Councils Authority (HPCA) • Health Care Complaints Commission (HCCC) • Australian Health Practitioner Regulation Agency (AHPRA)
Conciliation	A process conducted by the HCCC with a view to a complainant and the subject/s of a complaint negotiating a resolution
Condition	Text attached to a practitioner's registration which imposes restrictions or obligations on the practitioner
Conducted	A matter has been conducted when an Adjudication Body or review/interview panel has received some or all of the evidence (by oral hearing and/or written submissions), but the matter is adjourned or not yet completed, in that the outcome and/or the written reasons have not been handed down
Closed	A complaint/notification is closed when there is a final outcome regarding the matters raised in or by the complaint/notification. (Closure may occur on initial assessment of a complaint by the Council and HCCC, or may not occur until the completion of the hearing of a matter before an adjudication body.)
Director of Proceedings	Following investigation of a complaint by the HCCC, if it appears disciplinary action may be warranted, the HCCC's Director of Proceedings is the person responsible for independently determining whether a complaint should be prosecuted. Prior to reaching this decision, the DP is required to consult with the Medical Council
Endorsed	Under the *Health Practitioner Regulation National Law (NSW),* Impaired Registrant Panels make recommendations for the Medical Council to consider. If the Council accepts the recommendations, they are considered to be endorsed and are put into effect. Similarly, a Performance Interview or Performance Assessment can make recommendations to the Council following an interview or assessment. Again, if accepted, the recommendations are considered to be endorsed, and are put into effect
Exiting Health Program	A practitioner who participates in the Health Program is described as exiting the program at the point where the Medical Council decides conditions relating to a practitioner's health are no longer necessary and health goals have been met. Exiting the Health program includes the practitioner attending an exit interview with the Council
Exiting Performance Program	A practitioner who participates in the Performance Program is described as exiting the program at the point where the Medical Council decides conditions relating to a practitioner's performance are no longer necessary and health goals have been met. Exiting the Health program includes the practitioner attending an exit interview with the Council
Finalised	A matter is finalised when there is a final outcome that can be described or measured by its effect, for example when an adjudication body delivers its findings and any orders and hands down its written reasons for decision
Impaired Registrants Panel (IRP)	An inquiry convened to enquire into impairment matters that come to the attention of the Medical Council. The Panel consists of two or three members appointed by the Council from a pool of doctors and lay members who are experienced in working with practitioners experiencing problems with their health

Impairment	As defined by the *Health Practitioner Regulation National Law (NSW),* in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect— (a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or (b) for a student, the student's capacity to undertake clinical training— (i) as part of the approved program of study in which the student is enrolled or (ii) arranged by an education provider
Interim Immediate Action	The suspension of a practitioner's registration or the imposition of conditions as an interim protective measure by the Council
Mandatory notification	A statutory obligation on registered health practitioners, employers of registered health practitioners and education providers to inform the relevant National Board of 'notifiable conduct', as defined under section 140 of the *Health Practitioner Regulation National Law (NSW)*
National Boards	Bodies appointed by the Ministerial Council with responsibility for the registration and regulation of health professionals. Functions are in the public interest and as set out in the *Health Practitioner Regulation National Law.* The Medical Board of Australia is the National Board for the medical profession
Notifiable conduct	Is defined in section 140 of the *Health Practitioner Regulation National Law (NSW).* It consists of practising the profession while intoxicated by alcohol or drugs, engaging in sexual misconduct, placing the public at risk of substantial harm because the practitioner has an impairment, or placing the public at risk of harm by practising in a way that constitutes a significant departure from accepted professional standards
Reprimand	A formal outcome of disciplinary proceedings consisting of a chastisement for conduct or a formal rebuke
Notification	Information or complaint about the performance, conduct or health of a medical practitioner made by another health practitioner, employer, education provider or another party
Open	A complaint/notification remains open until such time as a final outcome or decision has been made by the Council and HCCC or other adjudication body. This decision disposes of the matter
Preliminary assessment	When the Medical Council and HCCC meet following the receipt of a complaint or notification to determine the most appropriate way to manage and respond to the issues identified in the complaint or notification
Professional misconduct	Defined in section 139E of the *Health Practitioner Regulation National Law (NSW).* A complaint of professional misconduct is more serious than a complaint of unsatisfactory professional conduct
Professional performance	Professional performance of a registered health practitioner is a reference to the knowledge, skill or judgment possessed and applied by the practitioner in the practice of the practitioner's health profession
Unsatisfactory professional conduct	Has several definitions in sections 139B and 139C of the *Health Practitioner Regulation National Law (NSW).* The most common definitions being 1) conduct that is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience, and 2) conduct that is improper or unethical that relates to the practice or purported practice of the practitioner's profession. A complaint of professional misconduct is more serious than a complaint of unsatisfactory professional conduct
Unsatisfactory Professional Performance	The professional performance of a registered health practitioner is unsatisfactory if it is below the standard reasonably expected of a practitioner of an equivalent level of training or experience

Glossary of monitoring terms

Drug and alcohol testing conditions

Urine testing

Urine testing is the main monitoring and rehabilitation tool utilised by the Medical Council. Urine testing may be a requirement for practitioners or medical students with a history of substance and/or alcohol abuse or about whom concerns have been identified regarding possible self administration of prescribed or illicit substances. Two types of urine testing are utilised the Council:

1. Urine drug testing

Drugs routinely tested for include cannabis, opiates (morphine and codeine), cocaine, amphetamine and benzodiazepines. In addition, specimens are tested for pethidine and tramadol. In certain cases, conditions may also require specimens to be tested for additional drugs (such as zolpidem (Stilnox), propofol and fentanyl).

2. Ethyl Glucuronide (EtG) Testing

Ethyl Glucuronide (EtG) is a specific and sensitive biomarker of ethanol consumption. EtG is a metabolite of alcohol that is much more slowly eliminated from the body than alcohol itself. It is the best marker currently available to monitor abstinence from alcohol and has been adopted by the Medical Council for use in circumstances where abstinence is required.

Blood testing

A practitioner or medical student may be required to undertake Carbohydrate-Deficient Transferrin (CDT) testing where the presenting health problem is related to the harmful use of alcohol. The test is designed to identify excess consumption or harmful use of alcohol.

Chaperone

From time-to-time the Council becomes aware of a medical practitioner facing criminal charges in the nature of sexual assault. In addition, complaints alleging serious sexual misconduct may be made which may not result in criminal charges. As well as referring a complaint to the Health Care Complaints Commission for investigation, the Council's usual practice is to seek information about the nature of the practitioner's practice of medicine and to obtain any available information about the matter and other relevant criteria, in order to consider whether or not urgent interim action should be taken.

This type of condition requiring the use of a chaperone may be ordered as a result of Council proceedings pursuant to section 150 of the Health Practitioner Regulation National Law (NSW). The imposition of such conditions is an interim protective measure pending finalisation of the matter that necessitated the conditions being imposed.

Mentor

This type of condition is most commonly imposed when a practitioner has been absent from clinical practice for some period of time, has encountered difficulties in their practice or suffers from a condition which affects or might affect their practice of medicine.

A practitioner is usually required to nominate a mentor who will be approved by the Council. The mentor may be required to report to the Council and to confirm that they have acted as mentor for a period of time or to notify the Council of significant difficulties experienced by the subject practitioner.

Supervisor

Supervision conditions may be imposed on a practitioner's registration for some or all of the following reasons:

- Monitoring compliance with conditions.
- Monitoring capacity to practise medicine safely.
- Monitoring performance.
- Providing the Medical Council with regular feedback on these matters.
- Providing peer support for the supervised practitioner.

Audit

An audit is an assessment of a practitioner's clinical practice by an independent body, namely an auditor appointed by the Council. Practitioners are required to undergo an audit of their clinical practice as a result of a hearing by a determining authority such as a Professional Standards Committee, Performance Review Panel, Section 150 proceedings, or the Medical Tribunal. The purpose of an audit varies from case to case, but is likely to include one or more of the following:

- Assessment of compliance with conditions or orders;
- Assessment of aspects of clinical performance; and/or
- Assessment of aspects of practice accommodation / facilities / equipment.

Critical Compliance

A Medical Tribunal or Professional Standards Committee may direct that a specific order or condition is a critical compliance condition. A breach of a critical compliance condition or order results in the immediate suspension of a practitioner's registration.

Index